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REDUCING HEALTH CARE COSTS FOR WORKING AMERICANS AND THEIR FAMILIES

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH, EMPLOYMENT, LABOR, AND PENSIONS

OF THE

COMMITTEE ON EDUCATION AND THE WORKFORCE

U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED EIGHTEENTH CONGRESS

FIRST SESSION

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QUESTIONS FOR THE RECORD

REDUCING HEALTH CARE COSTS FOR WORKING AMERICANS AND THEIR FAMILIES

Wednesday, April 26, 2023

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH, EMPLOYMENT, LABOR, AND PENSIONS,
COMMITTEE ON EDUCATION AND THE WORKFORCE,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:15 a.m., Room 2175, Rayburn House Office Building, Hon. Bob Good [chairman of the subcommittee] presiding.

Present: Representatives Good, Walberg, Allen, Banks, Smucker, Bean, Burlison, DeSaulnier, Courtney, Norcross, Wild, Jayapal, McBath, Hayes, Omar, Manning, Scott.

Staff present: Cyrus Artz, Staff Director; Mindy Barry, General Counsel; Michael Davis, Legislative Assistant; Cate Dillon, Director of Operations; Daniel Fuenzalida, Staff Assistant; Sheila Havenner, Director of Information Technology; Taylor Hittle, Professional Staff Member; Alex Knorr, Legislative Assistant; Andrew Kuzy, Press Assistant; John Martin, Deputy Director of Workforce Policy/Counsel; Hannah Matesic, Director of Member Services and Coalitions; Audra McGeorge, Communications Director; Rebecca Powell, Staff Assistant; Seth Waugh, Brittany Alston, Minority Operations Assistant; Ilana Brunner, Minority General Counsel; Daniel Foster, Minority Health and Labor Counsel; Carrie Hughes, Minority Director of Health and Human Services Policy; Stephanie Lalle, Minority Communications Director; Kota Mizutani, Minority Deputy Communications Director; Veronique Pluviose, Minority Staff Director; Dhrtvan Sherman, Minority Staff Assistant; Banyon Vassar, Minority IT Administrator.

Chairman GOOD. The Subcommittee on Health Employment Labor and Pensions will come to order. I note that a quorum is present. Without objection, the Chair is authorized to call a recess at any time. The subcommittee is meeting today on solutions to address healthcare challenges facing working families and small businesses.

Good morning, everyone, and welcome to today's hearing. I can remember President Obama's promises regarding Obamacare. If you like your plan, you can keep your plan. If you like your doctor, you can keep your doctor. Premiums will go down with the Affordable Care Act. Sadly, but not surprising, these were all misleading, empty, broken promises.

In reality, Obamacare's regulations mandate inflationary subsidies and misguided economic incentives have made healthcare

even more unaffordable for Americans in the commercial market. It is no surprise that for 13 years of Obamacare, three in four Americans grade the healthcare system as a D or an F.

Working Americans and their families are being crushed, and the American people are tired of their premiums going up. They are tired of their deductibles going up. They are tired of their copay going up. Today, in this first Health Employment Labor and Pension Subcommittee hearing of the 118th Congress, House Republicans will put forth a vision for free market healthcare reform that offers Americans much needed relief.

As a nation, we cannot settle for less than American exceptionalism. We cannot turn to socialist countries for our healthcare advice. We need to listen to the American people. A vast majority of Americans are actually satisfied with their employer sponsored insurance.

78 percent of employees choose to enroll in employer sponsored insurance when given the option. It is still too expensive. That is because Democrats have created an unlevel playing field for employers. Democrats are not interested in addressing affordability issues for employers because the truth is they are scheming with the Biden administration to force every American into a government funded one size fits all plan, such as the Obamacare Marketplace Plan.

By increasing Obamacare subsidies and overregulating the market, employer-based healthcare is becoming unaffordable, especially for small business owners. This is an intentional attack by Democrats on private insurance is the proverbial trojan horse for Medicare for all. One size does not fit all.

The correct path forward is to respect and protect a free market and individual choice. Republican solutions seek to decrease healthcare costs, while strengthening the public option that 159 million Americans who are covered enjoy today. Yesterday, I introduced the Self Insurance Protect Act. This bill allows small businesses to access stock loss insurance, a form of insurance that helps employers self-insure, and protects them from catastrophic health costs.

Another reasonable solution is to increase association health plans. These plans allow Americans to save up to 50 percent on healthcare costs by allowing small businesses to band together to offer lower cost healthcare insurance like large employers are able to do.

The free market and increased competition will lower prices if we are bold enough to let them do that. A free market only works when there is competition, transparency, and accountability. Consolidation of marketplace has led to dishonest billing practices. Dishonest billing occurs when big hospitals buy up independent doctors' offices, and then charge higher prices for doctor services as if they were occurring in a hospital setting.

Hospitals should bill the proper rate for their services and not use bogus facility fees as an excuse to tack on thousands of dollars in extra charges. Finally, we should ensure that workers retain access to the deregulated telehealth options they enjoyed during the COVID–19 health restrictions. With that, I look forward to the hearing today, and yield to our Ranking Member.

[The Statement of Chairman Good follows:]

STATEMENT OF HON. BOB GOOD, CHAIRMAN, SUBCOMMITTEE ON HEALTH, EMPLOYMENT, LABOR, AND PENSIONS

I remember President Obama's promises regarding Obamacare:

"If you like your plan, you can keep your plan."

"If you like your doctor, you can keep your doctor."

"Premiums will go down with the Affordable Care Act."

Sadly, but not surprisingly, these were all misleading, empty, broken promises.

In reality, Obamacare's regulations, mandates, inflationary subsidies, and misguided economic incentives have made health care even more unaffordable for Americans in the commercial market.

After thirteen years of Obamacare, three in four Americans grade the health care system as a "D" or an "F."

Working Americans and their families are being crushed. The American people are tired of their premiums going up. They are tired of their deductibles going up. They are tired of their co-pays going up.

Today, in the first Health, Employment, Labor, and Pensions Subcommittee hearing of the 118th Congress, House Republicans will put forth a vision for free-market health care reform that offers Americans much-needed relief.

As a nation, we cannot settle for less than American exceptionalism. We cannot turn to socialist countries for health care advice.

We need to listen to the American people. A vast majority of Americans are actually satisfied with their employer-sponsored insurance. Seventy-eight percent of employees decide to enroll in employer-sponsored insurance when given the option. It is still too expensive.

That is because Democrats have created an unlevel playing field for employers.

Democrats are not interested in addressing affordability issues for employers, because the truth is, they are scheming with the Biden administration to force every American into a government-funded, one-size-fits-all plan, such as the Obamacare marketplace plans.

By increasing Obamacare subsidies and overregulating the market, employer-based health care is becoming unaffordable, especially for small business owners.

This is an intentional attack by Democrats on private insurance. It is the proverbial "trojan horse" for Medicare-for-All.

One size does not fit all. The correct path forward is to respect and protect the free market, and individual choice.

Republican solutions seek to decrease health care costs while strengthening the private options that 159 million covered Americans enjoy.

Yesterday, I introduced the Self-Insurance Protection Act. This bill allows small businesses to access stop-loss insurance, a form of insurance that helps employers self-insure and protects them from catastrophic health costs.

Another reasonable solution is to increase Association Health Plans. These plans allow Americans to save up to 50 percent on health care costs by allowing small businesses to band together to offer lower-cost health insurance like larger employers are able to do. The free market and increased competition will lower prices if we are bold enough to let them.

A free market only works when there is competition, transparency, and accountability. Consolidation in the marketplace has led to dishonest billing practices. Dishonest billing occurs when big hospitals buy up independent doctors' offices and then charge higher prices for doctor services as if they were occurring in a hospital setting.

Hospitals should bill the proper rate for their services and not use bogus facility fees as an excuse to tack on thousands of extra dollars in charges.

Finally, we should ensure that workers retain access to the expanded telehealth options they enjoyed during the COVID–19 waivers. On May 11, employees may lose access to telehealth coverage when the COVID–19 Public Health Emergency expires. The Telehealth Benefit Expansion for Workers Act will ensure that telehealth coverage is not terminated for these workers.

Stop-loss insurance, Association Health Plans, honest billing, and increased access to telehealth will help increase affordability for American workers and their families.

Employer-sponsored insurance is the greatest threat to, or defense against—depending on your perspective—Medicare-for-All.

Letting Democrats continue to further diminish employer-sponsored insurance—to the detriment of American families—is a major step toward realizing their coveted cradle-to-grave nanny state.

That is not America. We are the most free and prosperous nation in history. Small business owners and working families, through hard work, perseverance, and determination have made our nation great. Washington bureaucrats should stay out of the way.

Let us empower Americans to have the health care they choose at an affordable cost.

Mr. DESAULNIER. Thank you, Mr. Chairman. I want to thank the witnesses for being here. I appreciate the comments as a former small business owner or restaurant owner. 13 years ago, 48 million Americans, more than 14 percent of the U.S. population, did not have health coverage at all.

Insurers could deny people coverage because of pre-existing conditions. Insurers could charge women more than men for health insurance. Most individual market plans only covered a fraction of prescription drugs. Today, more Americans are covered and have better health care protections than ever before.

This is a direct result of the key steps Democrats took to expand and protect access to affordable high-quality health care coverage. In 2010, President Barack Obama signed into law the Affordable Care Act, which provided millions of Americans with access to quality coverage and key consumer protections. Thanks to this milestone achievement, insurers could no longer deny people coverage for pre-existing conditions.

Plans must cover preventative services, like cancer screenings and birth control at no cost. Mental health and substance use disorder treatment is considered an essential health benefit. During the last two Congresses we built on the progress of the ACA and took decisive steps to lower health care costs even further for Americans.

We passed bipartisan legislation to protect Americans from surprise medical billing, and improved transparency and health care. Congressional Democrats passed the American Rescue Plan, which enhanced the ACA tax credits to lower monthly costs for low-income individuals, and eliminated the subsidy cliff, so that more low-and moderate-income individuals could get coverage.

Last, Democrats passed the Inflation Reduction Act. This historic legislation extended the premium on tax credit enhancements, capped the cost of insulin. For people with Medicare, and for the first time, directed the Federal Government to negotiate lower prices for prescription drugs covered by Medicare.

These victories have yielded real results, lowering costs, and making health care more affordable. Clearly, we have a difference of perspective. In August, we brought the number of Americans without health insurance down to the lowest level ever. In fact, during the most recent Open Enrollment Period, a record 16.3 million people signed up for coverage, and the average consumer has saved hundreds of dollars a year in premiums.

Unfortunately, our progress under the ACA continues to be threatened. For more than a decade, our colleagues and conservative groups have worked relentlessly to erode or eliminate the ACA. Just last month, the conservative judge in Texas ruled to weaken the ACA's preventive services requirement.

This has jeopardized access to preventative care ACA for millions who otherwise would not be able to afford it. For context, this is

the same judge who attempted to eliminate the entire ACA, before it was upheld by the U.S. Supreme Court. I am concerned about the development since I know that many of us may not see eye to eye on many things, but the value and importance of preventative care is undeniable to ensuring the health and well-being of our country.

Moreover, we know that preventative care can result in lower costs by managing chronic disease, supporting mental health costs, and more, and it helps employers and employer-based health care. Unfortunately, many of our colleagues' proposals that we will hear today could undermine affordability and ultimately make it harder, not easier, to access quality coverage.

However, we will keep an open mind and hope for progress in compromise with our colleagues. Expanding American health plans might provide low premiums for some enrollees, but it would increase costs for other consumers in the traditional insurance market, while adding nothing to address the underlying price of health care.

This is a bad deal for American workers, and for small businesses. Similarly, exempting telehealth plans from key consumer protection, such as mental health parity on the ACA's preventive services requirement, could expose workers to deceptive marketing practices that we have seen emerge when employers offer similar unregulated arrangements.

Done properly, I think that is something we could look at. Instead of going backward, we should be focusing on expanding quality health coverage for all Americans, workers and families, employers, and their employees.

This Congress, we have several opportunities to make bipartisan progress, and I look forward to that engaged discussion, irrespective of where we may start on these issues. We can work together to strengthen the ACA, and close the Medicaid coverage gap, which would help millions of people access subsidized coverage.

We can bolster enforcement of mental health parity and ensure that health plans follow the law. We can build on our progress to empower the Federal Government and all Americans to be able to negotiate and have the benefit of lower costs for even higher quality and more controls over prescription drugs, many of which have started their discovery process with taxpayer investments at the National Institutes of Health.

We can increase transparency in our health care system and take a careful look at business practices that lead to higher prices and provider consolidation. Look, there are many different views on how to lower health care costs, and I think you have heard some different perspectives already from the Chairman and myself.

I hope we can work together in good faith to deliver on our commitment, that we mutually agree that extraordinary health care, and the idea of American exceptionalism is something we should all expect for all Americans. I look forward to the discussion, and I yield back.

[The Statement of Ranking Member DeSaulnier follows:]

STATEMENT OF HON. MARK DESAULNIER, RANKING MEMBER, SUBCOMMITTEE ON HEALTH, EMPLOYMENT, LABOR, AND PENSIONS

Thank you, Mr. Chairman. I want to thank the witnesses for being here. I appreciate the comments as a former small business owner-a restaurant owner.

Thirteen years ago, 48 million Americans-more than 14 percent of the U.S. population-did not have health coverage at all.

Insurers could deny people coverage because of pre-existing conditions. Insurers could charge women more than men for health insurance.

Most individual market plans only covered a fraction of prescription drugs. Today, more Americans are covered, and have better health care protections, than ever before.

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These victories have yielded real results—lowering costs and making health care more affordable. Clearly, we have a difference of perspective.

In August, we brought the number of Americans without health insurance down to the lowest level ever. In fact, during the most recent Open Enrollment Period, a record 16.3 million people signed up for coverage. The average consumer has saved hundreds of dollars a year in premiums.

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Just last month, a conservative judge in Texas ruled to weaken the ACA's preventive services requirement. This has jeopardized access to preventive care for millions who otherwise may not be able to afford it. For context, this is the same judge who attempted to eliminate the entire ACA before it was upheld by the United States Supreme Court.

I am concerned about the development, since I know that many of us may not see eye to eye on many things, but the value and importance of preventive care is undeniable to ensuring the health and wellbeing of our country. Moreover, we know that preventive care can result in lower costs by managing chronic disease, supporting mental health costs, and more. It helps employers with employer-based health care.

Unfortunately, many of our colleagues' proposals that we will hear today could undermine affordability and ultimately make it harder—not easier—to access quality coverage. However, we will keep an open mind and hope for progress and compromise with our colleagues.

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We can increase transparency in our health care system and take a careful look at business practices that lead to higher prices and provider consolidation.

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I look forward to the discussion, and I yield back.

Chairman GOOD. Thank you, Ranking Member DeSaulnier. Pursuant to Committee Rule 8(c), all members who wish to insert written statements into the record may do so by submitting them to the committee clerk electronically, in Microsoft Word format by 5 p.m., 14 days after the date of this hearing, which is May 10, 2023.

Without objection, the hearing record will remain open for 14 days to allow such statements and other extraneous materials referenced in the hearing to be submitted for the official hearing record.

I now turn to the introduction of our distinguished witnesses. Our first witness is Ms. Tracy Watts, who is a Senior Partner with Mercer, and leads the company's healthcare policy and group benefits portfolio for regions of the United States. Thank you, Ms. Watts.

Our second witness is Ms. Marcie Strouse, who is a small business owner, and founder of Capitol Benefits Group in Des Moines, Iowa. Thank you, Ms. Strouse.

Our third witness is Ms. Sabrina Corlette, who is the Senior Research Professor at the Center on Health Insurance Reforms, Georgetown University's Health Policies Institute.

Our final witness is Mr. Joel White, who is President, Council for Affordable Health Coverage. I thank all of our witnesses for being here today. We look forward to your testimony.

Pursuant to committee rules, I would ask that each of you limit your oral presentation to a 5-minute summary of your written statement, and I would also like to remind the witnesses be aware of the responsibility to provide accurate information to this subcommittee. I will first recognize Mrs. Tracy Watts.

STATEMENT OF MRS. TRACY WATTS, SENIOR PARTNER, MERCER

Mrs. WATTS. My name is Tracy Watts, and I am the Senior Partner and U.S. Health Policy leader at Mercer. I am also the immediate past Board Chair of the American Benefits Council. I have more than 35 years of experience helping large companies design, finance and manage their health benefit programs to control costs, and to improve the health of the workforce.

First of all, we applaud the committee's work and commitment to address healthcare affordability. We surveyed over 4,000 workers in late 2022, and 68 percent say they had challenges getting the healthcare that they need for themselves and for their family.

Those most concerned with affordability are low-income workers, female workers, workers below the age of 25, and over the age of 44. Access to healthcare is also an issue, finding a doctor, getting into a specialist, and getting time off from work to go to the doctor.

In our employer research two-thirds of large employers say that improving healthcare affordability for their employees is a very important, or important priority for the next few years. A couple of examples of how they are doing that from a plan design perspective, 39 percent are offering a copay medical plan with little or no deductible. From a contribution perspective, 15 percent are offering free employee only coverage in one medical plan.

Given the outlook for faster healthcare cost growth, you might expect that employers would start to pull back on health benefits. From our February/March survey on benefit strategies for 2024, it does not look like it. Nearly two-thirds say that they are planning to make enhancements to their health benefits as a way to improve attraction and retention—two-thirds.

I would like to quickly touch on three topics associated with new legislation being introduced. Telehealth, when offered as an accepted benefit, meets a very specific need for certain employers, with a large number of employees who are not benefits eligible. These are mostly part-time workers in retail, hospitality, and healthcare.

Because of legislative uncertainty, we saw a decline in employers using this strategy. 7 percent use it in 2023, that is down from 17 percent in 2022. This is a benefit that is hugely valued by workers, but employers need permanent legislation for this coverage to be restored.

As an example, we worked with a large restaurant chain that extended telehealth to its part-time population. They viewed this benefit as a critical way to provide access to behavioral health services and appropriate medication when the employee who was not enrolled in the health plan gets sick. Next, with regard to legislation to ban unfair hospital billing practices, market consolidation and cost pressures have driven opportunistic billing practices by obfuscating where service is provided.

Non-hospital services are billed using a hospital address as the place of service to optimize reimbursement at the hospital reimbursement rate. This raises prices for patients, it raises prices for employer plan sponsors. It raises prices for the Federal Government, and it is unfair. The most common example is the addition of hospital facility charge on a bill for an office visit that takes place miles away from the hospital, or worse yet, for a virtual visit.

Another example is an urgent care facility where care is billed as a hospital emergency department visit. As a country, we cannot fix this problem if we cannot see the problem. The practices are increasing the costs for everyone, and if we are serious about managing costs and making healthcare more affordable, we need to address the core issue.

We need more transparency on this. With regard to regulation of stop loss for small businesses, in the small 50 to 499 employee

group size, 71 percent of those companies buy an insured plan. The 29 percent self-fund the stop loss. That number flips to 71 percent to self-fund the stop loss in the 500 to 999 category.

Self-funding with stop loss allows companies to balance their financial objectives with their ability to manage risk, and it allows for greater flexibility to design benefits to address affordability and employees' needs. In this competitive environment, even with healthcare inflation, employers are looking for ways to enhance benefits, and to address affordability, and that means workers win.

Thank you for the opportunity to be here today.

[The Statement of Tracy Watts follows:]

Testimony Before the Committee on Education and the Workforce
Subcommittee on Health, Employment, Labor, and Pensions

April 26, 2023

Tracy Watts
Senior Partner and US Healthcare Policy Leader
Testifying on behalf of Mercer and The American Benefits Council

My name is Tracy Watts. I'm a Senior Partner and US Healthcare Policy Leader at Mercer. I am also the immediate past Board Chair of the American Benefits Council. Mercer is a business unit of Marsh McLennan, the world's leading professional services firm in the areas of risk, strategy and people. We are a U.S. company with more than 85,000 colleagues worldwide, advising public and private sector clients in 130 countries. The American Benefits Council is a Washington D.C.-based employee benefits public policy organization advocating for employers that are dedicated to the achievement of best-in-class solutions that protect and encourage the health and financial well-being of their workers, retirees and families.

I have more than 35 years of experience helping large and jumbo companies in the US design, finance and administer their healthcare programs to control costs and improve the health or their workforce.

Starting off with affordability. We applaud the work of your committee and Congressional focus on health care affordability.

From Mercer's Inside Employee Minds research conducted in the 3rd quarter of 2022 with over 4,000 **workers**, 68% say they have challenges getting healthcare for themselves and their family. Affordability and provider availability were the top concerns overall – with low income workers, female workers and workers below age 25 and over age 44 most concerned with affordability. Access is also an issue – finding a doctor, getting into a specialist, getting time off from work to go to the doctor.

In our **employer research**, two-thirds of large employers said that "Improving healthcare affordability" for their employees is an important or very important health program priority for the next few years. In response, 39% are offering a co-pay medical plan with little or no deductible. From a contribution perspective, 19% have salary based contributions, designed to help lower-salaried workers, and 15% are offering free employee-only coverage in one medical plan.

Given the outlook for faster heath care cost growth, you might expect employers to start to pull back on health benefit offerings. But based on results from our latest Survey on Health and Benefits Strategies for 2024, fielded in February and March of this year, it doesn't look like it. Nearly two-thirds – 64% – say they are planning to make enhancements to their health and well-being offerings to improve employee attraction and retention and better meet employee needs, and over a quarter made health benefits enhancements within the past two years. This tells us employers and employees are focused on the need to reduce costs while maximizing access.

I'd like to quickly touch on three topics associated with new legislation being introduced.

Telehealth, when offered as an excepted benefit, meets a very specific need for certain employers with large numbers of employees who are not benefit eligible mostly in retail, hospitality and healthcare. Because of legislative uncertainty, we saw a decline in employers using this strategy – to 7% in 2023 from 17% in 2022. This is a benefit that is hugely valued by employees – but employers need permanent legislation for this coverage to be restored.

As an example, we work with a large restaurant chain that extended telehealth to its non-enrolled, part-time population. They view the telehealth benefit as a critical way to provide access to behavioral health services and appropriate medication when an employee who is not enrolled in the health plan gets sick.

Legislation to ban Unfair Hospital Billing Practices: Market consolidation and cost pressures have driven "opportunistic billing practices" by obfuscating where a service is provided. Non-hospital services are billed using a hospital address as the place of service to optimize reimbursement at the hospital reimbursement rate. This raises prices for patients. This raises prices for employers. This raises prices for the federal government and it is unfair.

In addition to higher prices, consumers may see other unfair hospital billing practices that increase their costs. The most common example is the addition of a hospital *facility charge* added to the bill for an office visit that takes place miles from the hospital, or worse yet a virtual visit. Another example is an urgent care facility where care is billed as a Hospital Emergency Department visit.

As a country, we cannot fix this problem if we cannot see the problem.

Government reimbursement policies are a driver of this market perversion. Those policies are increasing costs for patients and the plans that pay their medical bills. If we are serious about managing costs and making health care more affordable we need to address the core issues. Starting with eliminating these Unfair Hospital Billing Practices.

Over-regulation of stop-loss for small business at federal and state level: Employers must have the flexibility to manage health care spending in a manner that best suits their financial needs and ability to manage risk. This is instrumental in keeping employers engaged with their employee's health care needs and enable them to continue sponsoring health plans.

I included some background information on the use of stop-loss insurance in an attachment. In the 50-499 employee group size 71% of the companies buy an insured plan, 29% self-fund with stop-loss. That number flips to 71% self-fund with stoploss in the 500 to 999 employee category. Self-funding offers companies flexibility to design benefits to address affordability and their employee's needs.

And as I mentioned in the beginning of my statement – in this competitive environment, even with health care inflation, employers are looking for ways to enhance benefits and address affordability – and that means workers win!

Thank you for the opportunity to be here today.

Mercer research

1. What workers want: 2022 Inside Employees' Minds Results
2. Survey on Employer Health & Benefit Strategies for 2024
3. Stop-loss 101

Mercer

welcome to brighter

1. Research on what workers want

2022 Inside Employees' Minds Results

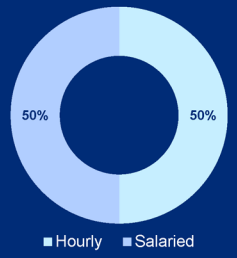
A business of Marsh McLennan

2022 Inside Employees' Minds

About this study

4,049

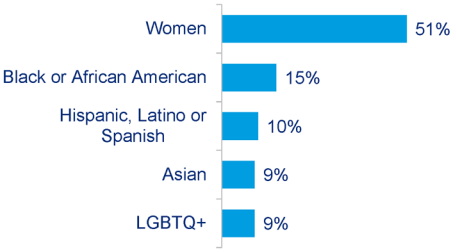
Full-time employees in the United States, working for organizations with more than 250 employees. The survey was conducted between August 26 and September 9, 2022.



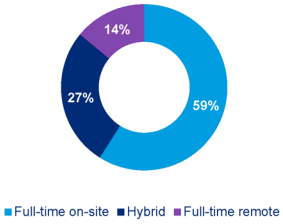
Top Industries with more than 500 employees

1. **Food Service, Retail and Hospitality**
2. **High Tech, Telecom and IT**
3. **Insurance, Financial Services & Banking**
4. **Healthcare**

Representation of diverse groups



Work arrangements



Source: Mercer's 2022 Inside Employees' Minds© Study

Mercer

What's keeping employees up at night?

Two years of multiple existential crises are weighing heavily on workers. They are worried about their health and well-being:

Short-term financial health

Covering Monthly Expenses

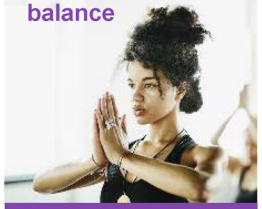
is the #1 concern of workers - up from #9 in 2021

Long-term financial security

Only 46%

of workers are confident they can turn their retirement savings into a consistent stream of income to last the rest of their lives

Work life balance



51%

of workers report feeling exhausted on a typical day at work

Physical health

#4

concern of workers; remaining a top concern – but down from #1 in 2021

Mental health

Top 5

concern of workers across most demographics – rising to #2 for workers below age 35 and LGBTQ

Source: Mercer's 2022 Inside Employees' Minds© Study

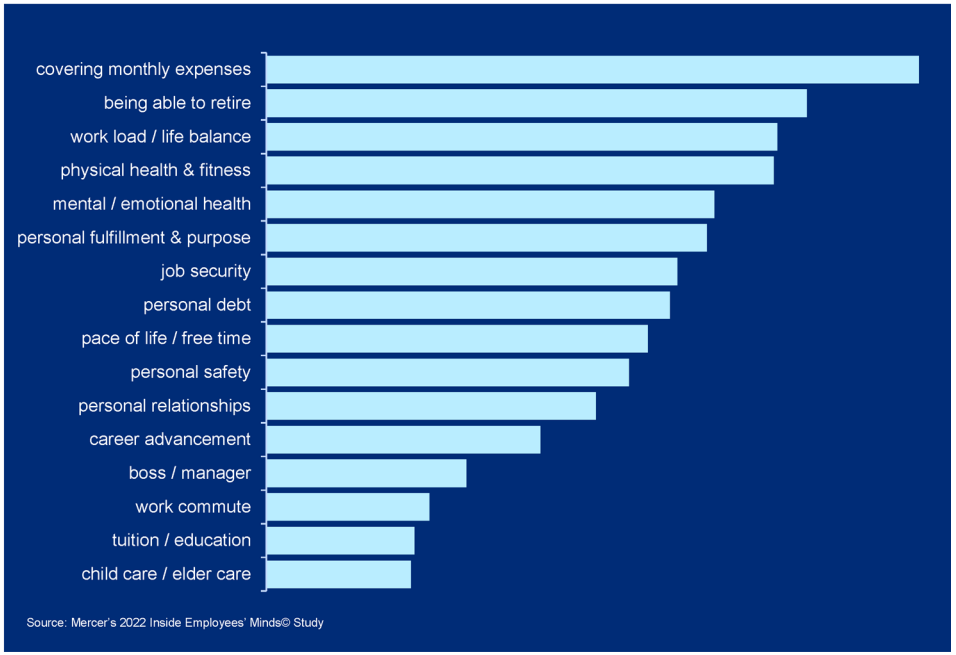
Financial concerns reign supreme

Financial concerns – Covering monthly expenses, ability to retire and personal debt are all top concerns

Burnout remains a top concern with work load / life balance and mental / emotional health remaining in the top 5

Physical health has declined in importance with reduced concerns over COVID, but still claims a top spot

Mercer



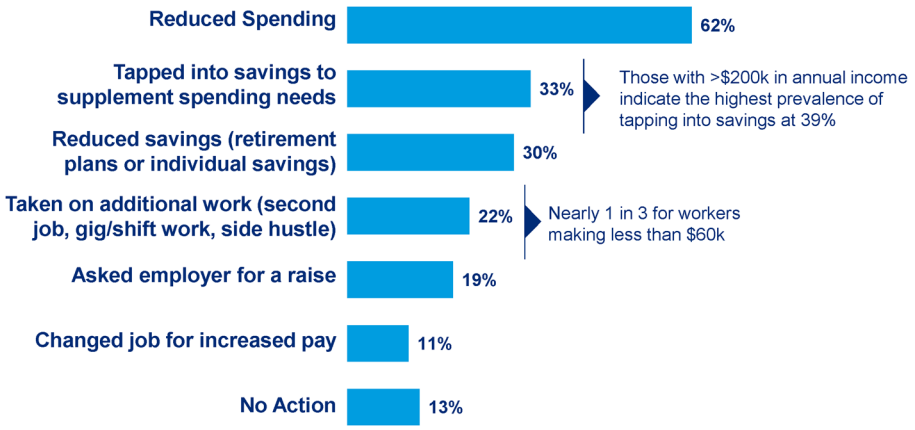
Inflation is hitting hard for everyone

Workers are making lifestyle changes to adapt

7 out of **10** employees say that high inflation and market volatility in 2022 has Significantly increased their financial stress…

…and this holds true across income levels

What changes have you made in response to the current inflationary environment?

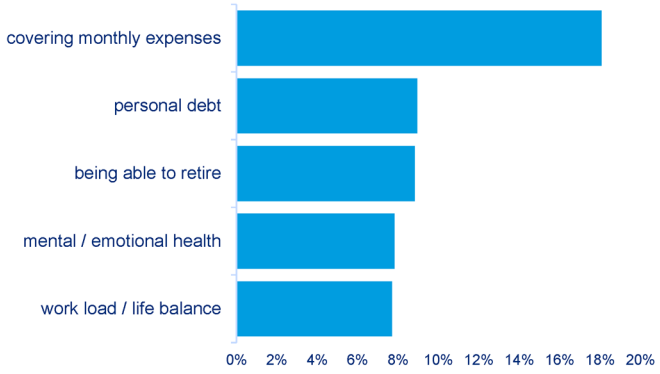


Source: Mercer's 2022 Inside Employees' Minds© Study

Low-income workers are particularly vulnerable

Workers are struggling to make ends meet

Low-income workers are TWICE as concerned about covering monthly expenses as their next highest concern – which is personal debt



45%

Nearly half of low-income workers say their considering switching employers

55%

More than half report do not feel they are compensated fairly

Living wages matter

83%

of employees say it's important that their employer support living wages through internal/external statements and tangible actions…

21%

…but only a fraction of employers today say they've adjusted pay to align with living wages

Source: 2022 Mercer US Compensation Planning Survey (August edition)

Source: Mercer's 2022 Inside Employees' Minds© Study

Employees struggle to get the healthcare they need

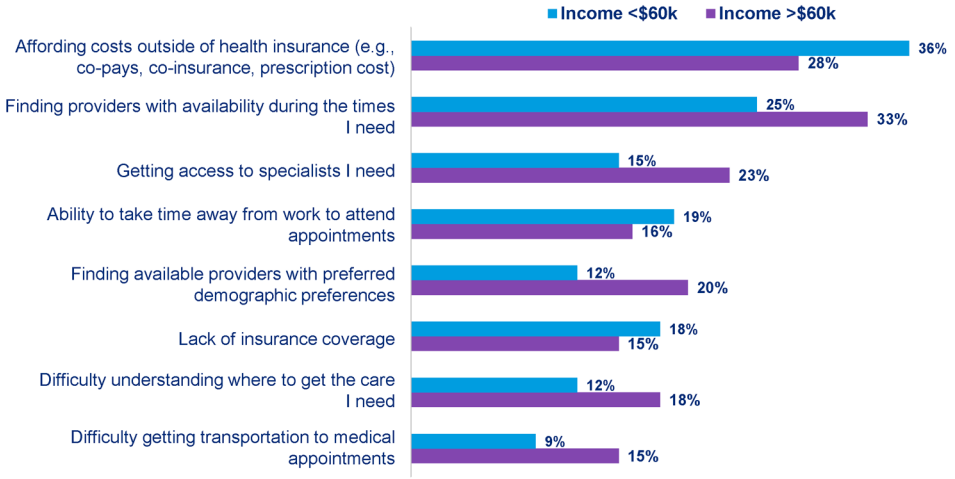
Healthcare affordability is the biggest struggle faced by employees – especially low-income workers

68%

of employees say they have challenges getting healthcare for themselves and their family

Those most concerned with affordability: low income workers, females and workers below age 25 and over age 44

What are your biggest challenges with getting the healthcare you need?



Source: Mercer's 2022 Inside Employees' Minds© Study

Fewer than half of workers are confident about retirement

46%

of employees are confident they can turn retirement savings into consistent stream of lifetime income

1 out of 4

Low-income employees (<$60k) are confident about retirement

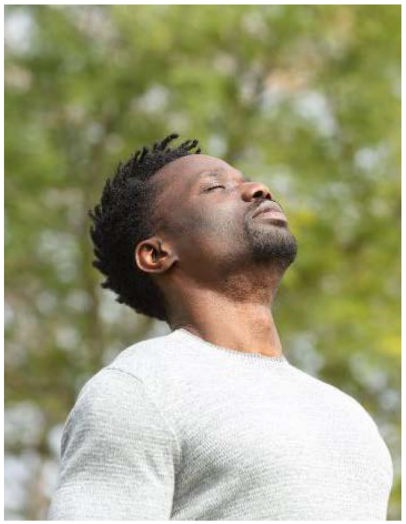
3x

Highest income earners are >3 times more confident vs lowest earners in ability to create a retirement income stream

Source: Mercer's 2022 Inside Employees' Minds© Study

Mental and emotional health remains a top concern

Concerns over mental health most pronounced for younger workers, women, LGBTQ+, Black, Hispanic and Latino workers



Mental health ranked as the #5 concern overall – but ranked of higher concern to some employee groups

#2	**Below Age 35** (drops below top 5 for age 45+)
#2	**Female Caregivers** (versus #7 for non-caregivers)
#2	**LGBTQ+** (versus #6 for non-LGBTQ+)
#3	**Black, African American, Hispanic & Latino workers** (Versus #6 for White workers)
#3	**Women** (Versus #8 for Men)

Mercer

Source: Mercer's 2022 Inside Employees' Minds© Study

Excessive workloads are weighing heavy on employees

Behind pay, employees say burnout is the reason they will leave

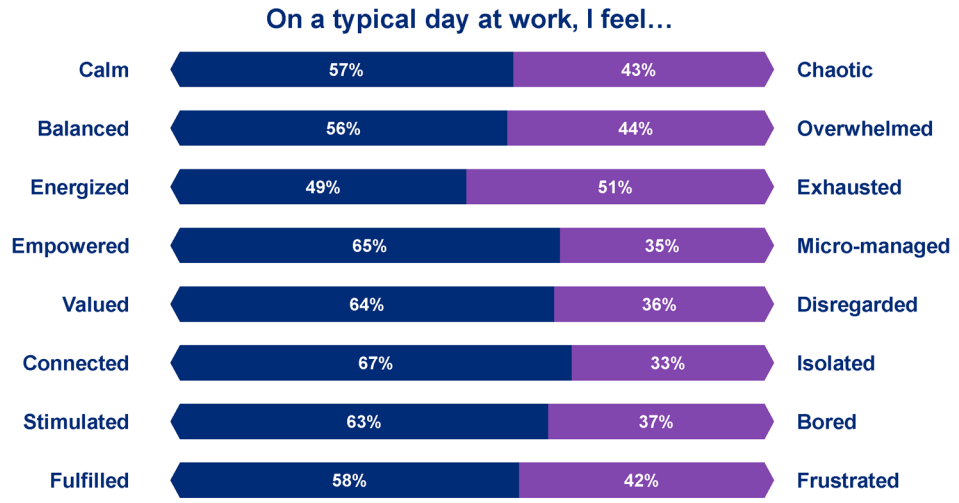
Industry spotlight

60%

of employees in healthcare, food service, retail and hospitality job functions feel exhausted on a typical day

59%

of employees in food service, retail, hospitality job functions report feeling frustrated on a typical day



Source: Mercer's 2022 Inside Employees' Minds© Study

Mercer

2. Survey on Employer Health & Benefit Strategies for 2024

welcome to brighter

Survey on Employer Health & Benefit Strategies for 2024

About the survey

- The survey was designed to discover how employers will prepare for rising health care costs while continuing to adapt benefit strategies for 2024 to improve attraction and retention and better meet the needs of the whole workforce. The survey was conducted from February 14 through March 10, 2023.

- The results in this report are based on **512 organizations with 500 or more employees**

- In total 721 organizations participated, from all industries and of all sizes:

Fewer than 500 employees	29%
500-4,999 employees	45%
5,000 or more employees	26%

In planning for 2024, employers are preparing for rising health care costs while staying focused on attraction and retention

Inflation is driving health care cost – but it also makes affordability a bigger concern

- With inflation creating financial stress for workers, health plan cost-shifting is off the table for many employers
- Budget concerns must be balanced with healthcare affordability and the need to offer attractive benefits

Employers are looking to enhance benefits by filling existing gaps

- Inclusive benefits provide something of value to everyone
- Flexibility is highly valued by workers
- Behavioral health care remains a critical need

As cost growth speeds up, think value

- Steering employees to higher-value care can lower their out-of-pocket costs and help slow overall health plan cost growth
- Virtual care helps solve for affordability while also addressing access issues

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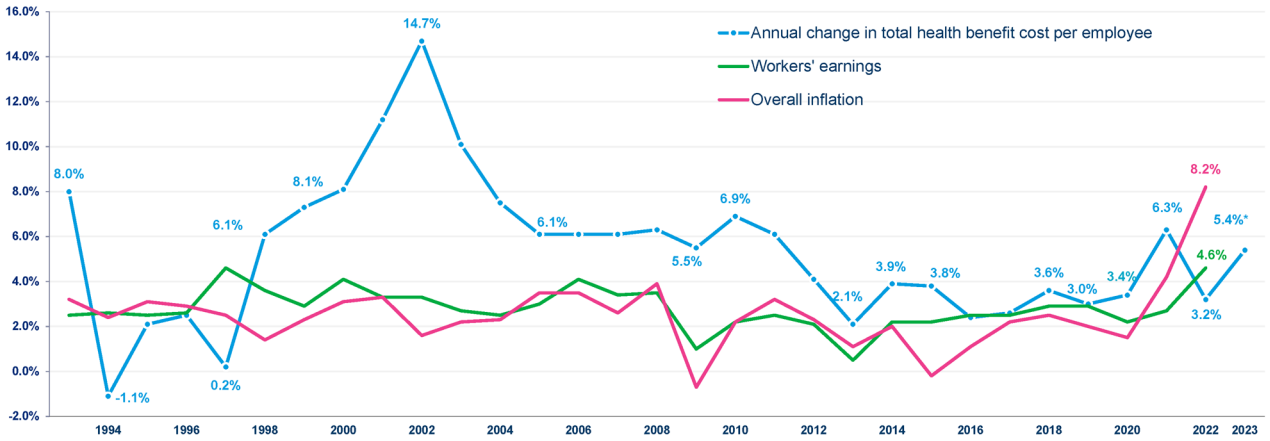
After modest growth in plan cost last year, employers expect an increase of 5.4% in 2023 as inflation drives up health care prices

Change in total health benefit cost per employee compared to CPI, workers' earnings



2022 Mercer National Survey of Employer-Sponsored Health Plans
Beginning in 2020, results are based on employers with 50 or more employees. *Projected.
Source: Mercer's National Survey of Employer-Sponsored Health Plans; Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April); Bureau of Labor Statistics, Seasonally Adjusted Weekly Earnings from the Current Employment Statistics Survey (April).

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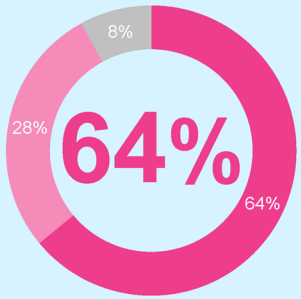
Employers continue to prioritize benefits enhancements — and to minimize cost-shifting to employees

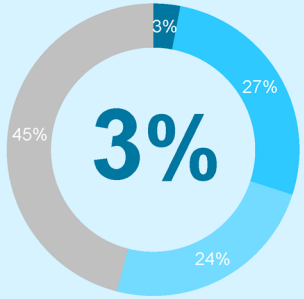
Will enhance health and well-being offerings in 2024



- Planning to make enhancements
- Not making enhancements in 2024, but did so with the past two years
- Not making enhancements

Employers with 500 or more employees

Will shift enough cost to employees via plan design changes to reduce projected health plan cost increase*



- Will raise cost-sharing enough to reduce projected cost increase
- To keep pace with the projected cost increase
- By less than the projected cost increase
- Will not raise any cost-sharing requirements

*In medical plan with the highest enrollment

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Enhancing benefits by filling gaps and addressing healthcare affordability

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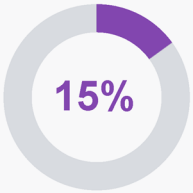
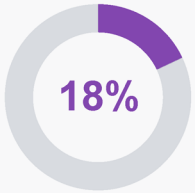
Boosting affordability

Helping employees keep more of their paychecks

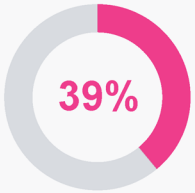


Offer free employee-only coverage in at least one medical plan



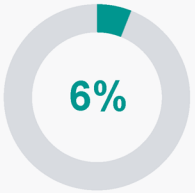
Use salary-based contributions

Removing financial barriers to seek care



Offer medical plan with no/low deductible (e.g., copay plan)

Providing cash to help pay for healthcare



Make larger HSA contributions to low-earners

Employers with 500 or more employees

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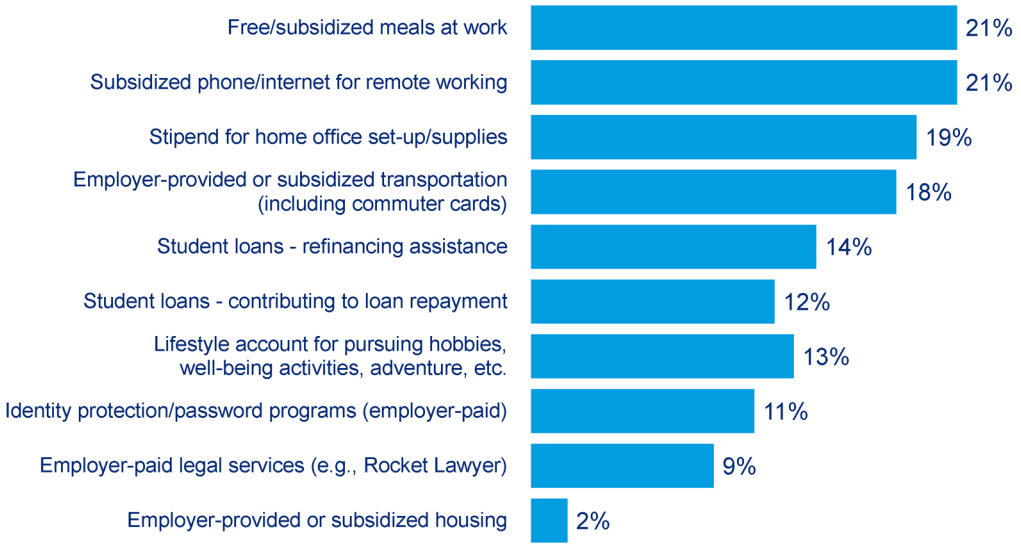
Financial support for work – and living – expenses

Offer or will offer in 2024



Employers with 500 or more employees

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Worker Survey

Health equity starts with affordability, but some employees are less confident they can afford needed care

Percent of US employees who **are not confident** they can afford healthcare…

if household income is…	if gender is…	if work status is…
Median income and above: **7%**	Male: **10%**	Full time: **17%**
Below median: **34%**	Female: **29%**	Part time: **28%**

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Q2. How confident are you that you can afford the healthcare you or your family may need?

Taking action to improve health equity, support DEI goals

78%
of employers are currently taking action to improve health equity

10%
are planning to develop a strategy

Only 12%
have yet to begin

Employers with 500 or more employees

Mercer Survey on Health & Benefit Strategies for 2024

Understanding the problem

27%	Collecting information on race, gender identity, or other demographics to facilitate equity analyses

Respecting differences

40%	Ensuring members can identify providers who are acceptable to them
24%	Multi-lingual and/or communications targeted to specific populations

Providing coverages that meet diverse needs

41%	Providing equitable family-building benefits
23%	Coverage for doulas, midwives, birthing centers or other alternatives to improve maternal outcomes
49%	Coverage for hearing aids

Committing to ambitious goals

20%	Meeting (or working towards meeting) the new Corporate Equality Index standards
35%	Taking other actions to improve health equity and support DEI

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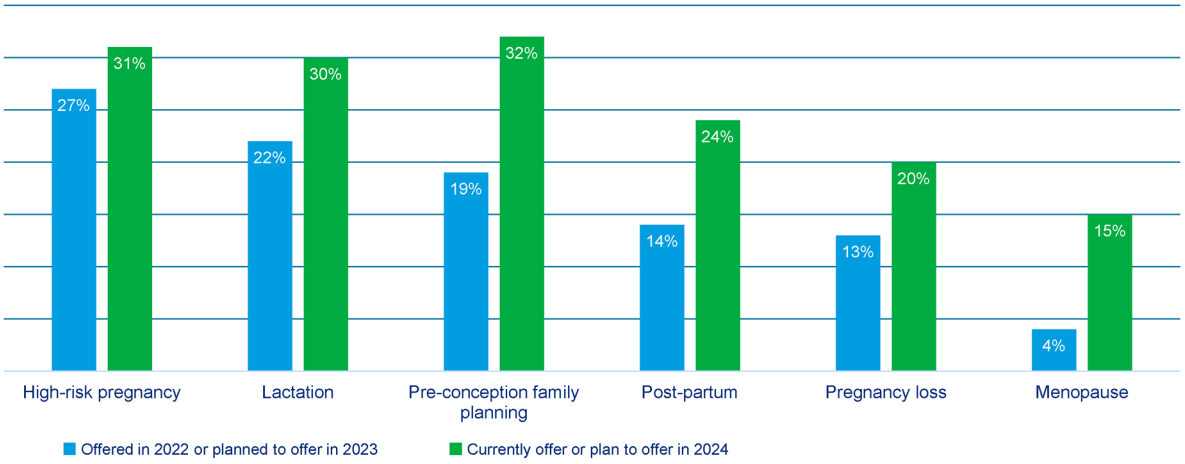
Employers moving quickly to add benefits or resources to support women's reproductive health

46% of employers will offer one or more of these benefits in 2024, up from 37% in 2023



Employers with 500 or more employees

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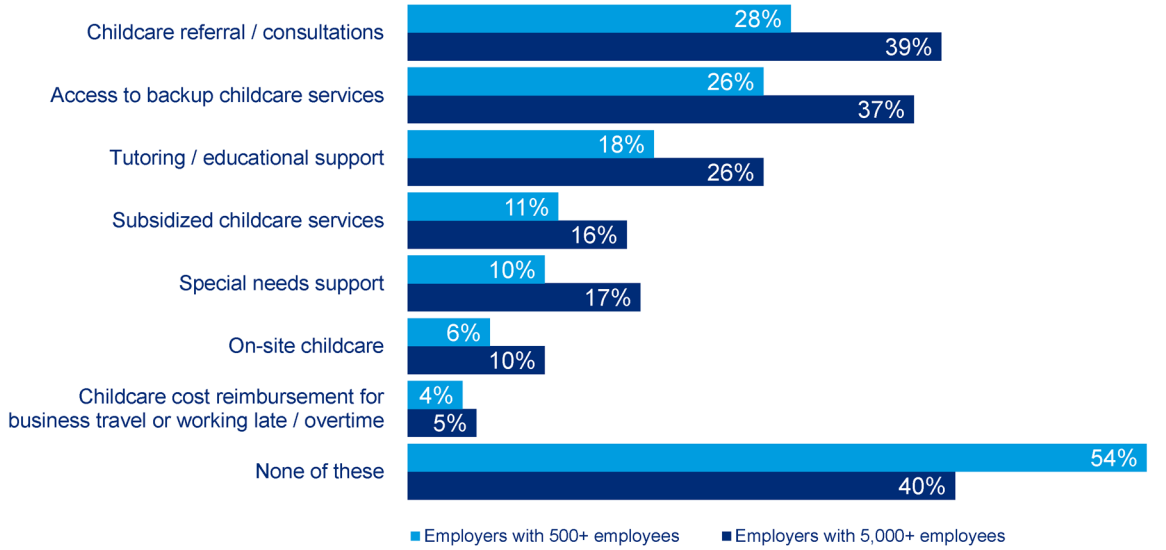
Supporting caregivers with childcare benefits and resources

Offer or will offer in 2024



Employers with 500 or more employees

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Focus on behavioral health care

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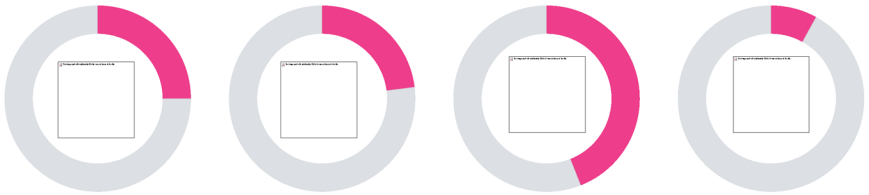
Most employers have recently assessed employee behavioral health needs, or plan to

Have assessed employee behavioral health needs within the past two years using:



25%	23%	44%	8%
Employee surveys/ focus groups	Health assessments	Claims analysis	Anxiety/depression screenings

Employers with 500 or more employees

Mercer

Mercer Survey on Health & Benefit Strategies for 2024

An additional 12% plan to conduct some type of assessment of employee behavioral health needs in 2023 or 2024.

Only 23% have not recently assessed needs and have no specific plans to do so

Effectiveness of actions taken to increase behavioral healthcare utilization or create a more supportive environment

			Of those taking action:	
		Have taken this action within the past 3 years	Has been effective or very effective	Has been fairly effective
1	Added supplemental network for virtual or in-person care	42%	69%	22%
2	Enhanced or expanded EAP	69%	59%	25%
3	Took steps to increase screenings for mental health and/or substance abuse	19%	58%	33%
4	Manager training in recognizing BH issues and steering to resources	36%	49%	30%
5	Conducted campaign to reduce stigma and encourage use of BH resources	49%	46%	33%
6	Added digital or in-person resources for managing stress/building resiliency	58%	44%	29%

Employers with 500 or more employees

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Room for improvement in supporting those with substance use disorders

48%

of employers have not taken any of these steps to address substance use in the workforce

Employers with 500 or more employees

Mercer Mercer Survey on Health & Benefit Strategies for 2024

Employee communications

29% Communications to raise awareness of substance use issues, treatment, and/or resources

Asking more from vendors

16% Have pushed medical, dental, and/or pharmacy plans to monitor prescribing behavior of network providers

18% Have pushed pharmacy benefit manager to use evidence-based formulary for pain medications

Plan design to meet needs, steer to quality care

13% Plan design supports screening patients for substance use

20% Plan design includes coverage for medication-assisted treatment

6% Have taken steps to reduce use of out-of-network treatment facilities

Continuity of care

4% Have addressed continuity of care from treatment into the recovery phase, including leave policies and "step down" care in the local community

6% Have evaluated effectiveness of return to work programs for employees returning after substance use treatment

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To address rising cost without shifting cost, employers are thinking *value*

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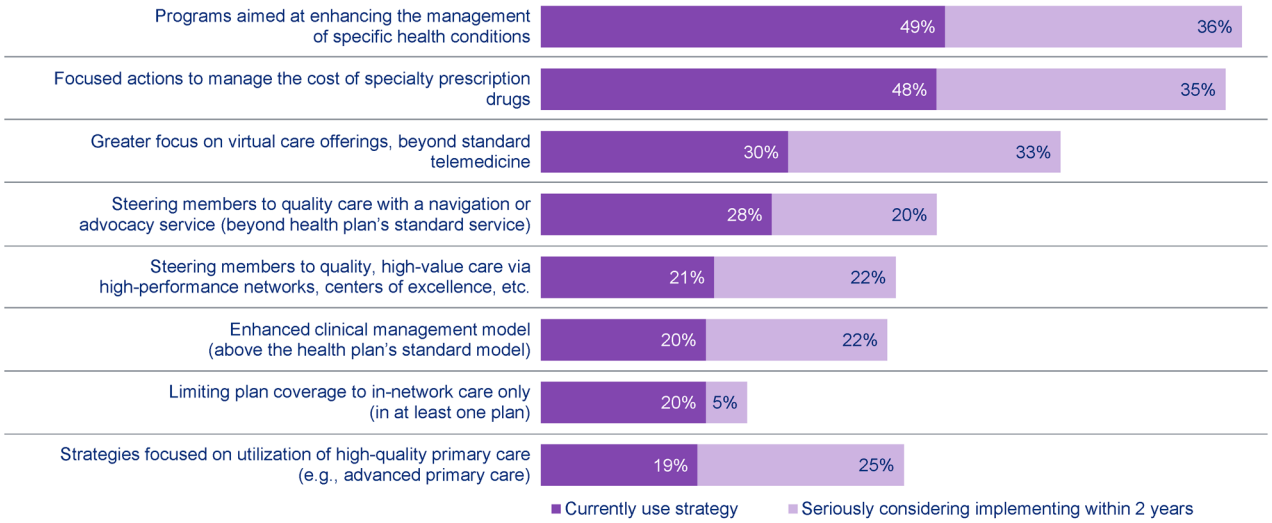
Strategies employers are using to slow health cost growth – without shifting cost to employees



Employers with 500 or more employees

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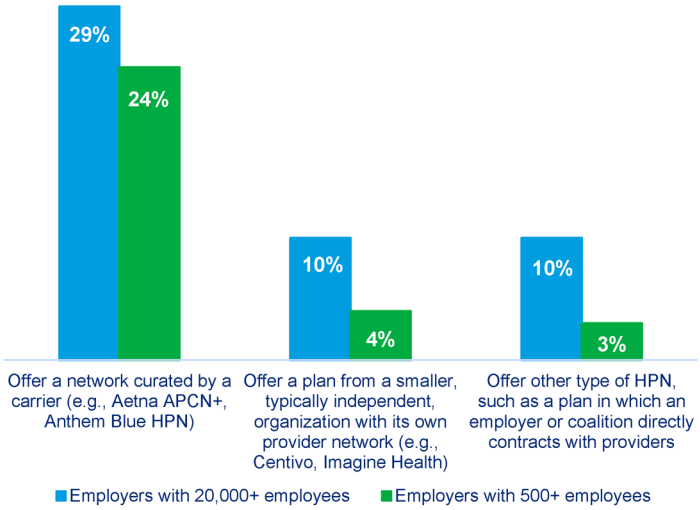
High-performance networks aim for better outcomes, less waste

Implementing a high-performance network strategy can be disruptive for plan members. But communicating the value of a network in which all providers meet higher standards can help – as can offering lower cost-sharing. While carrier-based networks are by far the most common, HPNs designed and managed by independent vendors are gaining traction, especially among the largest employers.

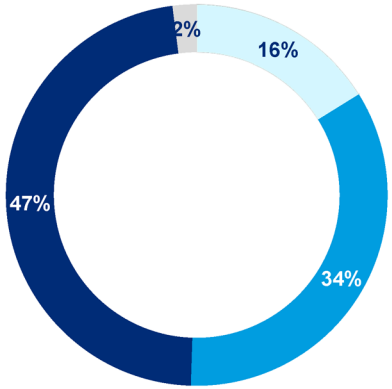


Mercer Survey on Health & Benefit Strategies for 2024

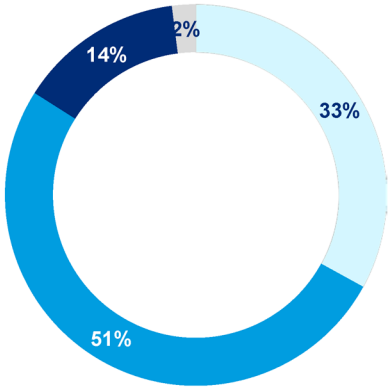
Telemedicine cost-sharing requirements

- Can access telemedicine pre-deductible and at no cost
- Can access telemedicine pre-deductible with cost sharing
- Participants pay the full fair-market value of a telemedicine visit until the deductible is met
- NA - telemedicine service is not offered through the medical plan

For HSA plan participants



For PPO plan participants



Employers with 500 or more employees

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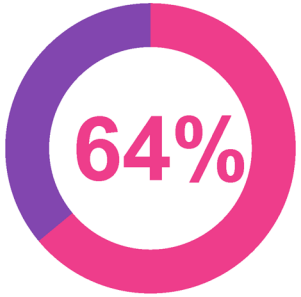
Mercer Survey on Health & Benefit Strategies for 2024

Expanding virtual care beyond traditional telemedicine

Telemedicine for acute care is a nearly universal offering. But today nearly two-thirds of sponsors provide other virtual solutions to address a broader range of healthcare needs



Provide virtual care beyond telemedicine or plan to in 2024

Mercer

Employers with 500 or more employees

Virtual care solutions offered*

Behavioral health care (network of exclusively virtual therapists, e.g., Lyra, Spring Health)

34%

Specific care categories, such as musculoskeletal or diabetes (e.g., Hinge Health, Livongo)

33%

Specialty care, such as dermatology or reproductive care (e.g., Luna, Thirty Madison)

17%

Primary care (e.g., 98point6, Medici)

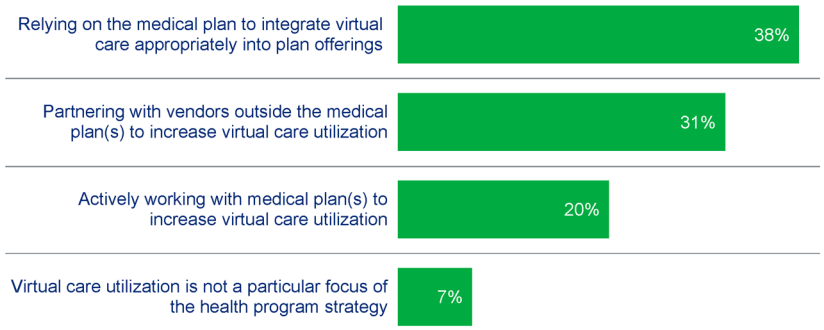
17%

*or planned for 2024

Mercer Survey on Health & Benefit Strategies for 2024

About half of employers offering virtual care beyond telemedicine are actively working with vendor partners to integrate virtual care into their health programs

Primary approach toward integrating virtual care in the health program



Employers with 500 or more employees

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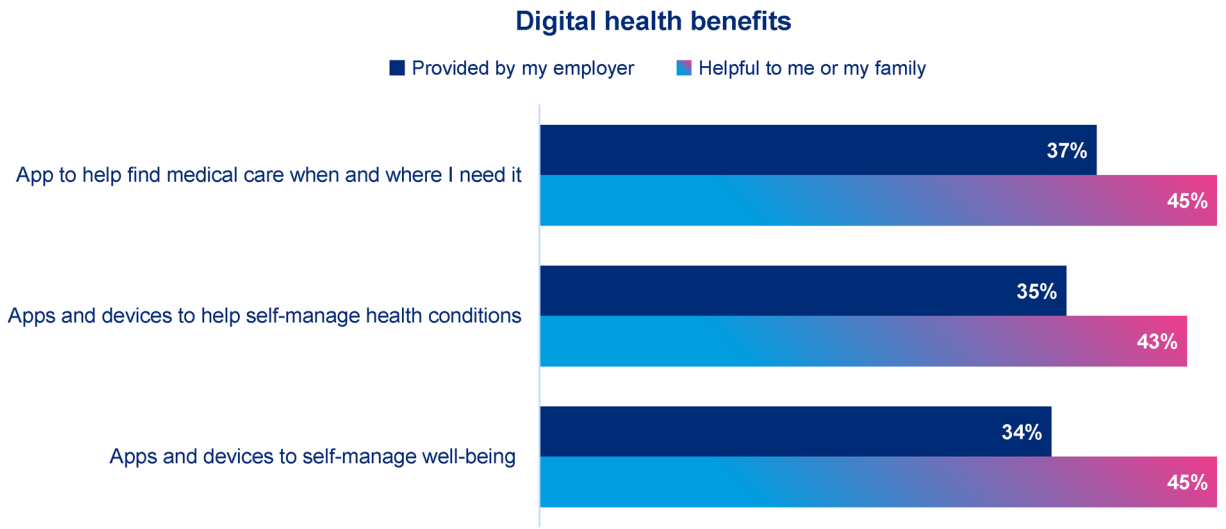
Worker Survey

Many employees find digital health benefits helpful – or believe they would be helpful



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Q13. For each of the following **digital health benefits**, please select any of the choices that apply:

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welcome to brighter

3. Stop Loss 101

April 2023

A business of Marsh McLennan

Stop Loss Insurance

Covering high cost claims

PURCHASING STOP LOSS AND THE LEVEL OF STOP LOSS SHOULD BE A JOINT DECISION BETWEEN HR AND FINANCE

Stop loss overview

Background

- Stop loss insurance is a $27+ billion market in the U.S.
- Self-funded clients who want to mitigate risks due to large or unanticipated claims purchase stop loss coverage through their claims administrator or from a third-party carrier
- Available stop loss products:

Individual (specific) stop loss

- Coverage per member in excess of a set threshold
- Most prevalent type of stop loss coverage

Aggregate stop loss

- Coverage for total claims spend above a corridor (e.g. 125% above expected)
- More prevalent with smaller employers

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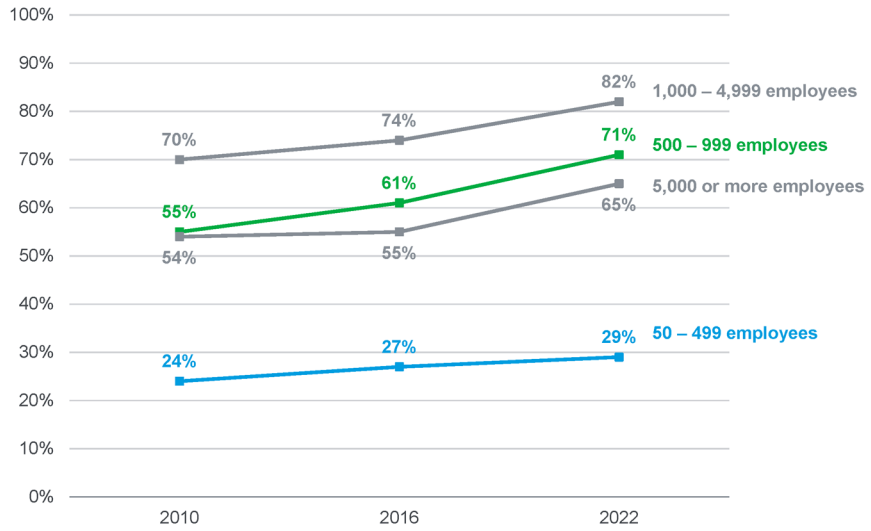
Employers that self-fund with stop-loss (largest medical plan, of any type), by employer size



- Most employers choose to self-fund their medical benefits because it is cheaper than fully-insured coverage
- They purchase stop-loss insurance to manage risk
- Self-funding also offers companies flexibility to design benefits to address affordability and their employee's needs.
- Annual and lifetime maximums served as de facto stop-loss – we saw more employers purchase stop-loss after enactment of the ACA
- Many third-party stop-loss carriers will not quote groups with <100 lives
- Jumbo employers (5k+ employees) are more likely to forego stop-loss insurance and retain 100% of the risk

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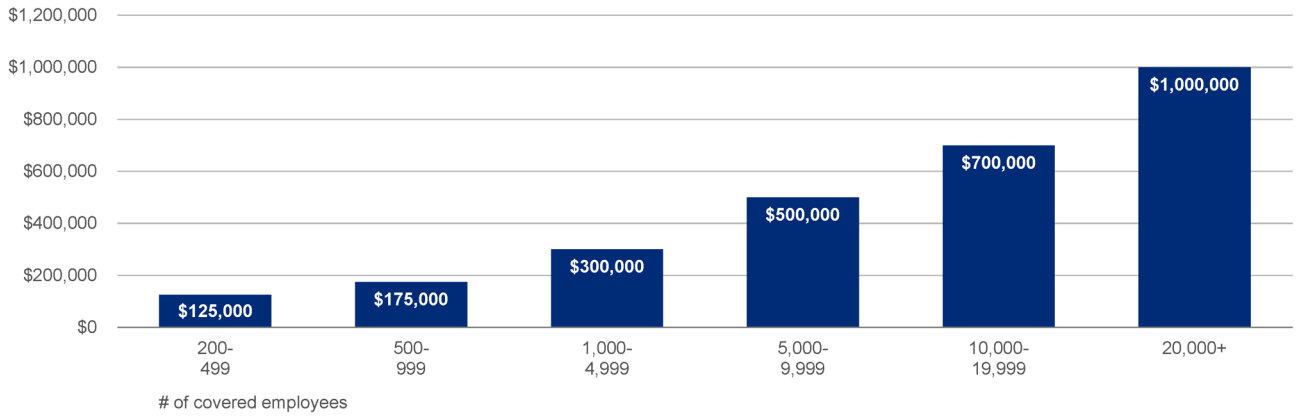
Mercer National Survey of Employer-Sponsored Health Plans

Median specific stop loss deductible

2022 Mercer survey



Source: Mercer's National Survey of Employer-Sponsored Health Plans, 2022

Mercer

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Uncompetitive stop loss terms

- Contract Basis:
  - <12 months of run-in or run-out protection can lead to claim denials with claims falling outside of the covered claim window (e.g. 15/12, 18/12, 12/15, 12/18).
- Run-in claims limitations:
  - Stop loss policies that limit the amount of run-in claims per member that can apply to the stop loss deductible, can lead to gaps in coverage and not all claims being reimbursed.
- Pharmacy Coverage:
  - Medical-only stop loss coverage creates a huge gap in coverage and ignores what has become a significant claims risk in recent years, with new high-cost drugs hitting the market. All stop loss policies should cover pharmacy claims along with medical claims.
- Lasers:
  - These are higher specific deductibles that are set for members with “known” ongoing claims risk; the stop loss carrier won’t start reimbursing claims for members until they reach the higher threshold.
- Renewal Rate Cap/No New Laser Provisions
  - Stop policies that do not place a limit on how high the premium can be increased at renewal, or allow the incumbent carrier to add new lasers, leave an employer with unlimited liability risk at renewal time.

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Stop loss marketplace

Managing General Underwriter

- Managing General Underwriter (MGU) are separate businesses from the insurance companies that issue stop loss policies. They generally act as the marketing, underwriting and claims department for the Stop Loss insurer, managing their Stop Loss products
- MGUs may also represent more than one Insurer, and may change issuing insurers, which could be disruptive from a continuity and coverage perspective
- MGUs generally do not take any of the insurance risk associated with the Stop Loss policies they underwrite, but may receive compensation based upon the performance of their block of business
- The MGU may require coordination between the MGU and Third Party Administrator (TPA), and claims may take more time to resolve because MGUs might review all paid claims data before issuing reimbursement
  - Larger payments may require approval from the Stop Loss Insurer, causing further delay and possible reduction in recoverable amounts.
- The stop loss insurance policies underwritten by the MGU may not cover all claims paid under the benefit program.
- There are frequently differences in what may be considered experimental under the program administrator's viewpoint and what the MGU might determine

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Chairman GOOD. Thank you, Ms. Watts, and we will now go to our second witness, Ms. Strouse.

STATEMENT OF MS. MARCIE STROUSE, PARTNER, CAPITOL BENEFITS GROUP

Ms. STROUSE. Good morning, Chairman, Ranking member, and members of the subcommittee. My name is Marcie Strouse, I am a Partner and Benefits Consultant at Capitol Benefits Group in Des Moines, Iowa. I am grateful for the opportunity to testify today on behalf of small business owners nationwide who are struggling with increasing healthcare costs.

For four decades, the cost of health insurance has remained the No. 1 problem for small businesses. The problem is now a crisis, with skyrocketing costs crippling Main Street. In fact, 98 percent of small businesses report that healthcare costs will become unsustainable in the next 10 years, threatening their ability to survive and remain competitive.

This is why it is important that lawmakers focus on policies that empower small business owners, and their employees, with more choice and control over their healthcare decisions. For 20 years as a benefits professional, I have had the privilege of directly helping small business owners throughout the State of Iowa. I am boots on the ground sitting across from business owners throughout the State.

As employers look today, we are trying to find ways to help solve problems. Healthcare affordability is particularly important for my family as well as we have experienced first-hand the importance of having access to quality care. We have three awesome children, Sid, Ella, and Libby. At just 7 years old, my twins were diagnosed with a neuromuscular disease, and this experience changed me forever.

Since then, I have worked closely with the Muscular Dystrophy Association and was appointed by Governor Kim Reynolds to the Iowa Medical Assistance Advisory Council working with Medicaid and MCOs in the State. I interact with small business owners daily, and I am a small business owner myself.

I can tell you myself the overwhelming stress and anxiety small business owners are feeling right now. Small business owners care deeply about their employees, customers, and communities. They are constantly worried about recruiting and retaining employees while keeping their businesses afloat, and this is particularly challenging in this environment, with sustained high inflation and acute workforce shortages.

Employee benefits have always been important but are even more crucial now. Our clients are more eager than ever to offer great benefits, and to meet the needs of a diverse workforce while remaining competitive, but unfortunately many lack the options. Many of our clients are forced to make tough choices every day.

Some go without pay to keep their employees working. Others are forced to raise their prices or take a profit loss to contend with rising healthcare costs. For instance, in Polk County, Iowa, average small business premiums for a family have increased 85 percent in the last 8 years.

For context, my family is currently enrolled in an individual grandmother plan through Blue Cross and Blue Shield. We have a $2,500.00 deductible, and our monthly premium is $903.00 for our family of five. A similar Affordable Care Act group plan today would be $1,952.00 in monthly premiums.

The status quo is unsustainable. I hope this committee will advance policies that promote affordability and increased choices for small businesses. The following reforms would be a great starting point in providing much needed relief for many of our clients.

First, Congress should significantly expand coverage options allowing small business owners, regardless of industry, to band together to form association plans, and give them the same bargaining power big employers have. Congress can also expand protections for small business owners who choose to self-insure, expanding access to stop loss and reinsurance, for instance can reduce financial risk, enhance plan design, and increase the business's competitiveness.

For example, a recent client with three members was able to save $5,000.00 annually through a level funded reinsurance plan. They were also able to lower the out-of-pocket maximum and copays for their employees. Employers can also benefit from greater transparency and competition in the industry. The system is too opaque to the detriment of employers.

Increasing transparency in the pharmacy benefit manager markets and reigning in healthcare hospital monopolies that engage in anti-competitive practices is key to lowering the cost of care. Last, lawmakers should reduce burdens on employers by streamlining and eliminating unnecessary reporting requirements.

In conclusion, small business owners deserve relief from rising healthcare costs. The folks that I work with are not distant CEOs, but rather hard-working Americans betting on the promise of the America dream. They are in their communities, they go to church and school activities with their employees, and their neighbors, who are also their customers who they care deeply about.

If small businesses thrive, we all thrive. Thank you for your attention to this important matter, and for allowing me to testify today.

[The Statement of Marcie Strouse follows:]

TESTIMONY BEFORE THE UNITED STATES CONGRESS
ON BEHALF OF THE

NATIONAL FEDERATION OF INDEPENDENT BUSINESS

Statement of Marcie Strouse
Partner, Capitol Benefits Group

United States House of Representatives
Committee on Education and the Workforce
Subcommittee on Health, Employment,
Labor, and Pensions

Reducing Health Care Costs for Working Americans and their Families

April 26, 2023

National Federation of Independent Business
555 12th Street NW, Suite 1001
Washington, DC 20004

Good morning, Chairman Good, Ranking Member DeSaulnier, and Members of the House Education and the Workforce Subcommittee on Health, Employment, Labor, and Pensions. My name is Marcie Strouse, I'm a partner and benefits consultant at Capitol Benefits Group in Des Moines, Iowa. I am grateful for the opportunity to testify today on behalf of small business owners nationwide who are struggling with increasing healthcare costs.

For four decades, the cost of health insurance has remained the number one problem for small businesses.[1] The problem is now a crisis, with skyrocketing costs crippling Main Street. In fact, 98% of small businesses report that healthcare costs will become unsustainable in the next ten years, threatening their ability to survive and remain competitive.[2] This is why it is important that lawmakers focus on policies that empower small business owners and their employees with more choice and control over their healthcare decisions.

For 20 years as a benefits professional, I have had the privilege of directly helping small business owners throughout the State of Iowa.[3] I am boots on the ground, sitting across the table from employers every day, helping them solve problems.[4] Healthcare affordability is particularly important for my family as well, as we've experienced firsthand the importance of having access to quality care. We have three awesome children, Sid, Ella, and Libby. At just seven years old, my twins were diagnosed with a neuromuscular disease, and this experience changed me forever. Since then, I have worked closely with the Muscular Dystrophy Association and was appointed by Governor Kim Reynolds to the Iowa Medical Assistance Advisory Council (MAAC).

I interact with small business owners daily and I am a small business owner myself. I can tell you firsthand the overwhelming stress and anxiety employers are feeling right now. Small business owners care deeply about their employees, customers, and communities. They are constantly worried about recruiting and retaining employees while keeping their businesses afloat, and this is particularly challenging in this environment with sustained high inflation and acute workforce shortages.[5] Employee benefits have always been important but are even more crucial now.

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[1] Holly Wade & Andrew Heritage, *Small Business Problems and Priorities*, NFIB Research Center, **2020,** .https://assets.nfib.com/nfibcom/NFIB-Problems-and-Priorities-2020.pdf.

[2] Holly Wade & Madeleine Oldstone, *Small Business Health Insurance Survey*, NFIB Research Center, March 2023, https://strgnfibcom.blob.core.windows.net/nfibcom/Health-Insurance-Survey-2023.pdf.

[3] *Twenty years ago, almost half of our nation's small businesses offered health insurance to their employees; today, that number stands at just 31%. Percent of private-sector establishments that offer health insurance by Firm Size, United States, 2001 to 2021*, Medical Expenditure Panel Survey (MEPS) Insurance Component (IC), Department of Health and Human Services, https://datatools.ahrq.gov/meps-ic?type=tab&tab=mepsich3ntl.

[4] *"Purchasing health insurance through an agent is general practice for most small business owners. Eighty-eight percent of small employers purchased or renewed their employer-sponsored health insurance through an agent or broker. Two percent did not know. The complexity of cost and coverage arrangements makes it almost necessary for owners to enlist the help of an expert to navigate the benefit."* Holly Wade & Madeleine Oldstone, *Small Business Health Insurance Survey*, NFIB Research Center, March 2023, https://strgnfibcom.blob.core.windows.net/nfibcom/Health-Insurance-Survey-NFIB.pdf.

[5] *"Twenty-three percent said that labor quality was their top business problem (up 2 points). Labor quality remains in second place behind "inflation" by 1 point as the top business problem."* William C. Dunkelberg and Holly Wade, *Small Business Economic Trends survey*, NFIB Research Center, April 2023, https://strgnfibcom.blob.core.windows.net/nfibcom/SBET-Mar-2023.pdf.

Our clients are more eager than ever to offer great benefits and to meet the needs of a diverse workforce while remaining competitive, but unfortunately, many lack the options. Many of our clients are forced to make tough choices every day; some go without pay to keep their employees cared for and working. Others are forced to raise their prices or take a profit loss to contend with rising healthcare costs.[6] For instance, in Polk County, Iowa, average small business premiums for a family have increased by 85% in the last eight years.[7] For context, my family is currently enrolled in an individual grand-mothered plan through Blue Cross & Blue Shield (BCBS). We have a $2,500 deductible, and our monthly premium is $903.05 for a family of five. A similar Affordable Care Act group plan in 2023 would be $1,952 in monthly premiums.

The status quo is unsustainable. I hope this committee will advance policies that promote affordability and increase choices for small businesses. The following reforms would be a great starting point in providing much-needed relief for many of our clients.

First, Congress should significantly expand coverage options. Allowing small business owners, regardless of industry, to band together to form an Association Health Plan (AHP) would give them the same bargaining power that big employers enjoy, resulting in lower costs and access to better networks in many cases. If done sensibly and with the appropriate guardrails, this can be a game changer in leveling the playing field for small employers.

Congress can also expand protections for small business owners who choose to self-insure. Expanding access to stop-loss & reinsurance, for instance, can reduce financial risk, enhance plan design, and increase the business's competitiveness. For example, a recent client with three members was able to save a whopping $5,000 annually through a level-funded reinsurance plan; they were also able to lower the out-of-pocket maximum and copays for employees.

Employers can also benefit from greater transparency and competition in the industry. The system is too opaque to the detriment of employers. Increasing transparency in the Pharmacy Benefit Manager markets and reining in healthcare hospital monopolies that engage in anticompetitive practices is key to lowering the cost of care.

Lastly, lawmakers should reduce burdens on employers by streamlining and eliminating unnecessary reporting requirements. Some of the smallest businesses out there are already

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[6] *"Almost half (49%) of small employers have taken a lower profit or suffered a loss to pay for health insurance premium increases over the last 5 years. Forty-six percent of small employers have raised prices and another 36% have become more productive and efficient. Eighteen percent have increased employee cost-share. Seventeen percent said they have delayed, postponed, or reduced business investment and 11% said freeze or reduce wages. Four percent have had to reduce non-health employee benefits, and none have cut employees or reduced their hours."* Holly Wade & Madeleine Oldstone, *Small Business Health Insurance Survey*, NFIB Research Center, March 2023, https://strgnfibcom.blob.core.windows.net/nfibcom/Health-Insurance-Survey-2023.pdf.

[7] *According to IRS data, the average annual family premium for a small group plan in Polk County was $22,233 in 2022; the average annual family premium small group plan was $11,993 in 2014. Form 8941 Instructions, Credit for Small Employer Health Insurance Premiums,* Internal Revenue Service, 2014 – 2022, https://www.irs.gov/instructions/i8941.

struggling to comply and lack resources and time. This is a commonsense way to relieve small business owners from burdensome red tape and allow them to focus on what they do best.

In conclusion, small business owners deserve relief from rising healthcare costs. The folks I work with are not distant CEOs but rather hard-working Americans betting on the promise of the American Dream. They are in their communities; they go to the same church as their neighbors, who are often also their customers, and they care deeply about their employees. If small businesses thrive, we all thrive.

Thank you for your attention to this important matter and for allowing me to testify today.

Chairman GOOD. Thank you, Ms. Strouse. Now we will hear from and recognize Ms. Corlette.

STATEMENT OF MS. SABRINA CORLETTE, J.D., SENIOR RESEARCH PROFESSOR, CENTER ON HEALTH INSURANCE REFORMS, GEORGETOWN UNIVERSITY'S HEALTH POLICY INSTITUTE

Ms. CORLETTE. Thank you, Chairman Good, and Ranking Member DeSaulnier. It is an honor for me to be part of today's discussion of policies to help reduce health care costs for working people and their families. In recent years, Congress has made several attempts to improve health care access, affordability, and quality.

None has had a greater impact than the Patient Protection and Affordable Care Act. Today, Americans with employer-sponsored insurance take for granted the many protections that they enjoy under the ACA, including protections for people with pre-existing conditions, coverage for young adults, cost-free preventive services, and caps on our annual out-of-pocket costs.

More recently, the Consolidated Appropriation's Act of 2021 now protects 177 million consumers from unexpected, surprise medical bills, and helps empower employers to be more effective purchasers of health benefits. Last year, the Inflation Reduction Act helped advance the coverage and affordability gains under the ACA and is lowering prescription drug costs for Medicare enrollees. However, challenges remain.

Since 1999, employee contributions to premiums have increased by about 300 percent. Average deductibles for a single worker have risen from $303.00 in 2006 to $1,562.00 in 2022. The primary reason for the affordability challenges in employer-sponsored insurance is rising health care prices.

On average, commercial insurers are paying twice the amount that Medicare pays for the same service. In some markets, three times the amount. There are a number of reasons for this. First, consolidation in the health care sector is granting providers with outsized market power to demand higher reimbursement rates.

Second, a lack of price transparency has left many employers in the dark about what is driving cost growth. Third, many of the third-party vendors and brokers that employers use to shape and administer their health plans have financial incentives to keep health care costs high.

Employers cannot solve the affordability crisis in health care alone. They need support from policymakers. Unfortunately, three of the four concepts under consideration today do not address the cost drivers in our system. They simply shift the burden of cost growth to employers with older, or less healthy workforces.

First, association health plans. The primary way that AHPs will offer lower premium rates is through the exemption from ACA rating regulations. This enables them to cherry pick healthy employer groups out of the ACA regulated market. AHPs just create new winners and losers, with the losers being those who are older and sicker.

Second, the Self-Insurance Protection Act. This proposal would further encourage the proliferation of level-funded plans in the small group market, posing two primary risks. First, many small

employers may be exposed to unexpected financial liability when they self-fund their plan.

Second, if small employers with younger, healthier employees shift to the level-funded products in significant numbers, it leaves employers with older and sicker workers behind. This causes adverse selection where premium rates rise for employers whose groups cannot pass the stop loss issuer's underwriting.

Just as with AHPs, this legislation does nothing to address the underlying reason why there is an affordability crisis for ESI—the prices that commercial insurers pay for provider services and prescription drugs. Third, the Telehealth Benefit Expansion for Workers Act. Let us be clear. There is nothing in Federal law today that prevents employer group health plans from covering telehealth services.

Indeed, 96 percent of large firms already do so. Employers are struggling to afford the rising cost of health care. This is indisputable. Encouraging the proliferation of stripped-down telehealth benefits, in lieu of a group health plan, will discourage care coordination. They do not cover basic things like hospitalization, prescription drugs, and labs, and they do not have to comply with consumer protections or mental health parity.

Last, I want to thank the subcommittee for attempting to roll back a hospital billing practice that is driving up costs for employers and enrollees alike. The facility fee proposal before this subcommittee is a step in the right direction. Thank you for your time, and I welcome your questions.

[The Statement of Ms. Sabrina Corlette follows:]

GEORGETOWN UNIVERSITY
McCourt School of Public Policy

CENTER ON HEALTH INSURANCE REFORMS

STATEMENT OF SABRINA CORLETTE, J.D.
RESEARCH PROFESSOR AND CO-DIRECTOR
CENTER ON HEALTH INSURANCE REFORMS
GEORGETOWN UNIVERSITY MCCOURT SCHOOL OF PUBLIC POLICY

BEFORE THE U.S. HOUSE OF REPRESENTATIVES COMMITTEE ON EDUCATION AND THE WORKFORCE, SUBCOMMITTEE ON HEALTH, EMPLOYMENT, LABOR, AND PENSIONS

HEARING ON

"REDUCING HEALTH CARE COSTS FOR WORKING AMERICANS AND THEIR FAMILIES"

WEDNESDAY, APRIL 26, 2023

Good morning Chairman Good, Ranking Member DeSaulnier, and members of the Subcommittee on Health, Education, Labor, and Pensions. My name is Sabrina Corlette and I am a Research Professor at Georgetown University's McCourt School of Public Policy, where I co-direct the Center on Health Insurance Reforms, or CHIR. At CHIR we study health insurance and health care markets.

It is an honor for me to be part of this discussion of policies to help reduce health care costs for working people and their families. In my testimony I will briefly summarize the impact of recent congressional efforts to improve health care affordability, discuss challenges that remain, and share my views on policy options for constraining the health care cost inflation that is cutting into workers' wages and the competitiveness of American businesses. Please note that these views are my own and do not necessarily reflect the views of Georgetown University or the McCourt School of Public Policy.

We've Come a Long Way: Congressional Actions to Improve Health Care Access, Affordability, and Quality

Over the years Congress has made a few attempts to improve health care access, affordability, and quality. None has had a greater impact than the Patient Protection and Affordable Care Act (ACA). In assessing the ACA, it is important to remember what health insurance looked like for people in 2010, before the law was enacted.

On the eve of the ACA, 48 million Americans were uninsured; over 80 million reported having to go without insurance for at least one month during the prior 12-month period. The evidence is clear: a lack of health insurance puts people's life and health at risk. Before the ACA was enacted, an estimated 26,000 people per year died prematurely, simply because they did not have health insurance. This is likely because the uninsured are more than six times as likely as the privately insured to delay or forego needed care due to affordability concerns. Uninsured cancer patients are more than five times more likely than their insured counterparts to forego cancer treatment due to cost.

Being uninsured also results in financial insecurity. In 2010, when the ACA was enacted, 60% of the uninsured reported having problems with medical bills or medical debt.

Prior to the ACA, the high and rising uninsured rate led to high and rising uncompensated care costs for providers; in 2009 these costs were estimated to be $1000 worth of services per uninsured person. Providers ultimately passed those costs onto insured consumers and taxpayers, amounting to almost $700 per family, per year.

Although the ACA focused most of its reforms on a dysfunctional individual insurance market, it also included policies to improve the adequacy and affordability of coverage for people with employer-sponsored insurance (ESI). Prior to the ACA, many people with ESI were in plans that left them with significant financial risk, should they get sick or injured. For example, before the ACA, an estimated 102 million people were in plans that had a lifetime limit on their benefits;

20,000 people hit those limits each year. Approximately 18 million people were in plans with annual dollar limits on their benefits, meaning that a single serious illness or traumatic injury could expose them to catastrophic health care costs.

Further, in spite of overwhelming evidence that preventive care like cancer screenings, medications to prevent heart disease, and mental health and substance use assessments saves lives, many employer plans imposed cost-sharing for these services before the ACA was enacted. Numerous studies have shown that cost-sharing results in people delaying or foregoing these critical services, which can lead to more severe illness down the road.

Today, Americans with ESI take for granted many of the protections they enjoy, thanks to the ACA, including:

- *Young adult coverage*. The ACA requires health plans that offer dependent coverage to allow young adults up to age 26 to remain on their parent's health plan. This provision, which went into effect in 2010, has helped lead to a significant decline in the number of young adults who are uninsured. Before the ACA, one-third of young adults were uninsured, the highest percentage of any age group. Today, their uninsured rate is just 9.7%.
- *$0 preventive services*. The ACA requires group health plans to cover, without cost-sharing, high-value preventive services that have been recommended by clinical experts with the U.S. Preventive Services Task Force, Advisory Committee on Immunization Practices, and the Health Resources and Services Administration. These services include cancer screenings, contraception, well-child visits, mental health screenings, childhood immunizations, and more. These benefits have boosted vaccination rates, increased the number of people who get recommended blood pressure, cholesterol, colorectal, and other screenings, and improved women's access to effective contraception.[1]
- *Caps on enrollees' costs*. The ACA set limits on the total amount of out-of-pocket cost-sharing a family can incur, each year, and bars plans from imposing lifetime or annual dollar limits on benefits. These provisions protect families from what can be catastrophic financial liability in the event of a serious illness or injury.

The ACA has had an enormous impact, reducing the numbers of uninsured from 48 million to 27 million, protecting 133 million people with pre-existing conditions, and improving coverage affordability. Access to Medicaid expansion, Marketplace subsidies, and dependent coverage has also reduced people's out-of-pocket costs for health care and led to improvements in financial well-being.

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[1] Many of these benefits are now at risk. A federal district court ruled on March 30, 2023 that the government can no longer enforce the ACA's preventive services coverage requirement with respect to services recommended by the U.S. Preventive Services Task Force after March 23, 201. The U.S. Department of Justice has appealed that decision to the 5th Circuit Court of Appeals. It is also seeking a stay of the lower court's ruling.

The Consolidated Appropriations Act of 2021/No Surprises Act: Providing Critical Financial Protections for Consumers and Empowering Employer-Purchasers

The Consolidated Appropriations Act of 2021 (CAA), which included the No Surprises Act (NSA), advanced several policies to protect consumers from high and unexpected medical bills and to empower employers to be more effective purchasers of health benefits.

The NSA created new protections for 177 million people with private health insurance. Specifically, the NSA protects consumers from surprise balance billing when they are treated by out-of-network providers in emergencies or when they are in an in-network hospital and have no choice of provider. Prior to this law, an estimated 18% of emergency visits and 16% of in-network hospital services resulted in at least one out-of-network charge for people in large employer health plans. Air ambulance services were even more likely to result in out-of-network charges. Balance bills in these scenarios could often be quite large, with bills in the range of $20,000 for air ambulances, $3,600 for surgical assistants, and $1,200 for anesthesiologists.

Today, thanks to the NSA, an estimated 9 million people who would have otherwise received a surprise balance bill last year, did not. An analysis of the law's implementation, published just last week by my CHIR colleagues, found that, one year after implementation, the NSA is working as intended, keeping patients "out-of-the-middle" of payment disputes between their health plans and out-of-network providers.[2]

Congress and the Biden administration should also be applauded for establishing a structure for the resolution of disputes between out-of-network providers and health plans that should, if allowed to work as intended, constrain inflation in payments to out-of-network providers and reduce premiums for employers and plan enrollees. Indeed, the Congressional Budget Office (CBO) estimated that the NSA would reduce premiums between 0.5 and 1.0% in most years. Unfortunately, provider organizations have filed multiple lawsuits to try to keep out-of-network prices high; it remains to be seen if they will be successful.

The CAA of 2021 also included policies designed to help employers become more effective purchasers of health benefits. These include:

- *A ban on gag clauses.* Group plans and issuers are barred from entering into or renewing contracts with providers if they prevent the plan from (a) disclosing provider-specific cost or quality information, (b) obtaining de-identified claims data, and (c) sharing provider-specific cost or claims data with a business associate.

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[2] Hoadley J, Lucia K, Volk J, Walsh-Alker E, Swindle R, Wengle E, "No Surprises Act: Perspectives on the Status of the Consumer Protections Against Balance Billing," Urban Institute, April 2023, https://www.urban.org/sites/default/files/2023-04/No%20Surprises%20Act%20Perspectives%20on%20the%20Status%20of%20the%20Consumer%20Protections%20Against%20Balance%20Billing.pdf.

- *Required vendor disclosures.* Employer health plan brokers, consultants, and other service providers who reasonably expect to receive at least $1000 in direct and indirect compensation must disclose financial transactions of $250 or more. These vendors must also provide a description of the services they rendered in exchange for the compensation.

I want to thank this committee for its December 2022 letter, urging the U.S. Department of Labor (DOL) to make explicit for vendors such as third-party administrators (TPAs) and pharmacy benefit managers (PBMs) that the CAA's disclosure requirements clearly apply to them. DOL should also consider developing standard templates for the disclosures, in order to avoid potential obfuscation by vendors.

The CAA also included several provisions designed to empower consumers to select more cost-effective health care services. These include:

- *Price comparison tools.* Group health plans and issuers must give enrollees' access to a "price comparison" tool that allows them to compare the amount of cost-sharing they would be responsible for across providers.
- *Advanced Explanation of Benefits.* Group health plans and issuers must provide an explanation of benefits (AEOB) to enrollees *before* they receive services. To inform the AEOB, providers must submit a good faith estimate of their costs to the plan.
- *Improved provider directories.* Group health plans and issuers must improve the accuracy of provider directories, post them on a public website, and establish a protocol for promptly responding to enrollees' requests for information about a provider's network status. The law also requires providers to submit timely updates to insurers about changes to their status.

The provisions of the CAA, combined with federal regulations requiring hospitals and health plans to publicly post data on their negotiated commercial prices, are designed to support better health care purchasing decisions by employers and consumers.

The Inflation Reduction Act: Building on the ACA and Improving Rx Affordability for Seniors

Last year's Inflation Reduction Act (IRA) has helped advance the coverage and affordability gains under the ACA. The law extended enhancements to the ACA's premium tax credits through the year 2025. These enhanced subsidies, combined with recent investments in Marketplace outreach and enrollment assistance, have boosted Marketplace enrollment to the highest level yet – 16.3 million people signed up for a Marketplace plan for 2023, an almost 50% increase in enrollment since President Biden took office. Marketplace enrollees on average enjoyed $800 in annual savings last year thanks to the IRA's more generous tax credit structure. During the most recent open enrollment period, four out of five consumers returning to HealthCare.gov had access to plans costing $10 per month or less.

The IRA also includes historic efforts to lower prescription drug costs for Medicare enrollees. In particular, the law requires the federal government to negotiate prices for some Medicare-covered drugs, requires drug companies to pay rebates to Medicare if their prices rise faster than inflation, caps out-of-pocket spending for Medicare Part D drugs, limits cost-sharing for insulin for Medicare enrollees, and expands eligibility for Medicare Part D's low-income subsidy program.

Challenges Remain: A Crisis of Affordability in ESI

Approximately 160 million Americans receive health insurance through their employers, making ESI the largest source of insurance coverage in the country. It is one of the most highly valued workplace benefits (alongside retirement) that employers provide. Yet for the last two decades, the generosity of ESI has been in decline, leaving more and more working adults underinsured. Since 1999, employee contributions to premiums have increased by about 300%, and the average deductible for a single worker has risen from $303 in 2006 to $1,562 in 2022. Today, one-third of people with ESI face an annual deductible of $2000 or more.

A recent Commonwealth Fund survey found that almost one-third of people with ESI are in plans that offer "inadequate" coverage, meaning that their out-of-pocket costs were 10% or more of their household income, or that their deductible constituted 5% or more of their household income. This financial burden is not borne equitably – lower-income and families with sick family members spend a greater portion of their income on premiums and deductibles than higher income and healthier families. Families with income below 200% of the federal poverty line (FPL) spend on average more than 10% of their income on premiums and cost-sharing in ESI, compared to just 3.5% for families above 400% FPL. The regressive nature of ESI hits Black and Hispanic families the hardest. While 73% of White families have coverage through an employer, that number drops to 51% for Black families and 48% for Hispanic families.

In addition to increasing the financial burden for workers, inflation in health costs is throttling the competitiveness of U.S. businesses. A recent survey found that a majority of small business owners cite health care costs as their biggest business challenge, with about 41% delaying growth opportunities and 37% increasing the prices of their goods and services because of health care costs.

The primary reason for the affordability challenges in ESI is *not* our health status or the excessive use of health care services. The culprit is rising health care prices. On average, commercial insurers are paying twice the amount that Medicare pays for the same service; in some markets commercial insurers are paying three times the amount. Hospital costs now account for nearly half of spending by employer health plans, while pharmacy benefits represent 23% of spending.

The prices paid by commercial insurers in the U.S. are substantially higher than the prices paid by commercial insurers in other advanced economies. Yet we're getting very little bang for

these bucks: health outcomes in the U.S. are worse than in our peer countries. For example, life expectancy at birth in the U.S. was 77 years in 2020 – three years lower than the average among our peers.

There are a number of barriers to employers purchasing health care benefits more effectively. First, consolidation in the health care sector, particularly among hospitals and physician groups, is granting providers with outsized market power to demand higher commercial reimbursement rates. Between 1998 and 2021, there were more than 1800 hospital mergers in the U.S. Prices at monopoly hospitals tend to be 12 percent higher than at hospitals with four or more competitors.

In addition to hospital-to-hospital mergers, prices are rising because hospitals are acquiring physician practices. Between 2012 and 2018, the number of physician practices acquired by hospitals grew from 35,700 to more than 80,000. By 2018, 44% of U.S. physicians were employed by hospitals or health systems, and this number is likely now significantly higher, driven in part by the economic impact of COVID-19. When physician groups are absorbed into a hospital system, their patients pay, on average, 6% more than patients of independent physician groups.

Second, many employers have not had access to data about the prices they are paying for health care goods and services, leaving them in the dark about what is driving premium cost growth, and thus unable to target strategies to combat it. Thanks to the recent federal regulations requiring hospitals and health plans to publicly post price data, and to the CAA 2021 provisions banning gag clauses, we are starting to get more transparency. But many employers still struggle to get access to their data, and many lack the analytical capacity to use it. They often rely on third-party vendors to do this work.

This leads to the third challenge: Many of the third-party vendors that employers use to shape and administer their health plans – third-party administrators (TPAs), pharmacy benefit managers (PBMs), brokers, and benefit consultants – have misaligned incentives. When health care costs are high, it helps keep their own revenues high. Thanks to recent federal requirements that health plans and hospitals post their prices, we're now starting to get a glimpse of the financial practices that are lining the pockets of health plan middlemen – and leaving employers and workers holding the bag. For example, a recent lawsuit against Elevance Inc. (formerly known as Anthem), alleges that although the company had guaranteed the employer a 50% discount on network provider rates, the newly available pricing data suggests that Elevance was only giving the employer a 30% discount and pocketing the difference. Other lawsuits have been filed over TPAs' hidden administrative fees and evidence that TPAs are holding on to overpayments to health care providers. These troublesome TPA practices can, directly or indirectly, contribute to excessive health care spending by employer plans, ultimately increasing costs for workers and plan sponsors.

Similarly, multiple studies have revealed that PBMs have misaligned financial incentives. Because their revenue often is based on a percentage of a drug's list price, it creates an incentive for them to prioritize higher cost drugs in plan formularies. There is also evidence that PBMs hold onto a significant portion of drug manufacturer rebates that could be passed on in savings to the employer health plan. PBMs also disfavor generic drugs that do not come with rebates, relative to higher cost brand-name drugs, that do.

Employers and Workers Need Policy Action to Address Affordability

Employers cannot solve the affordability crisis in health care alone – they need support from policymakers. In a September 2022 report, CBO has assessed several policy interventions that could help constrain health care cost growth.[3] These include:

- *Directly or Indirectly Regulating Health Care Prices*. CBO finds that direct government regulation of provider prices is likely to have the most impact on affordability. Such regulation can include direct measures like capping prices, capping the growth of prices, or capping the growth of premiums. They can also include more indirect measures like state-level cost-containment commissions and strengthening state rate review processes.
- *Reducing Consolidation and Anti-competitive Behavior.* CBO finds that more robust anti-trust regulation and enforcement can have a modest impact on health care prices. Other policy options include prohibiting anti-competitive clauses in provider-payer contracts and promoting market entry. The Biden administration has been boosting its anti-trust enforcement, and pending bipartisan legislation would limit the anti-competitive contracting practices of monopolistic provider systems.
- *Improving Price Transparency*. CBO finds that improving the transparency of the prices employers pay for health care goods and services, by itself, is likely to have a very small downward impact on price inflation, but it can serve as a catalyst for more significant action by employers and policymakers. The Transparency in Coverage and Hospital Price Transparency regulations and the ban on gag clauses in provider-payer contracts are important first steps to break open the black box that surrounds prices in the commercial market.

The Bipartisan Policy Center (BPC) has published a report with several recommendations for policy interventions that could improve ESI affordability.[4] In addition to recommending several of the strategies analyzed by CBO, the BPC report includes policies to:

- Establish a national all-payer claims database (APCD) to promote a more comprehensive understanding of our health system costs;

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[3] Congressional Budget Office, "Policy Approaches to Reduce What Commercial Insurers Pay for Hospitals' and Physicians' Services," Sept. 2022, https://www.cbo.gov/system/files/2022-09/58222-medical-prices.pdf.
[4] Bipartisan Policy Center, "Improving and Strengthening Employer-Sponsored Insurance," Oct. 2022, https://bipartisanpolicy.org/download/?file=/wp-content/uploads/2022/10/BPC-Improving-and-Strengthening-Employer-Sponsored-Insurance-Oct-2022.pdf.

- Create a database to track health care ownership and require private equity firms to report provider purchases;
- Boost accountability for TPAs and other vendors;
- Develop a standard model provider-payer contract;
- Cap hospital prices in highly consolidated markets;
- Support multi-payer purchasing coalitions; and
- Prohibit settlements between biologic and biosimilar manufacturers that postpone market entry of lower cost biosimilars.

Policies to Advance Affordability Should Target the Drivers of Cost Growth, Not Shift Costs

I applaud this committee for elevating the issue of the looming affordability crisis in ESI, and encourage you to focus your efforts on policies that will target the drivers of health care cost growth. Unfortunately, three of the four concepts under consideration today simply shift the burden of that cost growth to employers with older, less healthy, or low-income workforces. They do nothing to address what is driving health care cost growth in the first place, namely, high hospital and drug prices. I discuss each proposal below.

Association Health Plans

Association Health Plans (AHPs) have long been and remain an option for small employers and the self-employed. Business and trade associations often offer coverage as part of their broader mission to serve the professional needs of their members. Some associations cater primarily to the self-employed, while others cater to employer groups. Prior to the ACA taking effect, some national associations were established by insurers with the sale of health insurance as the main, or in some cases only, purpose of membership.

The regulation of AHPs has been a combined federal and state endeavor. In general, states are the primary regulators of health insurance and health insurance issuers. Although state laws that relate to employee benefit plans are generally preempted under the federal Employee Retirement Income Security Act (ERISA), a 1983 law explicitly exempted AHPs from that preemption. This means that states may apply and enforce state insurance laws with respect to these arrangements. And, to the extent an AHP constitutes an employee welfare benefit plan, states and DOL have concurrent oversight responsibility.

AHPs can offer lower premium rates to small groups and self-employed people even if they offer fairly comprehensive benefits, if they are permitted to adjust rates based on health status or age, and if they do not have to participate in the ACA's single risk pool. If they can successfully enroll healthier employer groups or individuals – through medical underwriting practices or otherwise – they do not have to "pool" those healthier risks with sicker groups in the ACA market. Further, they do not have to participate in the ACA's risk adjustment program, which requires insurers that have healthier than average risk to compensate insurers with sicker risks.

AHPs have a long history of fraudulent practices and solvency problems. For example, as insurers and associations vie for employers' business, some may offer low "teaser" premium rates and use underwriting or other tactics to cherry pick and enroll the healthiest employer groups in the market (something ACA-compliant plans are prohibited from doing). In the worst-case scenario, the low teaser rate is insufficient to cover the groups' claims costs, and the AHP goes under, leaving employers, employees, and providers holding the bag. More commonly, when member employer groups try to renew their policies, they find that their rate reflects their claims experience, meaning that employers with older, sicker employees are asked to pay much higher premiums upon renewal. If this happens, many of these member-employers will drop out of the association and re-enter the ACA-compliant small-group market. Meanwhile, if AHPs lure healthier people out of the ACA market, that means higher premiums for those employers who remain there. Indeed, an actuarial analysis found that if the Trump administration's AHP rules had been allowed to go into effect, self-employed individuals leaving the ACA-regulated market would be, on average, 54% healthier than the individuals who remained. This shift in morbidity would have resulted in a 4.4% increase in claims costs for ACA-compliant insurers.

Some AHP sponsors argue that they achieve lower premiums because they are somehow exercising market clout. This is a fallacy. If they are not engaged in risk selection, then the primary way to reduce costs is to negotiate lower reimbursement rates with providers. It is highly improbable that AHPs are able to do this better than traditional insurers.

Additionally, if history is any guide, many AHPs may seem strong at first because they are able to attract healthy groups and can offer low rates and generous benefits to those groups. Over time, however, as workers get older and sicker, the risk in the pool deteriorates. AHPs then either must raise rates, reduce benefits, disband, or, in the worst cases, become insolvent. AHPs may seem like a simple solution to a real and very serious problem: the high and rising price of health care. But AHPs just create new winners and losers, with the losers being those who are older and sicker. They do nothing to solve the real problem, which is the high and rising commercial prices for providers and prescription drugs.

Self-insurance Protection Act

High health care costs are driving many small employers out of the fully insured group market and into "level-funded" health insurance arrangements. These products combine a self-funded health plan with a stop-loss insurance policy. An estimated 35% of covered workers in small firms are now in a level-funded health plan.

In general, self-funded employer plans purchase stop-loss insurance to protect themselves against catastrophic losses. The stop-loss policy indemnifies the employer once the health care expenses of the health benefit plan reach a certain dollar amount, which is called an "attachment point." Once the attachment point is met, the employer plan is no longer responsible for claims expenses. The lower the attachment point, the less financial risk for the employer plan, putting into question whether the plan is, in reality "self-funded."

Self-funded plans, with a stop-loss policy (known as level funded products) can be attractive to employers with younger and healthier workers, just as AHPs are. They are exempt from most state insurance laws, including reserve requirements, mandated benefits, premium taxes, as well as state and federal consumer protection regulations. For example, they are not required to cover the ACA's minimum essential health benefits. Further, because issuers of the stop-loss policy can use underwriting (i.e., the analysis of an employer's claims experience) to determine a group's eligibility for the policy and the rate, they are able to cherry pick healthy employer groups out of the fully insured market. Later, if an employee or dependent in one of those groups gets a high-cost medical condition, the issuer can dump the employer back into the fully insured market.

The proposal under consideration today would further encourage the proliferation of level-funded plans in the small-group market, posing two primary risks. First, many small employers are not sophisticated purchasers of health benefits, and may not realize the financial risks and fiduciary duties they take on when they self-fund their plan. As members of this subcommittee know better than anyone, the employer is the plan fiduciary under ERISA, and can be personally liable if they fail to fulfil their fiduciary responsibilities. They can also be liable if they know, or should have known, of any breach by a co-fiduciary, such as the insurance company providing claims administration and issuing the stop-loss policy. The National Association of Insurance Commissioners (NAIC) has documented a number of consumer protection concerns associated with level-funded products, including excluded benefits, deadlines that leave the employer responsible for late-submitted claims, termination clauses that give the stop-loss issuer just 30 days to end the contract, without cause, and clauses that authorize premium increases at any time, including retroactively.

Second, if small employers with younger, healthier employees shift to level-funded products in significant numbers, it will leave employers with older, sicker workers in the fully insured small-group market. This causes adverse selection and in the worst cases, an insurance "death spiral," in which premium rates rise for employers whose groups cannot pass the stop-loss issuers' underwriting. Just as with AHPs, federal policies that encourage the expansion of level-funded products will create winners and losers among small employers. Those with young and healthy workers pay less (although they could have unexpected financial liability if an employee gets sick), while employers with older, less healthy workers pay more. As with AHPs, the legislation does nothing to address the underlying reason why there is an affordability crisis for employer-based insurance: the prices that commercial insurers pay for provider services and prescription drugs.

Telehealth Benefit Expansion for Workers Act

There is nothing in federal law that prevents employer group health plans from covering telehealth services, whether they are delivered by brick-and-mortar physician groups or by telehealth-only service providers. Indeed, 87% of small firms and 96% of large firms cover at least some health care services through telemedicine, according to the most recent KKF

employer health plan survey. A full 76% of large employers predict that the use of telehealth in their health plans will either stay the same or increase. And strong majorities of both large and small employers believe that telehealth will be very or somewhat important to providing enrollees with access to a wide range of health care services, particularly for behavioral health.

Stand-alone telehealth benefits were allowed during the COVID-19 public health emergency (PHE) only to try to enable people not eligible for their employer's group health plan to access at least some care during the pandemic. Stand-alone telehealth benefits could not be offered to people eligible for the group health plan. The PHE flexibilities also exempted these benefits from some, but not all, rules for employer group health plans. For example, these plans were not exempted from their obligation to comply with the Mental Health Parity and Addiction Equity Act (MHPAEA).

Under the bill being considered today, telehealth stand-alone plans would be available to all employees (and potentially dependents), even those eligible for the group health benefits. And, as excepted benefits, they would be exempt from the rules that apply to employer group health plans, including MHPAEA. Doing so creates the risk that employers, particularly those with lower-income workers, will substitute a telehealth-only benefit for a comprehensive group health plan.

The legal concept of "excepted benefits" has typically applied to the types of benefits that lend themselves to separate coverage, or where there is a need to offer specific benefits. Dental and vision insurance are examples of excepted benefits. However, this legislation contemplates that the telehealth benefit could cover a broad range of medical or behavioral health services, through a very specific type of telehealth provider – a vendor who is not connected to the patient's regular primary care provider. Such a structure can hinder efforts to encourage care coordination and the establishment of a strong patient-provider relationship, both of which have been shown to be critical to chronic disease management and positive health outcomes.

Furthermore, excepted benefit products are largely unregulated, and do not have to comply with even basic ACA protections like coverage of pre-existing conditions, first-dollar preventive services, and minimum essential health benefits. They also do not have to comply with other critical protections, such as MHPAEA. Numerous market studies have found that many unscrupulous insurers and brokers deceptively market excepted benefit products such as fixed indemnity insurance as substitutes for comprehensive insurance, when in fact they are anything but. Too often, consumers believe they are purchasing health insurance coverage that will provide financial protection if they get sick or injured, only to find out that the plan does not cover even a small fraction of their costs.

Employers are struggling to afford the rising cost of health insurance – this is indisputable. But encouraging the proliferation of stripped-down telehealth benefits that do not cover basic things like hospitalization, prescription drugs, labs, or preventive care, and do not have to comply with the ACA's consumer protections or mental health parity, is not the solution. These

kinds of products leave workers financially on the hook if they get sick or injured, a risk that will have a disproportionate impact on low-income workers. Further, there is no evidence that current federal rules inhibit employers from covering telehealth services in their health plans – indeed – the vast majority already do. Lastly, this proposal also does nothing to address the real reason employer-based insurance is facing an affordability crisis: the prices that commercial insurers are paying for health care services and prescription drugs.

Hospital Facility Fees

I want to thank the Subcommittee for attempting to roll back a hospital billing practice that is driving up costs for employers and enrollees alike. A recent report by the Committee for a Responsible Federal Budget found that policies to encourage site-neutral payments in commercial insurance could, over the next decade:

- Reduce national health expenditures by $458 billion;
- Reduce commercial premiums by $386 billion and patient cost-sharing by $73 billion; and
- Reduce the federal budget deficit by $117 billion.

As hospitals have increasingly acquired physician practices around the country, plans and patients are seeing an increase in "facility fees" for services that can be safely and effectively delivered outside of hospital facilities. For billing purposes, hospitals are treating physician offices as hospital outpatient departments (HOPD), where a fee is often charged to cover the overhead costs of running a full-service hospital even though the patient is not using these services.

However, facility fees, when added to the bill for a physician's services, often mean the cost of the visit is significantly higher than it would be for a visit to an independent physician's practice. For example, the cost of a mammogram is typically 40% more at an HOPD than at an independent physician's office. These additional costs must either be paid by the health plan or passed onto the patient in the form of higher cost-sharing.

Congress and the administration have made some progress on site-neutral payment policy for the Medicare program, but not for the commercial insurance market. There has been some activity at the state level. Connecticut, for example, has barred the collection of facility fees for certain office visits at off-campus hospital-based facilities as well as for telehealth services. The state is also requiring hospital-based facilities to provide notices about their facility fees.

The proposal before this subcommittee is a good step in the right direction by standardizing the information that providers must include on billing forms. This will help ensure that insurers know the location where care was actually provided, rather than just the health system that provided it, and seek to adjust payments accordingly. As you refine it, my colleagues and I at the Center on Health Insurance Reforms look forward to working with you to help ensure that the bill keeps inappropriate and unnecessary costs in check.

Chairman GOOD. Thank you, Ms. Corlette. Finally, we will recognize our fourth witness, Mr. White.

STATEMENT OF MR. JOEL WHITE, PRESIDENT, COUNCIL FOR AFFORDABLE HEALTH COVERAGE (CAHC)

Mr. WHITE. Thank you, Chairman Good. There we go. How is that? Thank you, Chairman Good and Ranking Member DeSaulnier for inviting me here to testify on the ways to reduce healthcare costs for working Americans and their families. My name is Joel White, I am the President of the Council for Affordable Health Coverage.

We are a coalition effort with a single focus of reducing healthcare costs for all Americans. While I address specific issues in my written testimony around association health plans, and self-funded arrangements, I would like to spend a few moments on the bigger picture.

I think we need to end policies that drive up costs for employers. Enact reforms that drive down costs for working Americans. In my mind, this is the most important issue since most people, about 160 million Americans, get their coverage through their job. This is more than the total enrollment of Medicare, Medicaid and Obamacare combined.

Workers like their benefits. A lot. They want to keep their coverage, and they want to improve it, not replace it with a government run healthcare program. I think this issue is also important because businesses and their employees can no longer shoulder the burden of skyrocketing costs. The average cost of a family plan today is about $22,000.00.

Costs have increased 288 percent over the last 20 years, consistently outpacing wages and inflation, making health coverage less affordable. That is not sustainable. I do not think it is any secret that the path to single payer healthcare runs through the small group market, and 90 million workers in small businesses are a soft target.

Under the Affordable Care Act, moms and pops are burdened by costly healthcare taxes and regulations that do not apply to large group plans. Only one-third of small businesses can even offer to afford to provide coverage. Those that decide to offer a company plan must then face unfair competition from the government.

They cannot complete with zero premium Obamacare and Medicaid plans bankrolled by U.S. taxpayers. Subsequent regulations have weakened the employer firewall, enriched subsidies have lured healthy workers into free coverage. This is a classic, predatory pricing scheme. It makes it unrealistic for paycheck-to-paycheck workers to choose private coverage, even when premiums are reasonable.

According to a recent survey by NFIB, equal numbers of small business owners now get healthcare through the government as they do through private insurance plans. All totaled 12 million small business workers now populate government-run safety net programs.

Some would call this a success, but in Obamacare these workers face deductibles that are twice as high as in the small group market, and three times higher than the large group plan average. In

both Obamacare and Medicaid, patients often struggle to find a doctor who will see them.

Millions have a government insurance card but cannot access the care they need. This is in fact, a disaster for those who support lower cost, private coverage, and want to preserve government safety net programs for the truly needy.

Polls consistently show that what employees want in healthcare is affordable employer benefits options, and they want their insurance to work better meaning lower out of pocket costs, and better access to doctors and drugs.

Congress should remove barriers that make it harder to get coverage at work. There are three things you can do. First, expand choices for employers and their employees. Second, provide financial incentives to ensure employer coverage remains viable. Third, enact policies that lower the cost of health services and drugs.

In terms of the first bucket, Congress should enact legislation to create new association health plans, which allow more employers to band together to pool risk and get a better deal. This could reduce premiums by up to 30 percent. You should also create a level playing field by ensuring small businesses can access the same policies as large businesses, including self-funded arrangements.

Congress should also allow stand-alone telehealth coverage for workers, a benefit that expires when the public health emergency ends in 2 weeks. To provide financial help, Congress should reform the small business healthcare tax credit so it is just as easy for mom and pop workers to get coverage from employers as it is in Obamacare and Medicaid.

Finally, to lower costs, Congress should end dishonest billing practices that allow hospitals to charge facility fees and higher prices for services delivered in physician offices. These reforms should be bipartisan. When Obamacare passed, its authors took great pains to argue employer coverage would remain intact. What we have seen since is a war on employer coverage.

Congress needs to take steps to end that war. Thank you for your time. I look forward to answering your questions.

[The Statement of Mr. Joel White follows:]

COUNCIL FOR AFFORDABLE
HEALTH COVERAGE

Testimony of Joel C. White
President, Council for Affordable Health Coverage

To the Subcommittee on Health, Employment, Labor, and Pensions
Committee on Education & the Workforce

On "Reducing Health Care Costs for Working Americans and Their Families"

April 26, 2023

Introduction

Chairman Good and Ranking Member DeSaulnier, I appreciate the opportunity to testify today regarding America's health cost problem that is leading to an affordability challenge for many Americans. My name is Joel White, and I am the President of the Council for Affordable Health Coverage. CAHC is a broad-based alliance with a singular focus: bringing down the cost of health care so that all Americans have access to affordable coverage. Our membership reflects a broad range of interests, including organizations representing small and large employers, patient groups, consumers, and insurers. Collectively, our members provide benefits to tens of millions of Americans and work tirelessly to offer affordable coverage to their workers.

Employers are the largest source of coverage in the US, representing more than half of all covered lives. Employees love their health benefits, and, according to our recent polling, want Congress to strengthen their health coverage.[1] Unfortunately, policies adopted in the last decade, in addition to rising health costs, inflation, a tight labor market, regulatory red tape, and taxes make it difficult, if not impossible, for businesses of all sizes to provide affordable coverage. Worse, some in Congress want to take away private employer insurance. I encourage the Committee to reject that approach and instead strengthen employer coverage by clarifying and expanding ERISA protections.

Congress should make health coverage more affordable and accessible in three ways: 1) expand options for employers and their employees; 2) provide financial incentives to ensure employer coverage remains viable; and 3) enact policies to lower the cost of health services and drugs to reduce premiums and out-of-pocket costs.

The Value of Employer Coverage

Most people have health coverage – 92 percent of Americans.[2] Although it is often masked in today's health care debate by discussions around Obamacare, employer provided coverage is by far the largest source of health insurance for Americans, exceeding coverage through ACA's

[1] CAHC Polling available here
[2] US Census Bureau data - https://www.census.gov/library/publications/2022/demo/p60-278.html

exchanges, Medicare, and Medicaid combined. For example, just 4 percent of Americans get coverage through ACA exchanges, but 160 million get coverage through work. [3]

And people like their coverage – a lot. According to a survey by Protecting Americans' Coverage Together (PACT), of which CAHC is a member, health insurance is the most important benefit an employer can offer workers and their families. [4] In fact, 96% of Americans believe it is important that a job offer health insurance. Additionally, by nearly a two-to-one margin, respondents said they would not accept a job that does not offer health insurance. Finally, 95% of poll respondents believe employer-sponsored health plans are more convenient than looking for coverage on the open market. This is perhaps the most important finding – people like employer coverage because the employer helps resolve problems and deals with a confusing and expensive market. For example, during COVID mental and behavioral health issues became more prevalent and more severe, especially as we became more isolated by working from home and attending school virtually. Many large employers responded by enhancing virtual care via telehealth and digital app solutions. Stand-alone health benefits played an important role in these strategies and filled a significant gap for the workforce.

People do not want to fend for themselves in the individual market and are ill-equipped to do so because they lack scale to negotiate better prices. They also do not want Congress to put them in an inflexible, one-size-fits some government program that only changes when a law is passed, or a bureaucrat changes a rule. Government is slow to keep up with medicine, science, and benefit innovation and the changing needs of a dynamic workforce.

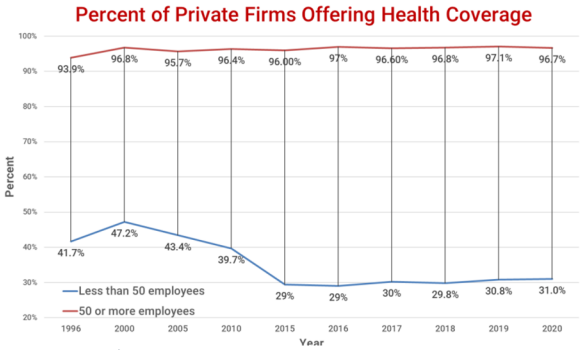
Challenges

Health coverage is expensive because health care is expensive. Premiums buy coverage that pays for medical services and drugs. As health costs increase, so do premiums and out-of-pocket costs like deductibles. The cost of an average family employer plan right now is about $22,000[5], which is roughly equivalent to the all-in one-year cost of an in-state 4-year public institution, including

[3] https://www.kff.org/report-section/ehbs-2022-summary-of-findings/
[4] https://www.uschamber.com/assets/documents/Final-PACT-Public-Opinion-Survey.pdf
[5] https://www.kff.org/health-costs/report/2022-employer-health-benefits-survey/

tuition, room, board, and fees.[6] Over the last decade, the cost of employer plans increased nearly 50 percent, twice as fast as wages, reducing the affordability of coverage.

Most large firms offer coverage to their employees. And while small business accounts for more than 60 percent of new jobs, the smaller the company, the less likely they are to offer health insurance. A full 97 percent of firms with more than 50 employees provide coverage for their workers. But for those companies with less than 50 employees, the offer rate is just 31 percent,



Source: MEPS/AHRQ Data

which represents a significant decline since the enactment of Obamacare. This is by design, as the law created significant new costs for small businesses and new incentives to drop coverage because workers could obtain subsidized coverage through Exchanges.

The biggest challenge small firms face? More than half (55%) of small business leaders cite high costs of health insurance as a barrier to offering health coverage.

Small businesses are also challenged to find relevant health care benefit packages. According to a recent survey from the Small Business Entrepreneurship Council, only 1 in 5 (17%) small business leaders strongly agree that the employer health care solutions available to them have kept up with changing market conditions. In addition, small firms do not have large pools of employees to

[6] https://educationdata.org/average-cost-of-college#:~:text=The%20average%20cost%20of%20attendance,or%20%24218%2C004%20over%204%20years.

spread risk across broad populations or to reduce the administrative costs associated with offering coverage. One sick person at a small business can blow a hole in profits and potentially sink the enterprise.

Government Policies

Congress has enacted laws that make it more difficult for employers to offer coverage, and that create incentives for people to leave employer coverage and join government programs. Chief among these is the Affordable Care Act, which significantly changed market rules for the individual and small group markets. The table below shows the mandates that apply to small firms but not large enterprises. Keep in mind, individual coverage is heavily subsidized, shifting the costs of the mandates onto taxpayers.

ACA Market Reform	Individual Market	Small-group Market*	Large-group Market*
Guaranteed issue	Yes	Yes	Yes
Pre-existing condition exclusions prohibited	Yes	Yes	Yes
Out-of-pocket maximums	Yes	Yes	Yes
Annual and lifetime limits prohibited	Yes	Yes	Yes
Preventive services covered without cost-sharing	Yes	Yes	Yes
Essential health benefits	Yes	Yes	No
Rating rules	Yes	Yes	No
Single risk pool	Yes	Yes	No
Risk adjustment program	Yes	Yes	No
Medical loss ratio	80%	80%	85%

*Applies to fully insured products. The small-group market is defined in most states to be groups of up to 50 employees, with large group defined as groups with 51 or more employees.

Source: New Rules to Expand Association Health Plans, American Academy of Actuaries Magazine, May 2, 2018

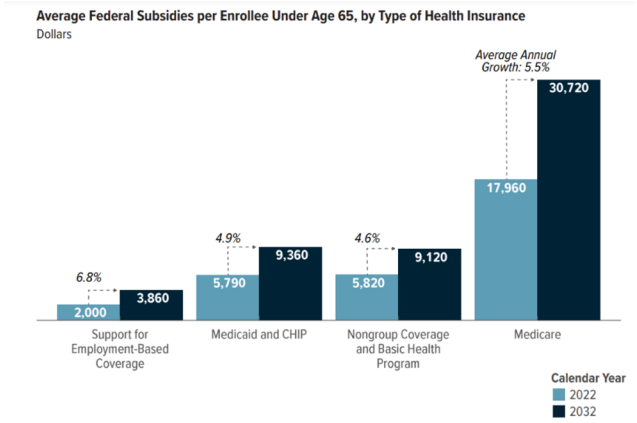
While Congress talked up the benefits of these reforms, the cost of imposing these changes were rarely discussed and created several important dynamics that are playing out in the market today. First, mandated benefits and new market rules increased the cost of coverage and shifted those

costs onto taxpayers via premium subsidies. Second, small businesses got most of the mandates that increased costs, but none of the benefits of premium reduction subsidies. Third, Congress created a tax credit for small businesses to offset these costs, but the credit was structured so poorly, just 7,000 firms (out of 30 million) took the tax incentive in 2016, the last year data from the IRS is available. Lastly, small businesses have no mandate to provide coverage. As Congress increased their costs and limited their choices, the authors of the ACA created powerful incentives for small businesses to drop coverage.

And they did. As a result, some hardworking Americans' only options are programs like ACA, where they struggle with higher deductibles and less access to care. Or they are enrolling in Medicaid, which has little access to doctors and drugs. It is estimated as many as 12 million people who work for small firms get coverage in ACA and Medicaid.

We need strong safety nets, but ACA and Medicaid are not a good deal for enrollees or taxpayers. In 2021, deductibles were twice as high in Obamacare than in small business plans ($4,500 versus $2,000), and access to care is often restricted by very narrow networks.[7] In Medicaid, doctors are increasingly unavailable.[8] So, while people may have a coverage card, they have limited access to doctors, and as a result, many seek care in high-cost settings like the hospital. Subsidies in both the ACA and Medicaid are three times more expensive than in employer coverage, according to CBO. Taxpayers pay the bill for higher costs and less access.[9] Those taxpayers include small business employees already struggling with the high cost of healthcare.

[7] https://www.gao.gov/assets/820/814141.pdf
[8] According to a November 2021 MACPAC report, "Adults with Medicaid coverage were significantly less likely to report having a usual source of care than adults with private coverage. They were also significantly more likely to report not receiving or delaying medical care, prescriptions, and dental services compared to adults with private coverage."
[9] https://www.cbo.gov/system/files/2022-06/57962-health-insurance-subsidies.pdf



Increasing Choices and Lowering Costs

Considering the challenges faced by all employers, including government policies that are not working well, Congress should take steps to: 1) expand options for employers and their employees; 2) provide financial incentives to ensure employer coverage remains viable; and 3) enact policies to lower the cost of health services and drugs to reduce premiums and out-of-pocket costs. These include:

1. Level the playing field: Give small businesses the same benefit design options available to large businesses;
2. Make a good thing better: Allow more people to form and join Association Health Plans; and
3. Extend telehealth flexibilities: Continue allowing employers to offer standalone telehealth benefits.

Level the Playing Field

Kaiser Family Foundation (KFF) reports that 65 percent of workers are covered by a self-funded plan[10], meaning that the employer directly funds the health plan benefits. Self-funded employers are able keep premiums low and exercise greater control over plan benefits. The ability to self-fund is at the disposal of big business, but for small businesses this attractive option is often out

[10] https://www.kff.org/report-section/ehbs-2022-section-10-plan-funding/

of reach due primarily to cost and availability.[11] Kaiser estimates that large firms cover more workers under self-funding arrangements than small business (82 percent versus 20 percent), but small firms are increasingly using self-funding as an emerging strategy to better manage costs and innovate benefits.[12]

A level-funded plan is a type of self-funded plan that is an exception to that rule, offering a self-funded model that is more accessible to small business because it reduces risk for small employers. Level-funded plans have three parts:

- Administration (processing of claims, estimating premiums),
- Claims costs (payment of actual employee medical expenses), and
- Stop-loss (insurance coverage for excess losses).

Level-funded plans reduce risk and streamline administration by offering a fixed monthly price that covers the cost of administration and stop-loss, and fully funds the claims' risk for the year. Employers have flexibility to design their plans, and they can shop for the best deals based on attachment points that make sense. Recognizing the savings and benefits of this model, 36 percent of covered workers at small firms reported enrollment in a level funded plan in 2022.[13]

Some states have started limiting small employers' ability to offer self-funded plans. While states lack jurisdiction over self-funded plans directly (which fall under ERISA and outside of state law in most circumstances), some states have effectively eliminated small employer access by banning the sale of level-funded plans to certain size groups or making the sale of low attachment point plans illegal.

To help small businesses across the country, Congress should protect access to level-funded plans and reinsurance (including low attachment point reinsurance) policies by ensuring they remain

[11] **2023 Small business Health Insurance Survey, NFIB.** https://strgnfibcom.blob.core.windows.net/nfibcom/Health-insurance-survey-NFIB.pdf
[12] https://www.kff.org/report-section/ehbs-2022-section-10-plan-funding/
[13] ***Ibid***

available for sale and purchase in all states. This would involve clarifying ERISA preemption with respect to self-funded arrangements for small businesses.

Make a Good Thing Better: Association Health Plans

Congress created ERISA decades ago, and insurance sold through associations had long been an option for employers to purchase coverage that works for their employees. Millions have done so. The Department of Labor (DOL) allows a group or association of employers to sponsor a single multiple employer plan if it is a bona fide group that shares a commonality of interests and the benefit arrangement is controlled by the employer members.

Under current law, insurance coverage provided through an employer association to individuals and small employers is regulated by the rules of those markets unless the coverage is through a single ERISA covered plan. Unless the arrangement constitutes a single ERISA covered plan, the regulatory framework disregards the group in determining what rules apply (individual, small or large group), and then regulators apply those rules. The size of each employer participating in the association determines the regulations that apply. As a result, different members of the association will have different rules apply based on their circumstances. This makes association health insurance very difficult to administer and discourages employers from banding together to provide association coverage.

In 2018, DOL concluded the ERISA rules treated association arrangements as mere collections of individual plans, subjecting employer members to a complex and costly compliance environment where members may be simultaneously subject to large group, small group, and individual market rules. On June 21, 2018, the Department issued a Final Rule[14] to expand the availability of association coverage for small businesses and self-employed individuals. The final rule would have broadened the types of employer groups or associations that may sponsor a single group health plan under ERISA. It made it easier for more groups to form AHPs by establishing a more flexible "commonality of interest" test if their members were in the same trade, industry, line of business, or profession, or maintained their business in the same geography (same state or

[14] **29 CFR Part 2510**

metropolitan area). It would also expand AHPs to self-employed individuals, former employees, and family members, creating important new coverage options for people who may slip between the cracks. Importantly, the rule allowed employer members to benefit from size to pool risk and be regulated under the ERISA framework. CBO estimated that almost 4 million more people would be covered by these arrangements, with nearly half a million newly insured, largely because premiums would be 30 percent less than in fully regulated small group market coverage.[15]

The rule was challenged in Federal District Court by 11 states and on March 28, 2019, was vacated, disrupting the market by creating legal and regulatory uncertainty. The Court's decision was appealed to the Court of Appeals for the D.C. Circuit where it sits to this day "in abeyance" due to the change in Administration. The Administration intends to propose rule changes to the 2018 AHP rules.

In the Memorandum Opinion, the Federal District Court found the Final Rule "…exceeds the statutory authority delegated by Congress in ERISA."[16] Congress must act to clarify the status of AHPs and expand AHPs as an option for the many businesses eager to lower costs.

A good start would be to pass Congressman Walberg's bill the Association Health Plan Act to ensconce AHPs in statute, clarify regulatory authority, and expand AHPs as an option for employers. The bill would also ensure AHPs cannot limit eligibility for coverage based on medical history or health status, fully insured AHPs must comply with state benefit mandates, and self-insured AHPs comply with state MEWA rules. It clarifies the definition of employer and removes the commonality of interest requirement, allowing more associations to form and pool risk to lower premiums. We expect premium reductions, and more people insured, a welcome relief to the status quo.

Don't Take Away Benefits: Continue Allowing Employers to Offer Standalone Telehealth Benefits

[15] https://www.cbo.gov/system/files/2019-01/54915-New_Rules_for_AHPs_STPs.pdf
[16] https://affordablecareactlitigation.files.wordpress.com/2019/03/5940153-0-12659.pdf

During the COVID-19 designated public health emergency (PHE), many employees have enjoyed access to telehealth services because employees who do not qualify for a group health plan offered by their employer, were able to access stand-alone telehealth benefits. On May 11th, the PHE is set to expire, and this flexibility will end. Seasonal and part-time workers will also lose access to telehealth services in many cases.

Congress should pass H.R. 824, the *Telehealth Benefit Expansion for Workers Act*[17], to change current law to allow employers to offer workers stand-alone telehealth benefits. Under the bill, stand-alone telehealth benefits would remain separate from traditional group health plans.

I. Conclusion

With the continued rise in health costs, CAHC is very concerned that we're dangerously close to a two-tier health system within the American workforce. If you work for a Fortune 500 company, University, or government agency – or anyone else with a large group plan – you get generous, high quality, private coverage. But if you're self-employed, work at a small business or earn working-class wages, you have to choose between two bad options – a high-deductible Obamacare plan or Medicaid, with a dearth of provider options. This is a disaster for those who believe in private healthcare and want to preserve government safety net programs for the truly needy. Workers deserve better access to private coverage and Congress needs to act.

Thank you for the opportunity to testify today, and I am happy to answer any questions.

[17] https://www.congress.gov/bill/118th-congress/house-bill/824

Chairman GOOD. Thank you, Mr. White. Under Committee Rule 9, we will now question witnesses under the 5-minute rule. I will wait to ask my questions at the end, and therefore recognize Mr. Walberg from Ohio for 5 minutes.

Mr. WALBERG. I am going to let you do that over, Mr. Chairman. I appreciate your comedy.

Chairman GOOD. Oh, Michigan. Of all things to say, Ohio versus Michigan, sorry to my early morning workout warrior, Mr. Walberg, from Michigan.

Mr. WALBERG. That is a Buckeye mistake.

Chairman GOOD. We fly over there.

Mr. WALBERG. I am glad to see Iowa there. I have got a twin brother living in Iowa, so. Thank you for allowing me this opportunity. I would like to thank the Chair and our panel of witnesses for joining today's important discussion. An important discussion that has gone on for too long and needs to come to a solution that I think we are working, and I think we are talking about that today.

The high cost of healthcare remains a struggle for small businesses, many of whom are facing lingering hardships from the pandemic as well as inflation, which is a tax on everyone. Association health plans are a commonsense solution that empowers small employers, and their employees when making health coverage decisions by providing small businesses with greater bargaining power.

It allows them to offer more quality options for workers at a better price. That is what we are looking for. The Association Health Plans Act will expand pathways to more affordable healthcare for small businesses and entrepreneurs across the country.

The other bill that I am pleased we are discussing is H.R. 824, the bipartisan Telehealth Benefit Expansion Act, which continues employer's ability to offer stand-alone telehealth benefits to their employees, especially part-time and seasonal employees, who would not otherwise be enrolled it the employer's medical plan.

Telehealth was a lifeline for millions during the pandemic, and has the potential to alleviate provider shortages, especially in mental health and behavior health. The last Congress I was proud to partner with my friend, the late Jackie Walorski, as she spearheaded congressional efforts to expand telehealth.

I am honored to take up this bipartisan bill with Representatives Bean, Allen, Craig, Estes, and Sherrill, and hope we can advance this bill in Jackie's memory and for the benefit of needs out there in the community. Ms. Strouse, large businesses can offer lower cost plans to their employees because their size allows it, and they enjoy economics of scale.

The administrative efficiencies, and the negotiation clout. In your experience, how would expanding association health plans for employers level the playing field for small and mid-size employers, and lower costs?

Ms. STROUSE. Yes. Well, I think we can all agree options are great. The more we can put on the table for employers to actually be able to access is a good starting point. In the association plan space, the large employers have the ability to bill based on the number of lives they have, the risk that they can spread across that.

When you look at association health plans, this has that same idea behind it. Once you get into that larger space, you actually have more access to carriers. You have more access to plans you have more flexibility with customizing those benefits for your employees. That is just one big thing for us looking at how out of pocket maximums have been going just through the roof.

I mean right now the average out of pocket maximum is $9,000.00. That is not sustainable. When we look at the association health plans with specific guardrails, which I think have been outlined in this bill, it gives those employers the ability to actually feel like a large employer, but then each employer is actually looked at within their own risk.

In the situation where maybe you do have an older population, or you might have some people that have some health issues, you still have that big, large pool that is helping that situation. You still have that risk that is being spread apart, but then those employers are still specifically looked at on their own, so they could have a rate.

Mr. WALBERG. Safety and security, and flexibility.

Ms. STROUSE. Absolutely. What we do see in these types of benefits are more robust benefits, so yes.

Mr. WALBERG. Thank you.

Ms. STROUSE. Yep.

Mr. WALBERG. Mr. White, Ms. Corlette's testimony alleges that association health plans may offer low so-called teaser premium rates to cherry pick health employer groups. Does the Association Health Plans Act allow for teaser premium rates?

Mr. WHITE. It does not. In fact, it sets a rate for the entire group, and if there was a teaser rate offered, that would be considered not actuarily sound, which the bill actually requires, so teaser rates are not authorized by this bill.

Mr. WALBERG. We do not want to tease.

Mr. WHITE. We do not want to tease.

Mr. WALBERG. We want the experience to be good and productive.

Mr. WHITE. That is right.

Mr. WALBERG. Let me move over to the telehealth benefits. Mr. Watts—Ms. Watts, excuse me, Mrs. Watts, what type of employers currently offer stand-alone telehealth benefits?

Mrs. WATTS. I have a couple of examples of our clients that do this. One is a national convenience store chain, that is very similar to the restaurant chain that I mentioned. A private daycare preschool employer, and a K through 12 employer who need teachers in the classrooms, and they just want to be able to continue doing business, and providing something that is valuable, and they have very low take up rate of their insurance, and so it is super valuable.

Then we have got like a smaller landscaping company. It is kind of a transient workforce, lower paid, and they just feel like they needed to do something, and so it was a way to provide that care.

Mr. WALBERG. Better health, better opportunity. My time has expired. I will submit further questions for the record. Thank you.

Chairman GOOD. Thank you, Mr. Walberg from Michigan, and we will now recognize our Ranking Member, Mr. DeSaulnier, for 5 minutes.

Mr. DESAULNIER. Thank you, Mr. Chairman. Well again, thank you for having this meeting. As I mentioned in my introductory comments, I am a former small business owner having owned restaurants in California, including places like San Francisco and Berkeley, California, so you could imagine working with my colleagues, sometimes from my perspective, might have been a challenge.

I was successful at it. I was also a long-time member of the NFIB, although I think when I was in the legislature you might have terminated my membership. I was also a member of the California Restaurant Association. Ms. Corlette, as a small business owner, I can see the benefit of banding together for small business.

I agree with much of the comments. Getting it right, to make it work for everybody, and human nature being what it is, a lot of the proposals allow for people to manipulate what should be a benefit for everybody. Could you comment a little bit about how we could get association and pooling together, like people like the California Restaurant Association for small members to get the benefit that large employers get, under the ACA.

Ms. CORLETTE. Thank you, Congressman, and first of all, I want to say that I think the Chairman and the other witnesses that I am here with. We are all, I think, equally concerned about the burden of health care cost for small businesses. They really are hindering competitiveness and threatening the financial success of small businesses.

With respect to association health plans, the concern that I and many have is that they offer lower premium rates to small groups when they are permitted to adjust rates based on each small employer's health status or age, and if they do not have to participate in the Affordable Care Act single risk pool, or risk adjustment programs.

This means that they can use underwriting practices to skim off the healthier, small employer groups, and they can offer a lower rate because they are paying less in health care services because it is healthier groups, leaving in the ACA market small employers who have older workforces, or who have workers who are not as healthy.

This leads to what we call an adverse selection problem in health insurance, which means that premiums start to go up and up for those employers who are not as healthy as the ones attracted to the AHP.

Mr. DESAULNIER. That was the case, but worse before the ACA, particularly in the restaurant business, because younger employees, and I was one once, when they first start, many times when they are still going to school, do not want to pay for health care. I had young employees who said, why do I have to pay anything, and you only pay a portion of it?

I prefer just to get a raise, a wage increase. The ACA is trying to address that, and I would not say it is a finished product by any stretch of the imagination, so hopefully we can work on it together. Let us talk about telehealth, first on the medical side. Now as a

survivor of stage four cancer, and a consumer continuing with an immune system that needs constant attention, telehealth can be a benefit.

I agree, particularly in rural areas, multiple benefits. Again, getting it right, and having a rational, less ideological conversation. As a survivor of cancer, I do not care what registration or ideology my doctor is, as long as he keeps me alive.

Here is an example of where I think we could work in good faith, acknowledging we start at different perspectives. Tell me about some of the pitfalls as you see it, as you have already explained in the beginning, particularly about being transparent, so people understand that telehealth could be a component in medical health, and maybe you can add a few comments about on the behavioral health side. Again, where I could see a great benefit, and have seen personally a great benefit.

Ms. CORLETTE. Sure. Absolutely. It is very clear that employers and employees highly value the delivery of health care services through telehealth. As I mentioned in my statement, 96 percent of large employers already offer some coverage of telehealth, and a vast majority of them think that the use of telehealth by their employees is likely to increase over time.

Employers are committed to covering telehealth services, and they see it as a really important part of their employees' health benefits. My concern with creating a telehealth benefit as an "excepted benefit" under ERISA is that it carves it out from the employee health plan, siloing it from major benefits.

It exempts it from all Federal regulations, including mental health parity, Affordable Care Act protections, and it leaves people without those protections. We have also seen with other excepted benefits such as fixed indemnity, that quite often these benefits are marketed to consumers in deceptive and misleading ways, leading them to believe that they are getting comprehensive health insurance, when they are actually getting a product that does not provide financial protection.

Mr. DESAULNIER. Thank you. My time is up. Mr. Chairman, I look forward to working with you on these issues because I hope you can tell from my comments, although I strongly disagree with many of your perspectives, I think there is an opportunity here to accomplish some real good for the American public. Thank you. I yield back.

Chairman GOOD. Thank you, Ranking Member DeSaulnier, and now I recognize Chairman Virginia Foxx from North Carolina.

Mrs. FOXX. Thank you, Mr. Chairman. I thank our witnesses for being here today. Mrs. Watts, most Americans were covered by employer sponsored insurance are satisfied with their coverage, yet our Democrat colleagues continue to push the expansion of government run, one size fits all healthcare programs. Can you discuss the benefits of employer sponsored insurance as compared to plans on the Obamacare exchange?

Mrs. WATTS. Of course, Chairman Foxx, I would be happy to. First of all, the benefits that are provided by employer sponsored plans for the most part are much better than those on the market. The deductible levels tend to be lower, and the out-of-pocket maximums are lower. In addition, the contributions are lower, even with

the government subsidies for many people with employer sponsored health plans.

I think one thing though that we maybe lose sight of is that the networks that the employers plans use tend to be a broader network of providers, and so it is not a narrow network. It gives members more choice of where they can seek care. One thing that is kind of near and dear to my heart is innovation. Employers are always looking to spend less and do more with their benefit packages. I think they really push the market, and they go after the new up and coming things that are available.

They are more quick to adopt those things, and they are not just, you know, caught up in a lot of regulatory barriers. Then, you know, I will say that employers work hard to offer, you know, a curated choice. They typically offer three or four benefit options. You know, there is a lot to choice architecture, and you can overload somebody with choices, and it becomes overwhelming, and they cannot decide what plan they want to be in.

I think the idea of meaningful choice is very important to employers. The last thing I will say is that we do a survey worldwide of workers, and when we ask them whether or not they agree that their employer cares about their health and well-being, 66 percent of workers globally say that their employer cares about their health and well-being.

In the U.S. it is 75 percent of workers feel that their employers care about their health and well-being, and I think that that's a big part of why employers offer healthcare benefits.

Mrs. FOXX. That is great news. Your comments mirror my experience in hearing from constituents. They hate Obamacare, and the government run programs because they are not flexible. Mr. White, Ms. Corlette wrote in her testimony that expanding access to association health plans, and tools that employers need to self-insure, such as reinsurance, will shift costs to the individual in fully insured market, and will result in employers offering worse coverage.

I think we have even heard those comments today. Do you agree? Why? Or why not?

Mr. WHITE. Yes. I disagree. I think our first goal should be to expand choices and options for employers, but I think the assumption is that healthy people will be the ones to switch, and that Will destabilize both the individual and the large group market, and we just disagree with that.

In fact, we think that there's a couple reasons for that. I think AHP's will actually be a richer set of benefits for people. First, I think the wider provider networks, more access to doctors and drugs and hospitals. We see a very narrow network on the ACA.

The second reason is I think AHP's will provide lower deductibles, and we see very high deductibles in Obamacare. $4,500.00 is the average in 2021. It is less than twice that in the small group market, so less cost sharing. That will attract people who have some claims experience, that have health conditions, right?

It is not going to be all the healthy people, it would be a mix of risk.

Mrs. FOXX. Right.

Mr. WHITE. Which means that risk will be pulled together, rates will be driven down because you have a larger risk pool, and people will experience lower premiums, but there are no subsidies in these AHP's or self-funded plans, to attract that healthy risk.

A lot of that healthy risk will continue to choose Obamacare, where the subsidies are very, very, very generous. So that is most of the reasons.

Mrs. FOXX. Thank you very much. Ms. Strouse, do you agree with Ms. Corlette's statement that "many small employers are not sophisticated purchasers of the health benefits, and may not realize the financial risk and fiduciary duties they take on when they self-fund their plan." Why or why not do you agree?

Ms. STROUSE. Well, I would say probably the majority of Americans are not sophisticated buyers of their health insurance, so this is the role of the insurance agent. This is why having an agent is so important today because we are looking for options across all lines, and in some cases that is actually using the marketplace as an option for small employers and group products.

Mrs. FOXX. Well, let me add to that. I think the left's attitude toward us as individuals, and to small business is very negative. They think we are all a bunch of dumb people who do not know how to make decisions for ourselves, that is why you need the government to do everything for us.

The Life of Julia shows, you know, government takes care of everything. I think it is a real slam on small businesses. My husband and I had a small business. My daughter runs a small business. Every small businessperson I know is very bright, and could not stay in business if they were not bright, and had to figure out how to get things done. I think this kind of attitude is an attitude that exists among Democrats and the left, and it really is terribly offensive to me. Thank you very much.

Chairman GOOD. Thank you, Chairman Foxx. Now I would like to recognize Congresswoman Wild from Pennsylvania for 5 minutes.

Ms. WILD. Thank you, very much Mr. Chairman. Let me just start by saying that it always dismays me the amount of vitriol and partisanship that we experience when we are even engaging in discussion and debate about health care in America. It is really a shame.

I think the one thing we could probably all agree on is that we are fortunate to have some of the best medical providers and hospitals in the world right here in the United States. It would be really nice if we could all come together behind making sure that every single American can afford these outstanding providers that they often need, but cannot afford.

One of my major goals in Congress, I will tell you I have been here since the beginning of 2019. This is my third term. One of my major goals is to try to find paths for bipartisanship, bipartisan bills that we could work on that will advance this cause.

I will be very open to any suggestions that any of the witnesses might have about that. Before I open it up to that, I just want to say that one of the things that I am proud of that we were able to do on a very bipartisan basis in 2020 was to advance legislation

to protect consumers from surprise out-of-network bills, and ultimately passing the No Surprises Act.

I personally in my family have seen the advantages of that, and I have talked to many others who have. Ms. Corlette, let me just start by asking you what your thinking is, what your knowledge is of how the No Surprises Act has made health care more affordable for consumers?

Ms. CORLETTE. Sure. Yes. Thank you for the question. As you know, the No Surprises Act protects people with insurance in certain situations when they really have no choice of providers, so those are emergency situations, and also if they are getting care at an in-network facility, they have done their homework, and they have made sure to go to an in-network hospital, and yet they are treated in some way by an out of network clinician, that can be an anesthesiologist, or a radiologist.

Ms. WILD. I am sure there is no person around who has not received a bill at some point in time, looking at it and saying I do not know who this doctor is. I do not know when I received this case, except for the date on the bill, and that is very frustrating for everybody.

Ms. CORLETTE. Right. Absolutely. The law went into effect last year, so we are about a year plus into it, and the good news is that it is working as intended. 177 million people now can have peace of mind that if they have an emergency, or if they are in a hospital that they know is in-network, they are protected from those surprise medical bills, so good news.

Ms. WILD. The one thing I would note on that is that I believe, if I am not mistaken, that we still have a lot of problems in terms of people who require ambulance service, EMS not being covered in-network, and I have talked to EMS providers in my own district.

That is an area that I would personally like to see us move forward in a bipartisan way and try to figure something out. I would like to open it up, if any of you have any—I wish I had far more than a minute and a half left because this is a really important topic, but I would love to hear any ideas that any of you might have for other initiatives that we might take on a bipartisan basis. I open it up to any one of you.

Mr. WHITE. I will jump in here. I think that you have mentioned one. It is expanding out No Surprises to cover ambulance services, huge out-of-pocket costs for a lot of people who get surprised, and not covered by the law, right?

That is important. The other thing I would focus on is telehealth. I mean the telehealth bill that we are discussing today is bipartisan. There are a number of Democrats and Republicans on that. I think what we saw during COVID was telehealth really filled the gap. It allowed people to access care that they otherwise would not be able to get.

Ms. WILD. Let me just—I am sorry to interrupt, but I will tell you I am a huge fan of telehealth. I actually sponsored a bill during COVID to make sure that older Americans had access to telehealth. I really am a big fan of it. I have a great concern about stand-alone telehealth plans, and whether they would be—that people could be misled into thinking they had a comprehensive

health plan, and when they needed a hands-on doctor, they would not have that ability.

Okay. With 15 seconds left, go ahead.

Ms. STROUSE. I just want to bring up the fact that the cost controls are a big thing too, so the site neutral payments and facility fees within the hospitals, and buying up all these small, little independent providers.

Ms. WILD. I actually plan to submit a question for the record. I knew that I would run out of time on that very issue, so thank you very much. Thank you all. Thank you for this important hearing.

Chairman GOOD. Thank you, Representative Wild. Now we will go to Congressman Allen from Georgia for 5 minutes.

Mr. ALLEN. Well, thank you, Mr. Chairman and Ranking Member. I miss sitting beside you by the way, those were some good hearings we had back in the day, but it is good to be here this morning. I come from the business world. I was in business, still my wife is in business now, I tell people a lot on a Tahoe and a Member of Congress, but yes, I served because I was involved in healthcare. I was Chairman of a hospital board for 9 years.

I was asked to serve on the Healthy Future Task Force. I will tell you what I learned is this government is driving up the cost of healthcare because the government is driving healthcare. Even the private sector has joined forces with the government.

They are all in it together. You know, and I challenge my colleagues, you know you talk about anger and vitriol, go to the emergency room on a Friday or a Saturday night. You know, get out in your districts, see what's going on. You will see anger in vitriol like you have never seen it before.

I personally, feel empathetic to those providers that have to sit there and put up with what these people are throwing at them, and then they have to take care of them. Unfortunately, that is where our country is. In fact, what I found in this process in talking to—we talked to hundreds and hundreds of professionals, patients, you name it, to try to get to some solution here.

Nobody is happy in healthcare. Nobody. The patients are not happy, the providers are not happy, and let me tell you. You talk to the American Medical Association we are experiencing a severe shortage in providers. That is not going to be good for any of us. I ask the question why?

It is because this government is in charge of your healthcare. We have only a government healthcare system. That is it. All the privates, all the hospitals, have got onboard, and are following it right down the road. Like I said, I come from the business world, and what I would like to ask Mr. White is this.

Obviously, the only way to bring down costs is competition. Right now, the only people that have a waiver, and our State has been trying to get waivers to drive down costs in our State of Georgia. We have got waivers from the Trump administration, and they were all taken away under the Biden administration.

We were driving down costs with these waivers. The only people that get waivers now are unions and the faith-based communities and thank goodness for the faith-based communities because they have some programs that are reducing costs for families of faith.

We have to have a private system in this country to compete with the government system. That will keep government accountable and competitive, because right now it is the wild, wild, west, and we are going to—and it is unsustainable. Mr. White, what are your recommendations?

Mr. WHITE. I think you highlighted the problem excellently. I think the fallacy is that people think that we have free market healthcare in the United States. We do not. We have 93 percent of all health markets that are highly concentrated, that means they lack competition for services, providers, doctors, hospitals, et cetera.

In those markets consumers pay much higher prices. One of the reasons is we have a lack of enforcement from government bureaucrats and agencies. The other reason is that we really have done a poor job explaining what free market health coverage is.

I think you are starting to take some of those steps here today to talk about competition.

Mr. ALLEN. Yes.

Mr. WHITE. Letting people band together to get big pools to negotiate lower rates.

Mr. ALLEN. Exactly.

Mr. WHITE. Look, Costco and Amazon can negotiate a lower price because they are really big.

Mr. ALLEN. You give the business community a waiver? They will fix healthcare in this country. Quality will go up, providers will come back because they do not have to deal with the force of this Federal, and the oppression of this Federal Government.

Mr. WHITE. Congressman, I am going to say one more thing. Fifty cents of every dollar spent on healthcare comes from Washington, DC.

Mr. ALLEN. Yes.

Mr. WHITE. Every entity in healthcare is regulated at some level, local, State, Federal, by regulations, and so they are constrained in what they can do and offer. What we are talking about today is flexing that upwards a little bit.

Mr. ALLEN. Yes. I have got to add one thing. I asked the question to every one of these professionals. Can you break down the cost of healthcare for me? Peel the onion. That way I can figure out where the money is going. Not a single one of them can do it, and with that, Mr. Chairman, I yield back, and that is the only way we are going to get to the bottom of this because somebody is on the take here. Thank you.

Chairman GOOD. Thank you, Congressman Allen. Now we will recognize Congressman Courtney from Connecticut for 5 minutes.

Mr. COURTNEY. Well, thank you, Mr. Chairman, and thank you for the witnesses for being here. I would like to start and followup with some questions with a basic sort of fact, which is that really, just months ago, we finally enacted a cap on insulin for Medicare patients.

Again, this is a drug that is been off patent for over 100 years. I mean any sort of argument that it needed to be priced two or three times higher than, you know, what people pay in Europe, or other parts of the world, you know, because we got to support R&D I mean is, you know, absurd when you talk about a drug like that.

You know, which again it has been off patent. Again, starting on January 1, Medicare patients are now paying no more than $35.00 a month for their insulin refills. I have friends in my district who say that is one-third of what they were paying before. When we passed the bill initially in the House, it actually extended that benefit to you know, working age individuals in their employer-based plans.

We unfortunately came up, I believe it was about three votes short in terms of overcoming the 60 vote threshold in the Senate, and you know, to me you know, that just sort of is blindingly obvious, that is a way of helping reduce the overall, not just that specific drug, but also the overall costs, and frankly we need to look at that deeper.

In Connecticut we just raised, we just had approval of small group plans, I think there is about 12.9 percent in the State of Connecticut, Department of Insurance. They identified prescription drug costs as the No. 1 cost driver in terms of what is making premiums go up.

Again, it is not because of the fact that we do not give the government enough authority to negotiate a better price, like we did with insulin, it is because we do not do enough of that. Again, you know, I just would ask Ms. Corlette, to just sort of comment on that. That if we are really serious about reducing costs, we have got to look at what insurance plans actually pay for, and try to figure out ways to reduce those costs.

Ms. CORLETTE. Thank you, Congressman, for the question. Yes, the Inflation Reduction Act made great strides in improving prescription drug affordability for Medicare enrollees but stopped short of extending that help to people with employer-based or commercial insurance.

A recent analysis by the Kaiser Family Foundation found that capping insulin at $35.00 a month for people with private health insurance would provide financial relief to about 20 percent of employees, and for people who pay currently more than $35.00 per month for insulin, half of them would save at least $19.00 a month, and 25 percent would save at least $42.00 a month, so really significant savings.

Mr. COURTNEY. You know, it is interesting because we are about to vote I guess this week on this debt ceiling plan, where huge pieces of the Inflation Reduction Act are being gutted for energy tax credits. It appears that the majority has kind of kept hands off the insulin price.

I mean again, I am not sure of that for a fact, but we will maybe find out more, but I mean to me that speaks volumes about the fact that it is just an undeniable policy advance in health care, which is to use the negotiating authority of Medicare, which is the second largest health plan in our country to really get, you know, a better deal in terms of what the taxpayer has to underwrite, as well as what the patient has to pay.

Again, the bill goes on though. It is not just about insulin, it also is going to cap out-of-pocket for anyone on Part D over a time period. I met with MS patients, multiple sclerosis patients, who are now getting injection treatment where, despite the fact that they are affluent, even good insurance, they are just totally hammered

by the cost of that, and most of them end up on Medicaid. They were in tears with gratitude for the fact that Congress did what we did in the Inflation Reduction Act, which was putting an overall cap, again, that will apply to their predicament.

Again, if you could Ms. Corlette, comment on that. We are talking about a broader universe of savings.

Ms. CORLETTE. That is right. I think expanding, leveraging the negotiating power of a large purchaser like Medicare to deliver savings to employer-based plans for high-cost prescription drugs will trickle down to savings for workers and their families. Then the other protections in the IRA, particularly related to that cap on out-of-pocket would also be incredibly helpful for a lot of families. Thank you.

Chairman GOOD. Thank you, Mr. Courtney. Now we will recognize for 5 minutes, Congressman Banks from Indiana.

Mr. BANKS. Thank you, Mr. Chairman. There are nearly a half a million small businesses in Indiana that employ over 1.2 million Hoosiers. Ms. Strouse, you wrote that 98 percent of small businesses report that healthcare cost will become unsustainable in the next 10 years, threatening their ability to survive and remain competitive.

I wonder if you could just be more specific and explain to us what are some of those main drivers of those costs that you are talking about?

Ms. STROUSE. Yes. Thank you for that question. I am going to continue on that pharmacy topic that we just opened up, and I love the starting point of addressing some of these insulin prices. When you negotiate on Medicare only, most of the time those drug manufacturers actually move those prices somewhere else. It gets moved into the private market, and so that becomes challenging.

Right now, 25 percent of premiums are driven by your prescription cost, and caps again sound lovely, but why are we not going to the drug manufacturers and making sure that those insulin prices are affordable for everyone across the board? So those are the conversations that need to be had, and if we do not address those, then that right there is a huge factor.

Our specialty medications are driving the majority of our claims that are coming in, and most of those people are seeing commercials on TV, and they are walking into their provider's office and asking for those specific medications. I have an employer right, now that 91 percent of their prescription costs are driven by ten specialty medications.

It is a huge spend for them. I would say that is first and foremost, and then the hospitals site neutrality payments. We love our providers. We have to have them. We live in a very rural State, and it is super important to make sure that doors are open. After the ACA rolled out there was a ton of consolidation, and so we saw a lot of private, individual practices move into that hospital's system.

Our doctors have lost the ability to care for their patients the way that they were, went to school, and the reasons that they went to school. We need to make sure that everybody is taken care of. That when people are going in to have a test within the same sys-

tem that the test costs the same, regardless if you are in small town Iowa, or if you were in Des Moines at a hospital system.

Those are two things that I think are driving the costs that I believe that Congress can actually do something about. You know, really just more access and options, getting association health plans out there, having that ability for employers to make choices for themselves and for their employees.

Mr. BANKS. Your State is a lot like my State, and maybe expand on that a little bit. Talk about how we got to this point where small businesses feel like they might not be able to provide the same level of quality healthcare options for their employees as what they used to.

I mean it seems like that is devastating to the families who you have put to work with good paying jobs. It seems that would be very disruptive to your ability to do business. How did we get to that point?

Ms. STROUSE. Yes. In Iowa specifically, before the ACA rolled out, we actually had protection across the board for everyone regardless if they had pre-existing conditions, and specifically in the employer market. When you came in as a new eligible employee into an employer group plan, they did not have pre-existing limitations on those plans. If you were somebody who chose not to enroll, and a year later decided to enroll, there could have been limitations based on that, but we had a high-risk pool in Iowa that accepted everyone that got denied coverage.

We had safety nets in place to actually make sure every single Iowan had access to care. In that high-risk pool we had $500.00 deductibles. Those are unheard of in Iowa today. We also saw the age rated bands, the age bands come out, and that created first of all, our older population paid more, but it did not offset the younger population. Their rates also went up where it was on average you could have a young, 20 you know, something.

Their premium could have been $125.00 on average. Those premiums went up over $300.00. That is why those young, healthy people did not enroll in those marketplaces. When we start to get that where everything is just driven by claims, and we do not have prevention on the front end of things, that is what is driving up costs, that is what is making it unsustainable for employers today.

Mr. BANKS. Well, I appreciate you sharing your unique perspective. Small businesses are the backbone of our economy in states like Indiana and Iowa, and throughout the country, and it is my sense that Members of Congress should be listening a lot more to people like you a lot more than what they do, so thank you. I yield back.

Ms. STROUSE. Thank you.

Chairman GOOD. Thank you, Congressman Banks. Now I would like to recognize for 5 minutes, Congressman Norcross from New Jersey.

Mr. NORCROSS. Thank you. At this point, I would like to yield 1 minute to my colleague.

Mr. COURTNEY. Just really quickly. Ms. Strouse, I just want to reiterate the point that I made, which is when the Inflation Reduction Act came out of the House, that insulin piece was not limited

to Medicare. It was extended to, we amended ERISA, to make sure that it would be extended to employer-based plans as well.

Unfortunately, Senator McConnell whipped a no vote on that, and that provision was stripped because it was ruled by the Parliamentarian not to be budget related. It was a policy issue.

The good news is that Susan Collins and Patty Murray are, on a bipartisan basis, going to be introducing a bill to do exactly what you just described, and which we supported already, and hopefully we can all have a nice bipartisan kumbaya, and come together and realize that those savings for insulin should be extended to working age Americans through their employer-based plans. I will now yield back to Mr. Norcross.

Mr. NORCROSS. Thank you. I appreciate it. I see the actual hearing notes says Reducing Health Care Costs for Working Americans and their Family. We can do that very easily by just cutting coverage. Obviously, any health care has to be comprehensive coverage and quality coverage.

Coming out of the pandemic we have seen just the massive impact that COVID has had on the average American, both physical and mental health. The question I want to get to is the mental health piece of this. Last year, the Department of Labor did a study to find widespread violations of the Mental Health Parity and Addiction Equality Act.

In the report, the Department recommends Congress provide additional tools to improve enforcement, including granting the Department of Labor the authority to issue civil monetary penalties for violation. Next month, I plan on reintroducing the Parity Enforcement Act.

When we look at what is in place now, the law says one thing, but without any meaningful employment, it is literally like having no police on the road and people will just drive whatever they want to do. Certainly, we have seen what happens when that doesn't work. The violations come flying in.

Ms. Corlette, what are some of the barriers to making the promise of the Parity Act an actual reality, and how could we improve the enforcement in making sure that this care is available to all Americans?

Ms. CORLETTE. Thank you, Congressman. As you said, enforcement of MHPAEA is absolutely critical. You know, when the Department of Labor recently asked group plans and insurers to share their analyses of how they were covering behavioral versus medical health services, not a single plan was able to submit documentation to enable Department of Labor to even assess what they were doing.

It is a clear sign that plans and issuers may not be taking their compliance obligations seriously enough. MHPAEA was enacted in 2008. We are 15 years into this. Civil monetary penalties certainly could help send a strong message that access to mental health services is really vital for workers and families. I think it could also be helpful for the Department of Labor to provide some guidance, and more clarity to plans and issuers about what those obligations are.

Knowing that there is a cop on the street is absolutely critical.

Mr. NORCROSS. Again, right now if there is violation, if they get caught, they just pay for it. Obviously, from the bottom line financially, we tried to allow the market, the free market, to go and take care of this. Again, your point, 15 years. It is not being done. I think this is incredibly important. I think everybody on this panel, both sides of the aisle understand mental health is a real issue.

The addictions, the list goes on. The idea that we are allowing part of the free market to just go and do what they want, and we see the violations is exactly why I think we should talk about implementing this, and moving this forward. With that, Chairman, I yield back.

Chairman GOOD. Thank you, Mr. Norcross. Now I would like to recognize Representative Smucker from Pennsylvania for 5 minutes.

Mr. SMUCKER. Thank you, Mr. Chairman. This is a great discussion this morning. I would like to thank the Chairman for scheduling this hearing, thank the witnesses for being here. I would like to thank the Ranking Member, and other members from the other side of the aisle for some of the comments that they have made in regards to the common ground that we have on these issues.

I think we are all interested in ensuring that every American can access the great healthcare system that we have here. We have differences about how we can best deliver that, but we have great discussions here today about potential solutions. I will use the term that the Democrats are often fond of, universal healthcare.

I would like to see universal healthcare. To me, that means that everyone can manage their healthcare expenses by having access to insurance if they want that access to insurance, and hopefully at a price that they can afford. We believe it can best be done by competition among providers, competition among hospitals, competition among insurers.

We think a system with that in place will deliver the best change of ensuring that access. I read about a 200 employee construction company, self-insured, and you have all talked about the benefits of self-insured, some of the problems with the red tape around that, the flexibility that it can provide, and so I just want to mention the benefit that I saw of also creating partnerships between employers and employees to improve healthcare, or improve health of employees, and reduce costs.

It was a shared risk in that, and then I have seen telehealth in my district. I have heard some of the concerns about telehealth, and I do not—it is the first I heard some of them because I have always seen telehealth as being sort of better access to healthcare. Part of a larger system, and literally helped to improve outcomes because patients tended to go to a doctor sooner, and maybe take care of a health problem before it became larger.

I have also seen, and I want to ask this question, and maybe Mr. White, I will ask you. We have some very innovative systems by employers in my area where telehealth is part of it, but also direct primary care. This is where there is a sort of a monthly fee to a doctor, that is then on call for employees. Even groups of employers are doing this at times.

People love it because they can call, rather than missing work having to go the distance. They can do telehealth and then some-

times the direct care provider will even be onsite if it is a large enough company. I have a bill that would help to—I did this, introduced it with Mr. Blumenauer, a Democrat from Oregon.

Essentially, it would ensure that employers who have access to direct primary care would also have access to HSA's, and it would be covered in HSA. Mr. White, are you familiar with that? Do you like it? If so, how could we expand direct primary care?

Mr. WHITE. It is a great idea. I love it. I think it expands options for workers to be able to access care on demand. It is kind of like the old concept when the doctor would come to your home, right, and you would kind of——

Mr. SMUCKER. Like a family doctor.

Mr. WHITE. A family doctor. You would get their attention, and their time, and that is what direct primary care seeks to offer is that direct attention, that direct time, dedicated to that worker so that they have access, good access, to care. I think coupling it with HSA's makes a lot of sense, so that people can pay any of their cost-sharing obligations.

Then on the telehealth side, I think you know, one of the things that we have seen during the pandemic is really a focus on behavioral and mental health issues.

Mr. SMUCKER. Absolutely.

Mr. WHITE. Really, 90 percent of those claims on telehealth.

Mr. SMUCKER. I want to get to one additional question, and I am really sorry to cut you off. Ms. Strouse, you had mentioned site neutrality payments, and I have heard from this on sort of both sides of the issue if you will, independent practices, who literally have gone out of business because they have been bought up by hospitals that they could charge higher prices. It is a system that we have in place that I think encourages that kind of consolidation, which I think then reduces competition.

On the other hand, I have great hospitals in my area who argue that they face unique circumstances that justify the increased price of services, and I would just like you to address that. Like how do you talk about that? How do you respond to hospitals that you are arguing that these higher prices are justified?

Ms. STROUSE. Yes. I am not—I am definitely not arguing that they are not seeing increased prices. Everyone in the country is experiencing increased prices across the board. I think what we want to get to is an easier, more transparent system so that if you are having a lab test in one clinic, and the same exact lab test maybe at a different facility, that it should be the same price.

We had a member that came forward in Indiana, and they—he and his wife both had exactly the same lab test. One had it at a clinic, one had it more through a hospital setting. His was $900.00, hers was $90.00. We need to make sure that we know that the price is the price. That type of thing should not be different.

Where we are also seeing some challenges are those facility fees. In some of those smaller clinics, now we are starting to see a facility fee be added on top of services that really there should not be a facility fee charged on. We recognize our hospitals are also struggling. We are doing everything we can in the State of Iowa to make sure that all of our rural hospitals are getting what they need.

Another piece of that is Medicaid, and the Medicare market. The reimbursements are not great, and so the private market literally holds them up. I have actually had a client who is a mental health provider, and she was contemplating lowering the amount of patients she was seeing in Medicare and Medicaid, just to keep their doors open, and it was a heart wrenching situation for her.

Reimbursements across the board, we need to get that figured out, so that it is there for everybody.

Mr. SMUCKER. Thank you. Thank you, Mr. Chairman.

Chairman GOOD. Thank you, Congressman Smucker. Now I would like to recognize Representative Hayes from Connecticut for 5 minutes.

Mrs. HAYES. Thank you very much. The Affordable Care Act dramatically expanded the affordability of health care for millions of Americans. As of January 2023, a record 16.3 million people were insured under the ACA. Additionally, last Congress, Democrats took bold action to reduce prescription costs by passing the Inflation Reduction Act, which grants the HHS Secretary the authority to negotiate the price of prescription drugs covered by Medicare, and caps out-of-pocket costs for insulin at $35.00 per month for Medicare beneficiaries.

I have to stress once again that we tried to expand this beyond Medicare, and we were stopped by Republicans. I was particularly disappointed that we would not be covering children with Type 1 diabetes, so it is something that we will continue to work toward.

While we have accomplished so much, there are still changes that must be made to make our health care system better. Currently, most insurance covers individuals from the neck down. Dental and vision health, which are critical components of overall health, are not covered.

Basic insurance health plans rarely cover routine eye exams, regular visits to the dentist, or even extended mental health services. People without access to dental care are more likely to suffer from chronic conditions, such as heart disease, diabetes, and cancer.

In 2023, there have already been 55,000 new cases of oral cavity cancers in the United States. Similarly, improving access to eye care allows health professionals to identify and treat problems before they become more serious. Vision screenings improve academic outcomes for kids.

If we are having a conversation about reducing health care costs, it should also be about full and total health care. Ms. Corlette, how did the ACA improve dental and vision access, especially for children? Can you elaborate on the remaining barriers to affordable dental and vision care that we are currently facing?

Ms. CORLETTE. Thank you Congresswoman, for the question. Sure. One of the key things that the Affordable Care Act did was establish a set of minimum essential health benefits, which included pediatric dental and vision care. For the first time, there was a minimum floor that all small group and individual market health plans had to satisfy.

In terms of remaining barriers, I would say No. 1, there are ten states that have still not expanded Medicaid under the Affordable Care Act, and that places about 1.9 million people in something called the Medicaid Gap. They are too poor for marketplace sub-

sidies but have too high of an income to qualify for their state's very, very, low eligibility.

The second thing I would point out is that in the employer market, dental and vision are sort of the traditional examples of excepted benefits. What has happened with these excepted benefits, is they end up being siloed, they are separated from the general comprehensive major medical benefit that we all have. Not only are they siloed out from the rest of your body, which is not logical, the benefits do not tend to be very good.

They do not provide a lot of financial protection. The medical loss ratios are quite low. I just point that out in part because before you today is this proposal to create telehealth as an excepted benefit, which I worry would lead you down the same path where the services are siloed from your regular health care and are not very comprehensive.

Mrs. HAYES. Thank you. To your point, I would argue that we need to make sure that it is more competitive, so that people cannot charge whatever they want to your point, $90.00 or $900.00 for the same benefits. In my State of Connecticut, 531,000 adults have a mental health condition, and many go without the necessary care or services to address their illness.

Unfortunately, this reality is felt nationwide, as half of adults with mental health do not receive treatment. We are facing a crisis. Ms. Corlette, how can Congress expand access to mental health care services to those who are in need under the ACA and job-based plans?

Ms. CORLETTE. Well, one thing your colleague mentioned earlier was enforcement. That is an area where there clearly needs to be more authority and more resources for ensuring that plans are complying with mental health parity. Then just the last remaining seconds, I think workforce issues are really critical, and my colleague here mentioned the reimbursement issues in particular, and making sure that there's reimbursement parity for those mental health services.

Mrs. HAYES. Thank you. Mr. Chair, I yield back.

Chairman GOOD. Thank you, Representative Hayes, and now I would like to recognize for 5 minutes, Congressman Burlison from Missouri.

Mr. BURLISON. Thank you, Mr. Chairman. I worked in healthcare IT for 20 years, and I have seen where the bodies are buried. I have seen good, the bad, and the ugly, but I came to this conclusion that the more that this place touches healthcare the worse it gets.

Some of my questions, and my thoughts are the only thing that is going to save the healthcare system is innovation and disruptive innovation, so I am going to gear my questions in that regard. I think telehealth is old technology, but at least it is here, and at least we have that.

Mrs. Watts, can you talk about the impact of the pandemic and how that has, you know, ushered in more telehealth finally gotten some level of adoption that really was resisted for quite some time?

Mrs. WATTS. The great thing about telehealth during the pandemic was that people that had never tried it before and tried it, when we surveyed and said, you know, will you do this again, they

said yes. Resoundingly, they said yes. I think it was a great way to try it out.

I also think it did a huge service to healthcare providers in this country because it kept people out of the doctors' offices and going to the hospitals, and it was a way to triage. It was really kind of a God send that we even had that as a resource for people to access, to determine whether or not their symptoms were related to the pandemic, to COVID, or something else.

Mr. BURLISON. In addition, it gives access to patients who might be in a rural healthcare setting to have very difficult times getting an appointment with a psychiatrist, or some of these specialists, so that is a huge added benefit as well. Can you elaborate, or give us an idea what is holding this back? What kind of structural issues are throwing water on this innovation?

Mrs. WATTS. I think virtual healthcare, digital healthcare, are all very fast-growing segments of the market. Part of that is driven by the fact that there is a shortage of providers, and people are not able to get an appointment, and so access to virtual digital care definitely helps.

The other thing that is so important related to behavioral health is that it has really helped us address a health equity issue with access to behavioral health in seeing low income and minorities be able to access care that they really didn't have access to before.

Mr. BURLISON. Let me ask this, and this may be a question for Mr. White. Do we have an issue with, you know, State after State they implement licensing laws, a lot of it is turf issues. Do we have, as a Nation, as we approach this increased demand for professionals, and people to get access to care, whether virtually or in person, what is the impact of these restrictive licensing laws where they stop potentially mid-level providers from practicing to the fullest extent of their education?

Mr. WHITE. Yes. Great question, and maybe to answer your last question, I think what we saw during COVID was the public health emergency was declared, and the government flexed up all the rules, and what did we see? We saw innovation come into the marketplace, right?

We deployed an empowered pharmacist to deliver care to patients, to fill gaps in access, which is really critically an important strategy. 250 million vaccinations through the pharmacy channel as a result of some of those policies.

Also, tests. Being able to deploy prescriptions for people who were sick, et cetera. We saw telehealth, which was a massive gap filler, once those rules came off. Care at home. We do a lot of care in very expensive settings, that we could actually deliver in the home now based on new technologies.

Mr. BURLISON. Yes.

Mr. WHITE. Strategies. With the licensure issues, I think what we have seen is we essentially have a really, maybe a 15th Century guild system.

Mr. BURLISON. A cartel.

Mr. WHITE. Blacksmiths and you know, and not to denigrate medical professionals, they work hard and get licensed, and do their things, but what I think we realized during COVID was you

can deploy these mid-level, or more junior level medical professionals.

Mr. BURLISON. Right. My time is getting close, so I want to go through quickly into this. I think, it is my opinion that you know, AI is going to radically change healthcare to the point where it empowers someone who is a mid-level to be more of an expert in diagnosing more accurate, provide better healthcare standards, the best medical professionals we have today. Could you elaborate?

Mr. WHITE. We will lower costs. I was in Iowa last year where you have got ophthalmology techs using AI to detect diabetic retinopathy and screen out the people who need the surgery.

Mr. BURLISON. They are just techs.

Mr. WHITE. Yes. They are just techs, right? We have a massive shortage of diabetic techs in this country. You plug the machine in, you run them through the tech, and they get the people who really are going to need more hands-on care from the physician. It works beautifully, it lowers costs, and it gets people the access they need.

Mr. BURLISON. Thank you.

Chairman GOOD. Thank you, Mr. Burlison. Now I would like to recognize Representative Jayapal from Washington for 5 minutes.

Ms. JAYAPAL. Thank you, Mr. Chairman. For decades, Democrats have proposed and enacted many policies to lower health care costs, which included the passage of the Affordable Care Act. We protected those with pre-existing conditions. We lowered out-of-pocket costs. I have also pushed for policies that expand Medicare, ensure homecare for our most vulnerable, and eliminate the many fees and copays charged by private insurance companies.

In contrast, Republicans have fought to repeal the savings from the ACA, and they continue to propose policies that actually increase health care costs for people across the country. Ms. Corlette, I am going to ask you just a series of questions about Republican policy proposals. You can just answer with a short yes or no on whether these policy proposals would increase health care costs for Americans.

The first one is the Republican proposal to take Medicaid away from up to 10 million people by instituting onerous and unnecessary work requirements as Speaker McCarthy proposed in his debt limit bill last week. Would that decrease health care costs for Americans?

Ms. CORLETTE. No.

Ms. JAYAPAL. What about repealing the prescription drug provisions in the Inflation Reduction Act, including repealing the cap on out-of-pocket prescription expenses for Medicare. Would that reduce health care costs for Americans?

Ms. CORLETTE. No ma'am.

Ms. JAYAPAL. How about cutting funding for the Children's Health Insurance Program by billions as proposed by President Trump. Would that reduce health care costs for Americans?

Ms. CORLETTE. No ma'am.

Ms. JAYAPAL. What about encouraging the formation of association health plans, also called junk health plans, with no additional regulation. Would that reduce costs for average Americans.

Ms. CORLETTE. No.

Ms. JAYAPAL. Let us do the same thing with the policies the Democrats have proposed, and you tell me if these would reduce health care costs for Americans. Capping the out-of-pocket costs for insulin at $35.00 per month for Medicare beneficiaries. Would that reduce costs?

Ms. CORLETTE. Yes.

Ms. JAYAPAL. How about capping out-of-pocket spending on prescription drugs at $2,000.00 per year for Medicare beneficiaries?

Ms. CORLETTE. Yes.

Ms. JAYAPAL. How about extending enhanced ACA premium tax credits, which saved my constituents an average of $1,200.00 per year. Would that reduce—has that reduced costs for Americans across the country?

Ms. CORLETTE. Yes.

Ms. JAYAPAL. Finally, I just want to ask you the same thing about policies that are proposed by Democrats, that Republicans have blocked. All those ones I mentioned were things that we already passed. These are things that have been blocked by Republicans, and you tell me if these would decrease health care costs for people. Extending the cap on insulin costs at $35.00 per month to all types of insurance. It was blocked on the Senate floor by Republicans. Would that have decreased costs for the American people?

Ms. CORLETTE. For diabetics, absolutely it would decrease costs.

Ms. JAYAPAL. How about closing the Medicaid gap to cover over two million people in the ten states that have not expanded Medicaid under the ACA. Would that reduce costs for people in those states?

Ms. CORLETTE. Absolutely. Yes.

Ms. JAYAPAL. I think I wanted to ask you those questions because I want to be clear about the stark contrast in how our two sides are approaching health care, which should be a universal and bipartisan effort to reduce costs for our constituents, but I think that this hearing makes it crystal clear that the Republican health care policy proposals are actually increasing costs for people.

Democrats have taken historic steps to decrease health care costs for Americans, we have allowed Medicare to negotiate with greedy pharmaceutical companies. We have capped the cost of insulin and other prescription drugs for people on Medicare, and provided support to families struggling with the high cost of health insurance premiums.

We did all of that without a single Republican vote, and we have more to do. I have great proposals to address some of the issues that Ms. Hayes raised around expanding Medicare to cover dental, vision, and hearing, providing all kinds of care that people need.

If our health care system can function, so that we keep people healthy, and we do not put barriers in their way to seeking health care, and particularly the equity concerns that we see in our health care system with people not being able to access care, particularly Black, brown, indigenous folks, particularly poor people, particularly people in rural areas, this country would be much better off.

I thank you, and I yield back.

Ms. CORLETTE. Thank you.

Chairman GOOD. Thank you, Representative Jayapal. Now we would like to—we are going to go continue with the minority party

since we do not have anyone here from the majority. We will recognize now, Representative McBath from Georgia for 5 minutes.

Mrs. MCBATH. Thank you so much, Chairman Good, Ranking Member DeSaulnier, for hosting today's hearing, and to our guests for taking the time to be with us today. I am a two-time breast cancer survivor, and the daughter of two health care professionals, so this issue today is very, very personal to me.

It is personal to me like it is personal for the mothers and children who live in the 50 plus counties in Georgia who do not have a pediatrician, or even an OBGYN. It is personal to me like it is for those in my State who are forced to take unpaid time off from work, that they cannot force—that they cannot simply afford. They are driving hours away to get themselves or their children the care that they need.

While our Governor, in the State of Georgia, knowingly leaves billions of dollars, Federal dollars on the table, and refuses to expand Medicaid. There is no justifiable reason why in the greatest country in the world that medical bills are the No. 1 cause of personal bankruptcy. There is no reason why the zip code or the country that you were born into should add or subtract another 10 years from your life expectancy, but that is the reality in America every single day.

Republicans love to talk about the high cost of health care after the passage of the ACA. They fail to recognize exactly how much higher these costs would be for working families without these critical protections and these critical programs. Thanks to President Biden, congressional Democrats, and the Inflation Reduction Act, the number of Americans without health insurance is down to the lowest level in the history of this country.

Thanks to the IRA, Medicare is finally able to negotiate with drug companies on behalf of American seniors and ensure that they aren't paying more for, than they need to, for prescriptions like insulin, and yes, that was my law, the reducing the cost of insulin to $35.00 out of pocket.

These protections would have gone even further to support working families by capping the price of insulin at $35.00 a month for private insurance as well as Medicare, but Republicans successfully stripped this provision from my bill, the final version of the IRA that was actually signed into law.

When insulin for human consumption was first discovered and synthesized by Dr. Banting, and his team. It was in the 20th Century. They sold the patent to the University of Toronto for one dollar, just one dollar, claiming that and I quote, "insulin does not belong to us, it belongs to the world."

I think that it is obvious that Dr. Banting and his team would be deeply disturbed by the exorbitant price that insulin is regularly sold in the United States today. It is up to Congress to right this historic wrong. Despite production costs between $2.00 and $4.00 per vial, one in four Americans who rely on insulin every single day of their lives, has had to risk getting seriously ill, and cut back or skip their dosages all together because of the price of insulin.

Because of the IRA, out-of-pocket costs where people on Medicare are now capped at $35.00 a month, and many states have taken similar action, as well as the drug manufacturers, three major drug

manufacturers. Congress has to do more to ensure that everyone who needs insulin can afford it, not just those on Medicare.

I am very proud to be a co-leader of the Affordable Insulin Act now, which would extend the $35.00 cap to people with private health coverage. Ms. Corlette, why is it necessary that Congress pass additional legislation such as this, to help cut the cost of insulin? Particularly for people with ERISA covered plans.

Ms. CORLETTE. Thank you for the question. The Inflation Reduction Act took tremendous strides to improve the affordability for insulin and for many drugs for Medicare beneficiaries, but it left, as you said, unfinished business. Addressing the costs of insulin and other prescription drugs for people in commercial or ESI insurance is critical.

As I mentioned, there was a really helpful KFF study that found that a $35.00 per month cap on prescription drug cost sharing would provide financial relief to about 20 percent of the 160 million people who are now covered in ESI, so it is really a tremendous benefit.

Mrs. MCBATH. Thank you so much, and I yield.

Chairman GOOD. Thank you very much, and now we will recognize Congressman Omar from Minnesota for 5 minutes.

Ms. OMAR. Thank you. It is pretty clear from the conversation that Representative McBath was just having, and Representative Jayapal, that Democrats have spent a significant amount of time thinking about and working on policies that reduce health care costs for Americans because our constituents are deeply worried about this.

Ms. Corlette, in your written testimony you referenced 2022 CBO that recommended three policy interventions on how to constrain health care costs. Regulating health care prices, reducing consolidation, and untied competitive behavior, and improving price transparency. You also pointed to the Bipartisan Policy Center report that made recommendations that furthered seven interventions, such as capping hospital prices in highly concentrated markets.

There are a lot of proposals that are out there, and interventions that are available to us. Can you speak to the importance of these policy interventions, and how they compare to the proposals that are currently in front of this committee, that my Republican colleagues are putting forth.

If there are differences in the approaches, and if there is a cost shift that will take place for Americans.

Ms. CORLETTE. Yes. Thank you for the question. The No. 1 reason why we are in an affordability crisis in private health insurance is the prices that commercial health plans are paying for health care goods and services. Particularly, hospital services and prescription drugs.

One of the reasons for that is consolidation. A lack of competition, particularly in the hospital sector. The Congressional Budget Office has looked at this issue, and they have identified three major policy areas that could help reduce costs for commercially insured people, and they looked at directly or indirectly regulating prices, hospital prices, and that will have the most impact on affordability.

Reducing anti-competitive behavior like clauses and provider payer contracts that restrict competition, that could also have an impact, as well as price transparency. Those will get at the underlying drivers of health care cost growth in this country.

Policies that simply move the deck chairs around on the Titanic, and lower prices for groups that have healthier workers, or younger workers, will simply just create new winners and losers. With the losers being employers that have workforces that are not quite as healthy, or older than their peers.

Ms. OMAR. Through this hearing, our Republican colleagues have been calling for the expansion of so-called associated health plans, claiming this policy change that can make—that will make health care more affordable. In your written testimony, you pointed out that some AHP sponsors claimed to achieve lower premiums because they somehow exercise market clout.

Can you tell us what evidence is there that they are actually negotiating lowering prices with health care providers, and if that is not how they are saving money, how is it exactly that they are able to lower prices?

Ms. CORLETTE. Sure. First of all, there is nothing preventing small employers, large employers, from banding together to form purchasing coalitions. There are examples of that in states that have been very effective. The way AHPs lower premiums are by attracting healthier employer groups, and using what is called claims experience rating. They look at the claims of each individual employer group to set the premium rate.

If you have got a healthier group, you get a lower premium. That really does not do anything to address the underlying driver of why health care is so expensive, which my colleague, Ms. Strouse articulated so well, which is prescription drug prices and hospital costs. Thank you.

Ms. OMAR. Thank you so much, and thank you all for being here and for your testimony. I do hope that we do get the opportunity to actually look at some of these bipartisan interventions, and some of the policies that are proposed by CPO to actually address the rise of health care costs, and so many people that are in desperate need of relief in our country, so thank you. I yield back.

Chairman GOOD. Thank you, Representative Omar. Now I would like to recognize my friend and fellow Virginian, Ranking Member Scott for 5 minutes.

Mr. SCOTT. Thank you. Thank you, Mr. Chairman. I appreciate you calling this hearing. I would like to ask Ms. Corlette a couple of questions. First one, we have heard a lot about businesses. One thing we did in the Inflation Adjustment Act was to—previously, was to eliminate the so-called cliff on premiums under the Affordable Care Act.

Can you explain how that would help a small business?

Ms. CORLETTE. By cliff, do you mean for people over 400 percent of—sure. Absolutely. The Inflation Reduction Act says for people who are essentially middle class, about four times the Federal poverty level. They will not have to pay more than 8.5 percent of their income toward premiums in the marketplace.

For small employers or individuals or self-employed individuals who have income at that level, their premium contributions are

capped at 8.5 percent, which is financial relief for a significant number of——

Mr. SCOTT. Yes, if they were just over the 400 percent of poverty, which is a little over for a family of four, a little over $100,000.00, what could a policy cost without any subsidies?

Ms. CORLETTE. Without any subsidies? In the individual market for a family of four without any subsidies, I think you could be anywhere close to, $20,000.00 a year.

Mr. SCOTT. $20,000.00 and just over the limit, and the limit is 8 and a half percent of poverty, it goes from $20,000.00 to eight and a half. That would be particularly helpful to individuals in business for themselves, particularly helpful to families and small business.

Back to the AHPs. You have talked about the fact that the premium is set at something actuarily sound for that group, which means if the group comes in and they evaluate it, and they get a price which is higher than average, what happens? Nobody will buy the policy if it is higher than average.

If it is lower than average, then they might benefit. Is that what you mean by cherry pick?

Ms. CORLETTE. Correct. If you have an employee group that is healthier than the average group in the fully insured market, you are likely to find a lower rate within the AHP.

Mr. SCOTT. When they come out of the general pool what happens to the average cost in the general pool?

Ms. CORLETTE. Sure. Actually, there is an actuarily analysis that was done of the Trump administration rules, and they found that on average the folks that would come into the AHP market would be about 54 percent healthier, meaning less morbidity in the AHP market, than in the fully regulated and ACA regulated market, and that would increase prices by about 4.4 percent for plans in the ACA regulated market.

Mr. SCOTT. If you do not get in one of these plans, and you allow people, healthy people to pull out, everybody else's premium goes up?

Ms. CORLETTE. Right. What happens is what we call an adverse selection dynamic, where healthier groups go into the AHPs and groups that have older or sicker workers are left in the ACA regulated market, and over time their premiums will climb every year.

Mr. SCOTT. What happens to an AHP if suddenly somebody gets sick and the rates go up, and they charge, start charging more than average. Are the people in the AHP required to stay there and pay those higher prices, or can they jump back into the pool and pay the average prices?

Ms. CORLETTE. Sure. In the AHP, they can look at the claims experience of each individual small employer group. If you have a group that is generating more costs, their prices will go up because it is underwritten, and they may choose to go back into the ACA regulated market, which of course, if they have high claims costs will increase the morbidity in that market.

Mr. SCOTT. While everybody else left behind pays higher prices when people pull out, they are essentially providing back-up insurance, so when things go wrong, and prices go up, they can jump back into the pool when the prices go up. Is that right?

Ms. CORLETTE. That is a very fair characterization.

Mr. SCOTT. There is a thing called cost shifting, and the fact that because of Obamacare and the Medicaid expansion we are at the lowest uninsured rate in history, what does that do to everybody else's insurance costs?

Ms. CORLETTE. Well, we know before the Affordable Care Act that providers had a lot more of what we call uncompensated care costs, and they were essentially shifting those costs onto the insured population at a cost of about $700.00 per family per year.

The Affordable Care Act, by dramatically decreasing the uninsured rate has reduced providers uncompensated care costs, and the amount that they shift onto the insured population.

Mr. SCOTT. Thank you. Mr. Chairman, I ask unanimous consent that I enter two documents into the record. One is a letter signed by 25 patient and consumer organizations, expressing concerns about associated health plans and created and excepted benefit exemption for telehealth plans, telehealth only plans.

The second is a statement from Families U.S.A. that, among other things, concludes that and I quote, "Proposals to expand the use of health plans that are exempt from State and local regulations, do not address the fundamental causes of our health care affordability crisis."

Chairman GOOD. Without objection.

[The information of Mr. Scott follows:]

Statement for the Record
On Behalf of Members of the Partnership to Protect Coverage
House Committee on Education and the Workforce
Subcommittee on Health, Employment, Labor, and Pensions
Hearing on "Reducing health care costs for working Americans and their families"
April 26, 2023

The 25 undersigned organizations represent more than 120 million people living with a pre-existing condition in the US. Collectively, we have a unique perspective on what individuals and families need to prevent disease, cure illness, and manage chronic health conditions. The diversity of our organizations and the populations we serve enable us to draw upon a wealth of knowledge and expertise that are critical components of any discussion aimed at improving or reforming our healthcare system.

Our organizations share three principles that we use to help guide our work on healthcare to continue to develop, improve upon, or defend the programs and services our communities need to live longer, healthier lives.[i] These principles state that healthcare must be adequate, affordable, and accessible.

With these principles at the forefront, we write to convey our concerns about two items on the committee's agenda: association health plans (AHPs) and creating an excepted benefit exemption for telehealth-only plans. Many of our organizations documented our concerns with these types of plans in the report: Under-covered: How "Insurance-Like" Products Are Leaving Patients Exposed.[ii] We offer the following information to help guide the committee's work. We look forward to partnering with you to make healthcare more accessible, affordable, and adequate for patients and their families.

Association Health Plans

Current law allows employers to work together to form a multiple employer welfare arrangement (MEWA) to provide certain benefits to their employees. An AHP — a health benefit plan sponsored by an employer-based association — is one type of MEWA.

Some AHPs can be classified as large employers and are therefore not subject to critical patient protections and state insurance regulations. This can pose risks to employers and their employees. The track record of AHPs and MEWAs in reliably providing comprehensive coverage for consumers is quite poor. According to state insurance regulators, these entities have a long history of fraud and "[making] money at the expense of their participants." State insurance regulators also say AHPs "have been notoriously prone to insolvencies."[iii]

AHPs are not required to provide comprehensive coverage or cover the Essential Health Benefits (EHB). AHPs may also charge higher premiums based on occupation (a loophole that allows discrimination based on gender and other factors[iv]) or even health status in some cases. As a result, these plans expose enrollees to high financial and health risks, and exacerbate rural and/or regional health disparities. Meanwhile, marketing these products can be confusing or misleading and can cause individuals to enroll in plans that do not align with their medical needs or expectations.

AHPs also pose risks to the many consumers who do not enroll in them. AHPs can siphon away healthy individuals from state individual and small-group markets by leveraging the regulatory advantages they enjoy. This leaves the individual and small group markets smaller and with a larger proportion of individuals with pre-existing conditions, leading to higher premiums and fewer plan choices for those who depend on those markets to access comprehensive coverage.

In 2018, the administration issued a rule that made it easier for small businesses to form an AHP that qualifies as a single large employer under ERISA, allowing them to more easily circumvent the patient and consumer protections that apply to the small group market. Though a federal court blocked the key provisions of that rule, the litigation is still pending, which has created significant confusion across stakeholders and state regulators. The current administration has signaled its intent to regulate AHPs this year.

As Congress contemplates the role AHPs play in our healthcare system today, we urge you to work with the administration and states to set common-sense restrictions that protect patients, consumers, and employers – limiting low-value plans rather than allowing them to proliferate further.

Telehealth as an Excepted Benefit

Telehealth has long been a vital care delivery method for improving access in underserved communities, particularly rural areas, areas with physician shortages, and areas with limited access to primary care

services. However, the COVID-19 pandemic has highlighted the role of telehealth in helping patients continue to receive timely and safe healthcare services and treatments from their providers. Telehealth – including telemedicine and telemental health – can help reduce gaps in access to services and care, including access to primary care and specialized providers, when in-person visits are not a safe or feasible option. Today, nothing prevents an employer or health insurance carrier from offering telehealth coverage in conjunction with their health coverage, and many do.

Telehealth can and should be used to increase patient access to care and our organizations have issued principles to aid lawmakers in setting appropriate policies to achieve that goal.[v]

We are concerned with the proposal to create a new excepted benefit for telehealth services. Excepted benefits are a category of coverage exempt from most federal and state standards that apply to health insurance. This means that a telehealth excepted benefit could discriminate against patients with a pre-existing condition by refusing to cover certain treatments, charging more for coverage, or denying coverage altogether.

Excepted benefits coverage can take many forms, including disease-specific policies like cancer-only, dental, and fixed indemnity plans. These plans are designed to supplement a major medical insurance plan. They are NOT comprehensive coverage and in many cases, they are not allowed to coordinate with other coverage. These products are often exempted from federal regulation and primary regulation authority lies at the state level. While telehealth is an important coverage, it is insufficient on its own without major medical health insurance.

The Administration allowed employers to offer stand-alone telehealth benefits during the COVID-19 pandemic health emergency as a means to give individuals not eligible for their employer plan access to at least some care during the pandemic. However, employers were not allowed to offer the stand-alone telehealth benefit to individuals who could enroll in their employer plan, nor did the guidance exempt these stand-alone benefits from all consumer protections.

What the committee is considering goes well beyond that guidance. Employers would be able to offer the stand-alone benefit as an alternative to their comprehensive plan. Low-wage workers, in particular, would be at risk of enrolling in the lower-cost telehealth plan, thinking it will provide comprehensive coverage when it won't.

Even in the best-case scenario, where an individual enrolls in a comprehensive employer plan and the telehealth-only policy, we fear a telehealth-only policy could create significant frustration and confusion for consumers who need in-person care to diagnose and treat their symptoms. Consider the scenario of a patient who sees a provider via telehealth and then in person, as many do in the course of receiving a diagnosis and treatment. Then imagine navigating two separate insurance companies to receive that care – two sets of paperwork, two sets of prior authorization, two sets of network limitations, two sets of cost-sharing responsibilities, and so on. Not to mention the telehealth provider and in-person provider may be two different providers within two different medical systems. As a result, the telehealth provider would not necessarily have access to the patient's medical history and thus would be hampered in their ability to adequately treat and diagnose the patient.

Lastly, we want to draw the committee's attention to a concerning trend. In recent years, excepted benefits have been marketed and sold – sometimes bundled – as replacements for traditional health insurance.[vi] This can lead to significant consumer confusion and a false sense of security for people who believe they've purchased high-quality coverage, only to find substantial gaps and higher out-of-pocket costs when they use their plan.

Conclusion
We look forward to continuing to work with Congress to expand affordable, accessible, and adequate healthcare coverage for patients.

Sincerely,

American Cancer Society Cancer Action Network
American Heart Association
American Lung Association
Asthma and Allergy Foundation of America
CancerCare
Cystic Fibrosis Foundation
Epilepsy Foundation
Hemophilia Federation of America
Immune Defciency Foundation
Lupus Foundation of America
Muscular Dystrophy Association
National Alliance on Mental Illness
National Coalition for Cancer Survivorship
National Eczema Association
National Health Council
National Hemophilia Foundation
National Multiple Sclerosis Society
National Organization for Rare Disorders
National Patient Advocate Foundation
National Psoriasis Foundation
Pulmonary Hypertension Association
Susan G. Komen
The AIDS Institute
The Leukemia & Lymphoma Society
The Mended Hearts, Inc.

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Statement for the Record

House Committee on Education and the Workforce

Subcommittee on Health, Employment, Labor, and Pensions

Hearing on "Reducing Health Care Costs for Working Americans and Their Families"

Prepared by *Families USA*

April 26, 2023

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Chairs Foxx and Good and Ranking Members Scott and DeSaulnier, on behalf of Families USA, we want to thank you for holding this timely hearing on legislative solutions to reduce health care costs for families.

Your focus on reducing health care costs comes at a critical time - our health care system is in crisis, too often providing poor quality care at unaffordable rates.[i] We look forward to today's discussion on meaningful ways to improve health care affordability, including by addressing dishonest billing practices that result in higher costs for consumers. However, we are also concerned that some policies being discussed as potential ways to improve affordability, such as proposals to expand the use of health plans that are exempt from state and federal regulations, do not address the fundamental causes of our health care affordability crisis. Instead, they threaten access to consumer protections and meaningful health coverage.

Urgent Need to Address the U.S. Health Care Affordability Crisis

Almost half of all Americans report having to forgo medical care due to the cost, almost a third have indicated that the high cost of medical care is interfering with their ability to secure basic needs like food and housing,[ii] and over 40 percent of American adults – 100 million people – face medical debt.[iii] High and rising health care costs are a critical problem for national and state governments, and affect the economic vitality of middle-class and working families - crippling the ability of working people to earn a living wage. Today's real wages — wages after accounting for inflation — are roughly the same as four decades ago, while employer health insurance premiums have risen dramatically.[iv] At the same time, nearly 90% of large employers say that rising health care costs will threaten their ability to provide health care benefits to employees over the next five to 10 years if costs are not lowered.[v]

At its core, our nation's affordability crisis is driven by a fundamental misalignment between the business interests of the health care sector and the health and financial security of our nation's families – a business model that allows industry to set monopolistic prices that have little to do with the quality of the care they offer. To meaningfully lower health care costs and improve affordability, Congress should focus on addressing these high and irrational prices, which are driven by trends in health care industry consolidation that have eliminated healthy competition.[vi]

To that end, we are encouraged by the consideration of draft legislation today that would crack down on 'dishonest billing' practices. These practices stem from broken financial incentives in the payment structures that provide hospitals higher reimbursement rates for outpatient services than for the exact same services provided at independent physician offices. This broken financial incentive encourages health systems to buy physician practices and rebrand them as outpatient facilities in order to generate higher reimbursement and charge consumers higher prices. Dishonest billing occurs when hospitals intentionally reclassify a doctor's office they own as a hospital-based setting in order to charge consumers higher prices. An analysis by Northwestern University found the price of physician services increases 14 percent[vii] after a hospital purchases a physician practice. The result is higher premiums, higher copays, and higher deductibles for families and individuals. This broken incentive is ripe for Congressional oversight and action.

Concerns with Association Health Plans and Stop-Loss Policies

It is important to note that proposals to improve health care affordability by expanding the prevalence of "junk insurance," including short-term plans and association health plans (AHPs), are not viable solutions as they undermine meaningful efforts to meaningfully increase affordability for our nation's families, and ultimately leave consumers without important protections and at risk of financial ruin. AHPs don't have to cover all of the benefits that other plans sold to individual and small businesses must cover.[viii] In many states, AHPs are not subject to the same licensure and oversight requirements, leaving consumers at risk if an AHP is badly managed.[ix] If that AHP experiences financial problems and cannot cover expenses, families may be exposed to financial ruin as state agencies may not be able to enforce consumer protections to ensure that their claims will be paid.[x] Moreover, companies that sell AHPs may try to avoid selling to businesses or populations prone to high medical expenses, focusing instead on particular businesses and geographic areas that tend to have healthy workers.[xi] This is deeply concerning, as it can leave those most in need of coverage without any options.

Efforts to further encourage the use of self-insured health plans coupled with stop-loss policies, or 'level-funded plans', are also concerning for individuals and families. These plans are also exempt from most state laws that provide important health insurance protections, including benefit mandates, requirements to cover people regardless of their health status, and protections for workers and employers from excessive financial risk.[xii] These types of plans fail to provide the affordable, comprehensive coverage they purport to provide and ultimately undermine meaningful efforts to provide comprehensive, affordable health coverage to families and individuals. Additionally, some small employers may not fully understand the risks of 'level-funded' plans. Currently, less than a third of covered workers in small firms are in self-funded health insurance plans with a stop-loss policy.[xiii] In some of these plans, the dollar amount of medical claims after which the stop-loss coverage kicks in, also known as the attachment point, is so low that the stop-loss carrier is really carrying the risk rather than it being a true self-funded arrangement.

AHPs and level-funded plans not only pose risks to those families who rely on them for insurance, they can negatively impact families that access insurance in the traditional insurance markets by eroding risk pools.[xiv] AHP and level-funded plans do not evenly spread out the cost of insuring less healthy individuals like traditional insurers do. As a result, the "cost-savings" that supporters of AHPs and stop-loss policies claim as a benefit are actually rooted in their reliance on discriminatory practices that push families who regularly utilize their insurance coverage for things like the treatment of chronic conditions into traditional, comprehensive insurance which increases costs for the entire market.[xv]

Conclusion

Millions of individuals and families lack access to affordable, quality health care. Congress has both the power and the responsibility to enact policy changes to address this crisis. Families USA appreciates the leadership from members of the Committee on Education and the Workforce on improving health affordability. We look forward to continuing to work closely with the Chairs and Ranking Members of both the full committee and the Subcommittee on Health, Employment Labor, and Pensions to ensure all families have access to quality, affordable health and health care.

Please contact Jane Sheehan, Director of Federal Relations at Families USA, JSheehan@familiesusa.org, for further information and to let us know how we can best be of service to you.

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[xii] Kaiser Family Foundation, *2022 Employer Health Benefits Survey*. October 27, 2022. https://www.kff.org/report-section/ehbs-2022-section-10-plan-funding/

[xiii] Ibid.

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Mr. SCOTT. Thank you. I yield back.

Chairman GOOD. Thank you, Congressman Scott. Without any further witnesses, or excuse me, members other than myself, I am going to go ahead and ask a few additional questions. Again, thank you to all of our witnesses for being here. One comment I will add as a Member of Congress, a lot of people do not know that Members of Congress are forced onto Obamacare.

I guess we, I use that term loosely, we deserve to suffer under that which we have placed the American people. I have the highest healthcare premiums I have ever had, far and away, it's $1,300.00 a month for just my wife and I. We are a healthy 50-some year old.

We are experiencing first-hand for the first time the peril of Obamacare, the lack of choice competition, transparency, accountability that plagues our healthcare system, that contributes to these higher rates, not to mention the fact the country is going bankrupt, and we cannot afford what we are doing from a government provision standpoint.

Mr. White, I want to ask a quick question of you. One of our members asked Ms. Corlette if the price cap on insulin was causing premiums to go down, and she gave a very specific answer and said for diabetics. Is the price cap on insulin causing the premium to go to down for everyone?

Mr. WHITE. No. CVUS made it that premiums would increase, and fewer options would be available.

Chairman GOOD. Yes, I thought so. Thank you very much. Ms. Watts, why is competition a good thing in the healthcare marketplace?

Mrs. WATTS. Competition is good everywhere, but with the lack of competition we see things happening like we have described already today with the unfair billing practices where you know, providers can charge what they want to for services. The savings that consumers could benefit from site neutral payment reform from focusing on more transparency with billing are enormous, depending on whose estimates you look at it, hundreds of millions of dollars.

Chairman GOOD. We are talking about the debt ceiling here. Negotiation, someone mentioned earlier, government is bankrupt, 32 trillion national debt, running deficits every year, record levels. Who ultimately bears the cost if the government is paying out more in healthcare payments?

Mrs. WATTS. We do.

Chairman GOOD. Yes. Absolutely. The consumer does. How about at the astronomical billing by hospitals. How does that affect care for patients?

Mrs. WATTS. Well, there are two things. First of all, when the cost of care goes up, some people will forego care, and that actually is more detrimental and more costly in the long run. There are many studies that have proven that. Second, we are all very familiar now the actuarial value of the plan. It is basically what the plan pays, and the consumer pays the remainder.

The higher the cost is, that actuarial value is the same, it is just that what we are all paying goes up.

Chairman GOOD. What is this legal price gouging impact on doctors do you think? The hospital cost, the dishonest billing that's going on?

Mrs. WATTS. I am not exactly sure, but I thought it was interesting in the prior questioning about the uncompensated care. I do not recall seeing trend go down as a result of the drop in uncompensated care, so I am not really sure where all the money goes.

Chairman GOOD. Ms. Strouse, thank you, Mrs. Watts. Ms. Strouse, I thought it was interesting when it was said earlier that consumers might not understand they were getting just a telehealth stand-alone policy. I do not know how anyone would not understand that and would be fooled by that.

My colleagues on the other side of the aisle seem to think that if a plan does not cover exactly what the Federal Government says it should cover, then it is a junk plan. Given your professional expertise, what sort of value do employees get when employers have more flexibility in the coverage they can offer? What is the value to employees?

Ms. STROUSE. Yes. Well, employers are always coming to the table to try and find solutions for their employees. Even if a part-time employee does not have access to healthcare, rolling out a telehealth plan is something. Otherwise, they would have nothing. When we look at these, the telehealth specifically, most of the plans that people are accessing right now are actually in part of their health insurance policies, and so they do have great coverage through those. They are not for everyone.

There is going to be situations where you need to actually go in and see your provider, but those telehealth services helped significantly in Iowa around the mental health space, and so again, agents are extremely important. We are not only working with employers, we are actually working with the employees on a daily basis to make sure that when policies are rolled out like this, or plans are rolled out, that it is communicated, and they fully understand what they have.

Chairman GOOD. Thank you very much. You know, I think my friends from the other side approach our responsibility to protect Americans from themselves, it is our responsibility they think to provide for Americans, that is the government's responsibility. They do believe.

They come from a mentality that employers do not care about their employees, when actually most employers really do care about their employees, want them to be happy and satisfied, safe and well with the healthcare they receive as Mrs. Watts spoke to specifically.

With that, we will conclude our questioning of our witnesses. I am sorry. I did not see Ms. Manning had slipped in, so now we will go and recognize—my time has concluded. We will recognize Representing Manning from North Carolina for 5 minutes.

Ms. MANNING. Thank you so much, Mr. Chairman. Mr. Chairman, I would like to point out that the Inflation Reduction Act put a cap on the price of insulin for seniors, and as a direct result of that Act, which was supported by House Democrats, and signed into law by President Biden, two major manufacturers of insulin, Eli Lilly and Novo Nordisk, have already announced that they are reducing the cost of insulin to $35.00 for everyone.

The law we passed has already had an enormous benefit for everyone who needs insulin. I would like to stick with that. The Infla-

tion Reduction Act, and to ask Ms. Corlette, can you give us your assessment of the IRA's emphasis, not only on capping out-of-pocket costs, but also on lowering the underlying prices of drugs like insulin?

Ms. CORLETTE. Sure. Full disclosure, I am not a Medicare expert, but I think one of the key pieces of the Inflation Reduction Act was to empower Medicare as a purchaser of prescription drugs to negotiate for a selected set of drugs on behalf of their beneficiaries, to try to get a lower price.

That is something that Medicare had been barred from doing. Obviously, the law is just being implemented, and so it will be a while before we see the full fruits of that negotiation power, but I do think there's unfinished business because I think many employer plans could also benefit from leveraging that negotiating power against drug manufacturers.

Ms. MANNING. In other words, extending these reforms to private health plans, including employer supported plans, or employer sponsored plans, could help make drugs more affordable for consumers and businesses?

Ms. CORLETTE. Absolutely.

Ms. MANNING. In your testimony, you raise the problem of anticompetitive behavior in the prescription drug industry, including financial practices that disfavor low-cost generic and bio-similar drugs that driver higher prices. This is concerning to me on a personal basis.

I myself had to fight for the coverage of my daughter's medication, which my health insurance company gave me the runaround on because it was going to cost $10,000.00 a month, and fortunately I was able to win that fight, but I know so many other people do not have the knowledge or the wherewithal to keep fighting when they should be getting medications covered by their health insurance companies.

At the level of pharmaceutical manufacturers, how can we ensure that lower cost biosimilars are able to enter the market without interference from brand name manufacturers? Can you talk to us a little bit about what happens, what some of the brand manufacturers do to prevent those generics from coming to the market?

Ms. CORLETTE. Congresswoman Manning, this is also a bit outside my expertise, but I can say that there is evidence that pharmacy benefit managers often hold on to a significant portion of rebates from drug manufacturers that should be passed on to employers' health plans, and they often can disfavor generic drugs if they do not come with rebates relative to higher cost prescription drugs.

Ms. MANNING. Thank you. Ms. Strouse, I saw you nodding your head on that one, so I wonder if you could comment on that, and also talk to me about the problem of transparency in the pharmacy benefit manager industry.

Ms. STROUSE. Yes. Actually, specifically in Iowa, we have been trying to address this on the State level, and last session we were successful in getting some transparency legislation passed, so we are really excited to start to dig into the information that we are receiving from the pharmacy benefit managers.

I can tell you we cannot solve problems if we do not go to the root cause of the problem, which truly is the drug manufacturers.

When we have medications that are truly lifesaving, like for instance, for your child, if it is $10,000.00, why is there not competition out there?

Why are they holding onto those prices? When we throw around words like cap, it makes me anxious because a cap to me means you are telling the insurance company they can only charge $35.00. Well, the manufacturer is still charging that full price through. Those are always going to feed into the premiums. That is going to be one way or the other, everybody is going to end up paying for that.

If we are not able to address it directly with the drug manufacturers, then I am very excited to hear the progress on the insulin side of things, because I do work in the Medicare market, and we have a lot of people that are on insulin. That is exciting, if that can drive change where the manufacturers are actually reducing the costs across the board for everyone, then that is going to be a solution.

If it is just capping through insurance, insurance is a middle man. The prices are still what they are behind the scenes with——

Ms. MANNING. I have to agree with you. It is very exciting that the law we passed to cap the price of insulin for seniors has resulted in the cost of insulin being reduced for everybody, and we can only hope that will continue. We are facing a mental health crisis, and we know that telehealth has become a key avenue for mental health services.

In my 10 seconds I have left, Ms. Corlette, how can Congress ensure that part-time workers have access to some form of telehealth, particularly for behavioral health?

Ms. CORLETTE. Well, there is nothing preventing employers from offering part-time workers access to health benefit with telemedicine. Also, if you are not offered an employer-based plan, you can choose to buy a marketplace plan, and many of these marketplace plans are also covering telehealth services.

Ms. MANNING. Thank you. My time has expired, and I yield back.

Chairman GOOD. Thank you, Congresswoman Manning, and without objection before we close, I enter in the record letters supporting efforts to enhance healthcare affordability from the following organizations: Americans for Prosperity, bipartisan organization supporting site neutral payments, the American Hospital Association, the ERISA Industry Committee, the National Association of Benefits and Insurance Professionals, NFIB, and the Partnership for Employer Sponsored Coverage.

[The letters of Mr. Good follows:]

April 25, 2023

Dear Members of Congress:

On behalf of the undersigned organizations and individuals, we urge you to advance reforms that promote site-neutral payments in Medicare and site of service billing transparency in commercial health insurance. These commonsense reforms would end disastrous subsidies for hospital consolidation and deliver lower costs to patients.

The federal government subsidizes hospital monopolies by paying higher reimbursements to physician practices and outpatient facilities when they merge with hospitals. Medicare pays hospital-owned facilities significantly higher rates — between 106 percent and 217 percent more — than independent medical practices and other outpatient facilities for the exact same services, including chemotherapy, cardiac imaging, and colonoscopies. Commercial insurers also pay higher rates for hospital-owned facilities in many cases. These higher payments create an enormous incentive for hospitals to acquire independent practices and charge patients and taxpayers high prices.

These wasteful subsidies have dramatically contributed to hospitals buying up community physician practices and reducing patient choices. Between 2013 and 2018, the share of physician practices that were hospital-owned more than doubled from 14 percent to 31 percent. By 2020, over half of physicians worked directly for a hospital or worked at a physician practice that was owned by a hospital, according to an analysis from the American Medical Association.

As hospitals buy up physician practices, they use market power and "dishonest billing" to raise prices for patients and taxpayers. "Dishonest billing" is when hospitals secretly reclassify a doctor's office they own as a hospital-based setting in order to charge patients and taxpayers higher prices. An analysis by Northwestern University found the price of physician services increases 14 percent after a hospital purchases a physician practice.

It is crucial that Congress end pro monopoly subsidies. Lawmakers should require Medicare to reimburse hospital-owned outpatient facilities at the same rate as independent outpatient facilities for services that can safely be delivered in a physician's office. Furthermore, Congress should promote billing transparency and address billing policies that enable hospitals to dishonestly bill patients.

Promoting billing transparency and site-neutral payments is an important step to lowering the cost of health care. The Congressional Budget Office estimates that ending Medicare's policy of paying hospital-owned facilities higher rates than independent physician offices will save taxpayers more than $140 billion over ten years. Doing so would also substantially reduce premiums and cost-sharing for Medicare beneficiaries, cumulatively by $94 billion over the next ten years according to estimates from the nonpartisan Committee for a Responsible Federal Budget.

We urge you to take swift action to enhance hospital competition and ensure more patients can afford the health care they need.

Sincerely,

Americans For Prosperity
Chief Government Affairs Officer and Senior Vice President
Americans for Prosperity

Loren Adler, Brookings Institute*
Dr. Brian Miller, American Enterprise Institute (AEI)*
Mark Miller, Arnold Ventures
Texas Public Policy Foundation
Americans For Tax Reform
Josh Gordon, Committee for a Responsible Federal Budget (CRFB)
Goldwater Institute
Progressive Policy Institute
Heartland Institute
Third Way
James Madison Institute
Independent Women's Voice
National Taxpayers Union
FreedomWorks
John Locke Foundation
Cardinal Institute
Docs 4 Patient Care Foundation
Nevada Policy Institute
Jackson W. Hammond, American Action Forum
Avik Roy, Foundation for Research on Equal Opportunity

*Affiliations are listed for identification purposes only and do not indicate the organization's support for the position outlined in the letter.

American Hospital Association™
Advancing Health in America

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Statement

of the

American Hospital Association

for the

Committee on Education and the Workforce

Subcommittee on Health, Employment, Labor, and Pensions

of the

U.S. House of Representatives

"Reducing Health Care Costs for Working Americans and Their Families"

April 26, 2023

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinician partners — including more than 270,000 affiliated physicians, 2 million nurses and other caregivers — and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to submit this statement for the record as the Education and Workforce Subcommittee on Health, Employment, Labor, and Pensions examines ways to reduce health care costs.

We appreciate the Subcommittee's interest in ensuring all Americans have access to affordable health care. The AHA and its members are committed to promoting affordability and value to advance the health of our patients. Given the hearing's focus of reducing health care costs, we provide comments on a number of policies aimed at increasing access to quality care at reduced costs. .

HOSPITAL PRICE TRANSPARENCY

Hospitals and health systems are committed to empowering patients with all the information they need to live their healthiest lives. This includes ensuring they have access to accurate price information when seeking care. Hospitals and health systems

are working to comply with both state and federal price transparency policies, which are varied and sometimes conflicting. At the federal level, these include:

- **Hospital Price Transparency Rule.** As of Jan. 1, 2021, hospitals are required to publicly post via machine-readable files five different "standard charges": gross charges; payer-specific negotiated rates; de-identified minimum and maximum negotiated rates; and discounted cash prices. The rule also requires hospitals to provide patients with an out-of-pocket cost estimator tool or payer-specific negotiated rates for at least 300 shoppable services.
- **Good Faith Estimates.** The No Surprises Act requires hospitals and other providers to share Good Faith Estimates with uninsured/self-pay patients for most scheduled services. Future regulations will require unaffiliated providers to combine their estimates for an uninsured/self-pay patient into a single, comprehensive Good Faith Estimate for an episode of care.
- **Advanced Explanation of Benefits.** The No Surprises Act requires insurers to share advanced explanations of benefits with their enrollees, though implementation is currently on hold pending rulemaking. Hospitals will need to provide Good Faith Estimates to health insurers to operationalize this policy.

Hospital Price Transparency Rule

Over the past several years, the AHA has engaged hospitals and health systems in substantial education and engagement on the Hospital Price Transparency Rule. This includes:

- Establishing a CEO-level Price Transparency Task Force that helped guide the AHA in developing policies and sharing best practices with respect to price transparency and patient billing;
- Conducting education through multiple webinars, bi-weekly "office hours" with AHA and Healthcare Financial Management Association technical experts, issue briefs, case studies and podcasts;
- Providing an implementation guide, including implementation checklists and FAQs;
- Conducting a three-part webinar series on health care consumer expectations and experiences with Kauffman Hall;
- Hosting a multi-stakeholder intensive design process, which included providers, payers, patient advocates, technology vendors and others, to develop solutions to improve the patient financial experience of care;
- Supporting the Centers for Medicare & Medicaid Services' (CMS) efforts to establish voluntary sample formats that hospitals may use to meet the federal requirement to make certain standard charges publicly available through a machine-readable file by connecting the agency with experts from the hospital field; and
- Updating the AHA's Patient Billing Guidelines, which include a focus on helping patients access information on financial assistance.

CMS has a process in place to ensure hospital compliance with the Hospital Price Transparency Rule. This includes a review, usually involving direct discourse with the hospitals; if deficiencies are identified, a warning letter is sent from the agency; and if the deficiencies are not corrected, a corrective action plan is requested. Should a hospital continue to fail to come into compliance, CMS then applies a civil monetary penalty.

CMS found that in 2022, 70% of hospitals complied with both components of the Hospital Price Transparency Rule, including the consumer-friendly display of shoppable services information, as well as the machine-readable file requirements. This is an increase from 27% in 2021. Moreover, when looking at each individual component of the rule, 82% of hospitals met the consumer-friendly display of shoppable services information requirement in 2022 (up from 66% in 2021) and 82% met the machine-readable file requirement (up from 30% in 2021).

These numbers show significant progress on the part of hospitals and health systems — while acknowledging the work that remains — in implementing these requirements. The lower compliance rate in 2021, however, should not be interpreted as a lack of hospital commitment to transparency. Instead, it reflects the incredible challenges hospitals were experiencing in 2020 and 2021 in addressing the most acute phases of the COVID-19 public health emergency, which strained hospitals' staffs and required the diversion of personnel and financial resources. As the pandemic phase of COVID-19 winds down and hospitals have been able to resume more standard operations, they are able to dedicate the resources necessary to build the full suite of price transparency tools.

CMS also shared information regarding how it has interacted with hospitals to support compliance and the issuance of penalties:

> "As of January 2023, CMS had issued nearly 500 warning notices and over 230 requests for corrective action plans since the initial implementing regulation went into effect in 2021. Nearly 300 hospitals have addressed problems and have become compliant with the regulations, leading to closure of their cases. While it was necessary to issue penalties to two hospitals in 2022 for noncompliance (posted on the CMS website), every other hospital that was reviewed has corrected its deficiencies."

Unfortunately, some third parties continue to issue reports mischaracterizing whether hospitals are complying with the Hospital Price Transparency Rule, as was detailed in a recent AHA letter to the House Energy and Commerce Committee. These reports fail to acknowledge CMS' requirements, such as how to fill in an individual negotiated rate when such a rate does not exist due to patient services being bundled and billed together. In this instance, CMS has said a blank cell would be appropriate since there is no negotiated rate to include. Despite this, some outside groups still count any file with blank cells as "noncompliant." This fundamental misrepresentation of the rules has only served to advance misinformation and confusion on the issue and distract from genuine

productive discussions and efforts around what patients want in terms of transparency data and how best to provide that information.

In addition to the CMS report on compliance, we would draw your attention to a recent report from Turquoise Health that found about 84% of hospitals had posted a machine-readable file containing rate information by the end of first-quarter 2023, up from 65% the previous quarter.

Hospitals and health systems are eager to continue working toward providing the best possible price estimates for their patients. We ask Congress and the Administration to take the following steps to support these efforts, including:

- Review and streamline the existing transparency policies with a priority objective of reducing potential patient confusion and unnecessary regulatory burden on providers;
- Continue to convene patients, providers and payers to seek input on how to make federal price transparency policies as patient-centered as possible; and
- Refrain from advancing additional legislation or regulations that may further confuse or complicate providers' ability to provide meaningful price estimates while adding unnecessary costs to the health care system.

SURPRISE MEDICAL BILLING

Congress enacted the No Surprises Act (NSA) to provide critical patient protections against unexpected medical bills for certain types of health care services when provided by out-of-network providers. The AHA strongly supports these patient protections. Congress intended for plans and other payers to appropriately reimburse providers for these services and included an independent dispute resolution (IDR) process, should negotiations between the two parties break down. Patients are fully removed from this process, and the outcome has no bearing on their cost-sharing obligations. However, this does not mean that the IDR process does not impact patients. Specifically, inappropriate reimbursement by payers can impact providers' ability to continue offering services or offering them in the timeframe or of the quality that patients deserve. In short, stripping the health care system of necessary resources ultimately impacts patients. A properly functioning IDR process is crucial for realizing the NSA patient protections.

The IDR process was intended to serve as a deterrent to inappropriate behavior by both payers and providers. Unfortunately, providers have seen payers use tactics such as delays in payments, knowing that providers can only serve patients for a limited time with constrained cash flow. This can be an effective method for dissuading providers from disputing inappropriate payments even when their claims are strong.

Certain policy decisions and implementation challenges also have undermined the unbiased and timely nature of the IDR process and contributed to the higher-than-anticipated volume of disputed claims. One of our primary concerns related to the

overweighing of the qualifying payment amount (QPA) was recently validated again by the U.S. District Court for the Eastern District of Texas. The AHA has encouraged the relevant oversight agencies to comply with the court's recent ruling and refrain from placing any constraints on IDR entities that were not authorized by Congress.

In addition, we urge Congress to encourage the agencies to consider the other reforms to the IDR process, such as:

- Revising the batching and bundling guidance to allow for a more rational process for facilities to dispute inappropriate reimbursement;
- Reducing the IDR administrative fee, which increased 600% in 2023, making the IDR process cost prohibitive for many facility claims when coupled with the current batching and bundling policies;
- Ensuring greater transparency and oversight regarding the calculation of the QPA;
- Monitoring and incentivize payer participation in the open negotiation process;
- Mandating that payers use the departments' Remittance Advice Remark Codes (RARCs) when communicating information about claims to providers and facilities;
- Requiring payers to include information on the patient's plan type at the time of initial payment or payment denial; and
- Ensuring timeliness of payments.

The AHA looks forward to continuing to work with Congress to ensure the NSA operates as intended in order to fully protect patients.

TELEHEALTH

At the outset of the COVID-19 pandemic, the federal government moved quickly to ensure hospitals and health systems were able to respond efficiently and effectively to a wave of unprecedented need. These actions included CMS waiving certain regulatory requirements and Congress providing significant legislative support to ensure hospitals and health systems could manage the numerous challenges facing them, including by an increased ability to administer virtual care. These swift actions provided hospitals and health systems with critical flexibilities to care for patients during what has been a prolonged and unpredictable pandemic.

Spurred in large part by these waivers and legislative support, virtual care and telehealth services have increased dramatically over the course of the pandemic. A report from the Department of Health and Human Services found that in 2020, telehealth services increased by over 51 million encounters, representing a 63-fold increase from 2019. There is a growing body of evidence to suggest that for the vast majority of specialties, telehealth services provided during the pandemic were not duplicative of in-person services. For example, most recently, a study of over 35 million records by Epic found that for most telehealth visits across 33 specialties, there was not

a need for an in-person follow-up visit within 90 days of the telehealth visit. In many cases, telehealth served as an effective substitute for in-person care and did not result in duplicative care.

Expansion of virtual care has transformed care delivery, expanded access for millions of Americans and increased convenience in caring for patients. Given some of the current health care challenges, such as major clinician shortages, telehealth holds tremendous potential to leverage geographically dispersed provider capacity to support patient demand. We applaud efforts by Congress to reduce barriers to care delivery by extending many telehealth flexibilities through the end of 2024 as a part of the Consolidated Appropriations Act that passed in December 2022. AHA continues to urge that certain telehealth waiver provisions be made permanent.

Hospitals, health systems, providers and patients have seen firsthand the benefits and potential that telehealth has in increasing access and transforming care delivery. We look forward to working with Congress to ensure legislation reflects the post-pandemic lessons learned, permanently adopts waivers that have improved access to care, and establishes a sustainable framework for the future of telehealth and care delivery as a whole.

HOSPITAL MERGERS AND ACQUISITIONS

Mergers and acquisitions are one of the most important tools that some hospitals use to increase access, provide quality care and manage financial pressures and risk. These partnerships enable hospitals to expand service offerings, broaden networks and access to specialists, improve quality and better serve patients where they live. They also provide scale to help reduce costs associated with obtaining medical services, supplies and prescription drugs, and enable health systems to reduce other operational costs. Ultimately, hospital mergers and acquisitions expand and preserve access to care.

Emerging research has demonstrated a clear association between consolidation and quality improvement. For example, one study found that a full-integration approach is associated with improvements in mortality and readmission rates, among other quality and outcome improvements.[1] Another study found significant reductions in mortality for a number of common conditions — including acute myocardial infarction, heart failure, acute stroke and pneumonia — among patients at rural hospitals that had merged or been acquired.[2]

Mergers and acquisitions help hospitals improve access to care by expanding the types of specialists and services available to patients. According to an analysis by Kaufman Hall, nearly 40% of affiliated hospitals added one or more services post-acquisition.

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[1] https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2787652
[2] https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2784342

Mergers and acquisitions also are a vital tool that some health systems use to keep financially struggling hospitals open, thereby averting bankruptcy or even closure.[3] When hospitals become part of a health system, the continuum of care is strengthened for patients and the community, resulting in better care and decreased readmission rates.

Mergers and acquisitions also have played a critical role in preserving access to care in rural areas. An AHA analysis of the UNC Sheps Center data on rural hospital closures between 2010 and 2020 shows that slightly more than half of the hospitals that closed were independent. Health systems typically acquire rural hospitals when these hospitals are under financial distress. Research has shown that rural hospitals are less likely to close after acquisition compared to independent hospitals and that mergers have improved access and quality of care for rural hospitals.[4] Acquired hospitals typically form new collaborations or partnerships with larger health systems, which promotes access to specialists, telehealth and other care for rural patients.[5]

CONCLUSION

The AHA appreciates your efforts to examine opportunities to reduce health care costs for Americans and looks forward to working with you on this important issue.

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[3] https://www.aha.org/system/files/media/file/2021/10/KH-AHA-Benefits-of-Hospital-Mergers-Acquisitions-2021-10-08.pdf
[4] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9250050/
[5] https://www.aha.org/system/files/media/file/2021/10/KH-AHA-Benefits-of-Hospital-Mergers-Acquisitions-2021-10-08.pdf

April 25, 2023

The Honorable Charles E. Schumer
Majority Leader
United States Senate
Washington, DC 20510

The Honorable Mitch McConnell
Minority Leader
United States Senate
Washington, DC 20510

The Honorable Kevin McCarthy
Speaker
U.S. House of Representatives
Washington, DC 20515

The Honorable Hakeem S. Jeffries
Minority Leader
U.S. House of Representatives
Washington, DC 20515

Dear Leader Schumer, Leader McConnell, Speaker McCarthy, and Leader Jeffries,

For decades, skyrocketing health care costs have put a squeeze on families' budgets and created a downward pressure on wages and income. Rising prices for health care are putting a larger than ever burden on consumers, employers, and state and federal taxpayers.

A new national survey shows an overwhelming majority of voters (94%) across the political spectrum believe it's important for Congress to take action to address high health care prices in the next two years. Similarly, voters on both sides of the aisle broadly support a wide range of policies to lower hospital prices. The findings show a large majority of voters (74%) are more concerned that Congress won't do enough to limit high prices—not that policymakers will go too far. This research underscores the frustrations voters have with health care affordability and highlights the bipartisan demand for more aggressive federal action to lower prices.

We are a non-partisan group of organizations that represent consumers, businesses, purchasers, and physicians who are working together to make high-quality health care more affordable. We promote action to protect consumers and employers from predatory pricing, and advance policies that prevent powerful health systems from engaging in business tactics that stifle competition and lead to higher prices. We believe that making health care more affordable for consumers, employers, and taxpayers is an economic and societal imperative.

Our work is centered around the following four principles:

1. **Making health care more affordable for consumers, employers, and taxpayers is an economic and societal imperative.** To do this, we must address the central driver of high health care costs for the privately insured—the high prices being charged for care—by increasing choices for consumers and purchasers, and limiting anti-competitive behavior to lower prices.

2. **Market failures must be directly addressed.** There is insufficient competition on price and quality in many health care markets where provider markets are highly consolidated. Dominant providers and health systems have the ability to demand high prices, and there is an imbalance in the information available to consumers. It is essential that action is taken where markets have failed to restore and increase competition and to lower prices.

3. **We need more complete and transparent information on pricing.** In order for families, purchasers, and policymakers to understand and fix the problem of high health care prices with common-sense solutions that work, we need more complete and transparent information on price, quality, and other aspects of our health care system.

4. **We must address high health care prices in a way that directs resources where they are most needed across the health care system.** A comprehensive solution to address high health care costs must ultimately create a more accessible, equitable, and sustainable system that provides high-quality affordable care.

While there are several drivers that contribute to high prices, we hope to continue to shine a light on some of the most egregious behaviors and practices that are increasing costs for patients, purchasers, and taxpayers. We know that policymakers and consumers need more complete and transparent information on prices, quality, and other aspects of our health care system to better understand and fix the pricing problem with solutions that work. We welcome the opportunity to share future related research and stand ready to partner with you to put affordable, equitable, and high-quality health care at the center of your legislative efforts.

Sincerely,

American Academy of Family Physicians

American Benefits Council

Arnold Ventures

Blue Cross Blue Shield Association

The ERISA Industry Committee

Families USA

Purchaser Business Group on Health

Small Business Majority

Statement for the House Education & Workforce Subcommittee on Health, Employment, Labor, and Pensions

April 26, 2023

Reducing Health Care Costs for Working Americans and Their Families

Submitted by
National Association of Benefits and Insurance Professionals

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.

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.[4] Further, 76 percent of workers see health insurance as a primary or important factor for continuing to work at their current employer.[5]

While employer-sponsored coverage remains one of the most popular forms of health insurance 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.[6] Thankfully, there are actions that Congress can take to control costs for employers and employees and, more broadly, preserve the popular employer-sponsored system.

One method of 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. The success of this system is possible because of the preferential tax treatment of employer-sponsored insurance coverage, where

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

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 would increase federal revenue, it would also eliminate most of the benefits of employer-sponsored insurance. Employers and individuals would lose many group purchasing efficiencies, and there would no longer be an effective means for spreading risk among healthy and unhealthy individuals. 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 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. At a time where employers are burdened by high inflation and high healthcare costs, eliminating this tax exclusion would be a grave mistake.

Regarding the viability of small businesses amid high inflation, tax credits are as crucial as ever. Certain small employers can qualify for the small business healthcare tax credit (SBTC); the SBTC was included as part of the Affordable Care Act to encourage small employers to provide health insurance to their employees, as roughly half of small employers offered health benefits to their workers at the time. Employers who purchase health insurance through the program may get a tax credit of up to 50 percent of their premium contributions. Unfortunately, many employers have been unable to claim the SBTC due to the current eligibility limitations. Presently, credits are only available to eligible small employers of up to 25 full-time equivalent employees that pay an average annual wage of less than an average of $50,000. Full credits are available to eligible small employers of up to 10 full-time employees with an average annual wage of $27,000 or less. As of 2014, small business owners can only claim the credit for two consecutive years in a row.

As a result of these limited qualification parameters, many employers who wanted to access the SBTC simply do not qualify, resulting in fewer employers claiming the credit. Most small employers who have not claimed the credit said it was due to the stringent wage eligibility standards, while others cited the overly complicated process for calculating the credit, which discouraged many from even applying. Sixty-three percent of small businesses feel that their business lacks the proper resources for handling tax credits.[8]

Another method of lowering healthcare costs for individuals and their families would be to establish reinsurance pools. Since the passage of the Affordable Care Act, we have seen adverse selection in the individual market – 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. To mitigate this, reinsurance

[7] Accenture. Employer Beware: Workers Demand Health Coverage. June 2015.
[8] Omega Accounting Solutions. Survey Finds Small Business Owners Lack Resources for Handling Tax Credits. December 2022.

pools or hybrid high-risk pools could be made available for the purpose of providing financial backing for carriers issuing coverage to higher-risk individuals.

Reinsurance programs work by spreading the costs of high-cost cases. Because employees with high expected healthcare costs can drive up the cost of coverage, reinsurance programs are designed to minimize the impact of high-cost cases on carriers and increase affordability of insurance for small businesses and individuals. The high-risk individual would not be aware that part of the risk of insuring them had been yielded to such a reinsurance pool, but doing so would lower costs for everyone purchasing coverage in the individual market. The covered individual would receive coverage through the carrier of their choice and could purchase the plan of their choice, and the carrier would have the option of ceding part of the financial risk of providing coverage to the reinsurance pool.

Every state that has implemented an innovation waiver-funded individual market reinsurance program has experienced lower unsubsidized premiums as a result.[9] Enacting a reinsurance program at this level would serve as a vital market stabilizer and would result in lower healthcare costs for Americans.

Widespread adoption of certain types of plan arrangements, such as association health plans (AHPs), have also been suggested as an effective way of lowering healthcare costs. An AHP is a type of group health insurance for employers that allows small employers, certain contractors, and self-employed individuals to access cost savings associated with the large group market. NABIP believes that, under certain circumstances, AHPs could provide ample cost savings and increased benefits that are very specific to the needs and desires of their membership. However, it is unlikely that widespread adoption of AHPs would result in significantly decreased healthcare costs for small employers or individuals broadly.

Each business member of the AHP will have unique service requirements, and both the human capital and actual costs of tending to many small businesses will be higher than those associated with a true single business entity. Even if an AHP attracts a considerable number of participants, its size and bargaining power is unlikely to overtake the scope of a smaller private health insurer's pool of participating small employers. Therefore, costs for many smaller companies' health insurance will be similar or even slightly more expensive than if coverage is purchased through a traditional small group plan. These entities may find the increased benefits AHPs could offer so attractive that any extra costs would be worthwhile but, based on the NABIP membership's longstanding observations of the health insurance purchasing behaviors of small employers, we do not believe there will be an overwhelming response by the small-business community to transition from the traditional small-group market to AHPs.

If Congress chooses to move forward with actions that expand the AHP marketplace, NABIP believes that there must be firm guidelines for the framework of new and existing AHPs. It is crucial that AHPs have a structure in place to support all members through their various health coverage needs. Their issues will include everything from ensuring sufficient provider network adequacy for associations with members in far-ranging states to maintaining appropriate service support for all members on a national

[9] Giovannelli, J, et al. The Benefits and Limitations of State-Run Individual Market Reinsurance. *Commonwealth Fund*. 11 November 2020.

level. There is a long history of consumer harm and fraud in the AHP market, which has cost small employers and their employees hundreds of millions of dollars in unpaid claims and excessive administrative costs[10]; NABIP urges Congress to address fraud prevention in any AHP legislation. We also believe that, for effective consumer protection, an AHP should be required to have a local presence in a specified state so that it is clear which state has regulatory jurisdiction over the plan. NABIP also cautions Congress to ensure that any AHP legislation does not make changes to Section 27 of the Public Health Service Act, which grants states the authority to regulate health insurance products sold within their boundaries.

Additionally, AHP beneficiaries will need a clear understanding of what association membership means and how it may differ from traditional coverage. To serve this need, we propose the development of an AHP-specific addendum to the Summary of Benefits and Coverage notice currently required to be distributed by all insurance carriers and group health plan sponsors. NABIP also requests that any AHP legislation be cognizant of the assistance and professional advice business owners require when it comes to their health coverage and allow for meaningful participation and fair compensation of health insurance agents and brokers.

Outside of plan arrangements, one factor in the United States' high healthcare costs is dishonest billing due to the lack of site neutrality among providers. 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 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.[11]

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.[12]

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[10] Hospital Trust Fund to Employee Benefits Security Administration. Definition of Employer – Small Business Health Plans RIN 1210-AB85. 6 March 2018.
[11] Morning Consult. Coverage and Reforming the System. February 2023.
[12] Schwartz, Hope, et al. How do facility fees contribute to rising emergency department costs? *Kaiser Family Foundation*. 27 March 2023.

Additionally, an analysis released earlier this month 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.[13] NABIP supports site-neutral rules to deter these facility fees and location-based gaming of coverage; enacting site-neutral payment reform will help decrease healthcare costs for workers and employers alike.

Regarding practices of dishonest billing, NABIP also implores Congress to ensure that the No Surprises Act is implemented as intended. The Consolidated Appropriations Act of 2021 included the No Surprises Act, which holds patients harmless from surprise medical bills, including from air-ambulance providers, by ensuring they are only responsible for their in-network cost-sharing amounts in both emergency situations and certain non-emergency situations where patients do not have the ability to choose an in-network provider. For other claims, this new surprise-billing agreement utilizes an arbitration process with some patient safeguards.

Following this law's passage, the Departments of HHS, Treasury, and Labor issued regulations on the arbitration process, including what entities could serve as arbitrators, and what data elements could be taken into consideration. Initially, agencies directed IDREs to focus their decisions on the qualifying payment amount (QPA), which is defined in statute as the payer-specific median contracted amount for an item or service in the geographic area. As a result, the local market payment was the most important factor in making payment determinations.

By using the QPA as a decisive point in the IDR process, the consumer would likely encounter lower costs at the end of the IDR process. In turn, driving down costs through IDR would yield lower premiums for all consumers as the costs of surprise bills become mitigated. Unfortunately, several lawsuits filed over the last three years have compelled agencies to release updated guidance that reduces the importance of the QPA and local payment rates substantially. NABIP supports the agencies' original interpretation of the No Surprises Act – which offered the greatest amount of cost savings to the consumer – and opposes any threats to the law's implementation.

When it comes to the impacts of inflation and high healthcare costs, rural communities have suffered the most. Since 2005, 190 rural providers have closed; of those 190 providers, 136 of them closed between 2010 and 2021.[14] 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,[15] 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.[16] 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

[13] Ellis, Phillip. Estimated Savings from Adopting Site-Neutral Payment Policies for Medicare. February 2023.
[14] The Cecil G. Sheps Center for Health Services Research. Rural Hospital Closures.
[15] 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.
[16] Frankhauser, Margaret. Health Disparities in Rural America. *JSI.* 16 November 2022.

poverty, fewer adults with postsecondary educations, more uninsured residents under age 65, and higher rates of mortality.[17]

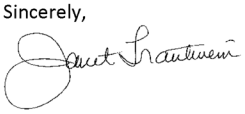
Another vital area of discussion is how to reduce healthcare costs for individuals covered by high-deductible health plans (HDHPs). While HDHPs are the best fit for some individuals, it can result in high out-of-pocket costs, with total yearly out-of-pocket expenses as high as $7,050 for an individual or $14,100 for a family.

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 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 health savings account.

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.

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,



Janet Stokes Trautwein
CEO, National Association of Benefits and Insurance Professionals

[17] The Cecil G. Sheps Center for Health Services Research. Rural Health Snapshot (2017). NC Rural Health Research Program. May 2017.

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for healthcare™

Chairman Bob Good (R-VA)
Ranking Member Mark DeSaulnier (D-CA)
House Committee on Education and the Workforce
Subcommittee on Health, Employment, Labor, and Pensions

Dear Chairman Good and Ranking Member DeSaulnier:

As healthcare prices continue their unsustainable rise year over year, we are calling upon policymakers to prioritize market-based solutions to address the affordability crisis impacting American workers and their employers. We appreciate the upcoming bipartisan hearings and roundtables to examine these important issues, and we call on Congress to take immediate action on these burdens facing employers and employees.

The escalating cost of healthcare services is a primary concern of businesses.[1] Both employees and their employers have been hurt by a 600% increase in hospital prices since 1990. Hospital services now represent the largest share of total healthcare spending, accounting for 44% of total spending for privately-insured Americans. Higher cost care settings can impose considerable financial burden on patients through higher out-of-pocket payments at the point of care and potentially higher health insurance premiums. It should be no surprise that the cost of employer-provided health coverage has increased by 43% in the last 10 years, with hospitals serving as the leading driver behind rising costs.

As Congress works to solve America's healthcare affordability crisis, we applaud your focus on the role that hospitals and large health systems play in driving up healthcare costs for consumers, employers, public sector purchasers, and the government. A lack of market competition, pricing transparency, and price mark-ups have exacerbated significant market distortions and undercut the stability and sustainability of the system.

We ask the committee to advance legislation that promotes and encourages market-based solutions and fair dealing among all stakeholders to address the uncontrollable rise of healthcare costs and reduce costs for all Americans. We look forward to working with you to drive the legislative proposals required to support our system's foundations, help fix areas that have become broken, and promote beneficial growth, innovation, and investment to protect the health of consumers, employers, and their families across the country.

Sincerely,

Better Solutions for Healthcare

[1] "Health Insurance, Labor, and Taxes Remain Top Issues for Small Business Owners in NFIB's Every-Four-Year Study." *NFIB*, 13 August 2020, https://www.nfib.com/content/press-release/homepage/health-insurance-labor-and-taxes-remain-top-issues-for-small-business-owners-in-nfibs-every-four-year-study/.

STATEMENT FOR THE RECORD

SUBMITTED TO THE

Committee on Education & the Workforce,
Subcommittee on
Health, Employment, Labor, and Pensions

Hearing on Reducing Health Care Costs for Working Americans and Their Families

April 26, 2023

SUBMITTED BY THE

The Coalition to Protect and Promote Association Health Plans

I. ***Overview***

The Coalition to Protect and Promote Association Health Plans (the "AHP Coalition")[1] respectfully submits this Statement for the Record.

Ever since its formation in August 2018, the AHP Coalition has been working tirelessly to correct-the-record.[2] Specifically, contrary to what critics are saying, Association Health Plans (AHPs) are *not* an "end-run around" the Affordable Care Act (ACA). Quite to the opposite. AHPs are currently offering better coverage than ACA-compliant "small group" and "individual" market plans.

How do they do that?

AHPs are *voluntarily* covering all ten of the ACA's "essential health benefits" (EHBs), including pediatric major medical coverage. AHPs also cover pediatric dental and vision services either through their AHP insurance contract or through a stand-alone product.

In addition, AHPs offer broader "health care provider networks" relative to many existing ACA "small group" and "individual" market plans, and they are priced at an "actuarially fair premium" for both young and old AHP participants. Doing so encourages more young and healthy individuals to enroll in AHP health coverage, which in turn benefits older and less healthy AHP participants by increasing the size of, and balancing out, the risk pool.

AHPs are also subject to specific rules that prevent them from discriminating against individuals/employees based on a health condition. Most importantly, AHPs are prohibited from denying people coverage if they have a pre-existing condition.

To date, at least 37 States allow small employers in the *same industry* to establish an AHP that is regulated like a "large employer health plan."[3] In addition, at least 30 States have signaled that they want to allow AHPs to (1) cover small employers in *different industries* and (2) cover *self-employed individuals with no employees*.[4] Note, 13 States currently do not allow employers in the *same industry* to establish an AHP that is regulated like a large employer plan,[5] while other States prohibit self-insured AHPs from operating in their State.[6]

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[1] The AHP Coalition is currently comprised of 18 like-minded organizations – including membership-based organizations and industry-service providers – that believe employees of small employers and self-employed individuals with no employees deserve quality and affordable health coverage with strong consumer protections. Our members include: American Farm Bureau Federation; American Society of Association Executives; Associated Employers Benefit & Trust; Consoliplex; Foundation for Government Accountability; Indiana Credit Union League; Manufacturer & Business Association; Marsh McLennan; McDonald's Licensees Health & Welfare Trust; Mercer; Michigan Business and Professional Association; Michigan Dental Association; National Association of REALTORS®; National Restaurant Association; NFIB; Small Business Association of Michigan; Tailorwell; Vimly Benefit Solutions.

[2] *See* Amicus Brief submitted by The Coalition to Protect and Promote Association Health Plans to the Court of Appeals for the District of Columbia Circuit at https://www.thepowerofa.org/wp-content/uploads/2019/06/Amicus-Brief-The-Coalition-to-Protect-and-Promote-Association-Health-Plans-and-AssociationHealthPlans.com_.pdf.

[3] These States include: AL, AK, AZ, AR, CO, FL, GA, HI, IL, IN, IA, KS, KY, LA, ME, MI, MN, MS, MO, MT, NE, NV, NC, ND, OH, OK, OR, SC, SD, TN, TX, UT, VA, WA, WV, WI, WY.

[4] *See* Bloomberg Tax, Tax Management Compensation Planning Journal, *Association Health Plans (AHPs) and States' Rights: An Accounting of How States Want to Regulate AHPs,* Nov. 2019 at https://www.thepowerofa.org/wp-content/uploads/2019/11/Condeluci_CPJ_Nov2019.pdf.

[5] These States include: CA, CT, DE, ID, MD, MA, NH, NJ, NM, NY, PA, RI, VT.

[6] For example, CA and WA refuse to grant a self-insured AHP a "license" to operate in their States.

II. ***Small Employers Want to Offer the Same Comprehensive and Affordable Health Coverage that Large Employers Offer***

It is important to emphasize that one of the main reasons why employers – both large and small – offer health coverage to their employees is to attract and retain talented workers and to keep their workers healthy and productive.

Large employers do just that, through an offer of comprehensive health benefits that talented workers typically demand, especially in a tight labor market. Small employers are no different. That is, small employers – needing to compete with large employers in today's market – *want* to offer comprehensive health benefits to meet employees' demands.

However, large employers with thousands of employees are in a better position to negotiate comprehensive, yet affordable coverage with insurers. Why? Because large employers offer insurers a bigger risk pool over which health claims may be spread and moderated. In some cases, these large employers can also negotiate lower rates with healthcare providers. How? Because large employers offer providers a large volume of patients to utilize their services.

Small employers, on the other hand, lack the resources and bargaining power of large employers, and therefore, the majority of small employers are unable to offer comprehensive coverage at an affordable price.

This is where AHPs play such an important and socially-beneficial role. By obtaining health coverage through an AHP – which is the same type of health plan sponsored by a large employer – small employers can "group purchase" and effectively compete with large employers by offering comprehensive and affordable health benefits to their employees.

III. ***Membership-Based Organizations Want to Offer Comprehensive and Affordable Health Coverage Too***

It is also important to emphasize that the type of "groups or associations" interested in sponsoring an AHP are membership-based organizations (this includes member-based organizations with self-employed individuals with no employees).

These organizations *want* to offer AHP coverage – which again, is treated like a large employer plan – not only to help their members obtain quality and affordable coverage, but as a member benefit to attract new members and retain their current members.

An offer of less comprehensive, sub-standard health coverage will actually be detrimental to these organizations (i.e., their current members will leave the organization and they will be unable to attract any new members).

IV. ***Self-Employed Individuals With No Employees Should Be Treated as an "Employer" and an "Employee" For Purposes of Participating In an AHP***

A self-employed individual with no employees provides services to the individual's own trade or business by providing services to a third-party entity, which itself is traditionally a trade or business or a third-party consumer. This self-employed individual generates revenue for its own trade or business through the provision of these services for these third-parties, and the Internal Revenue Code treats this

revenue generated as "income," which is taxed for both income and employment tax purposes, similar to "wages" that are paid to an employee by an employer.

Over the past three decades, our nation's economic environment has evolved into a competitive, global economic environment. Our nation's workforce has similarly evolved from a traditional employment-based setting where "employees are employed by an employer," to a non-traditional employment-based setting where a growing number of workers are self-employed individuals with no employees, who in reality operate as *both* (1) an "employer" and (2) an "employee."[7]

Stated differently, while self-employed individuals with no employees do not act in the capacity of "employees who are employed by an employer" in the traditional employment sense, these self-employed individuals continue to provide services just like an employee (generating income that is taxed just like wages). These same self-employed individuals also operate as an employer of a trade or business. A failure to recognize that these revenue generating, taxpaying self-employed individuals operate in an employment setting is a failure to recognize that we now live in a competitive, global economy that no longer relies on a workforce made up of the traditional "employee employed by an employer."

Recognizing these changing economic dynamics, it is imperative that Congress update our nation's laws by developing a flexible framework that permits self-employed individuals with no employees to access affordable and comprehensive health coverage through an AHP.

V. *Our Coalition Members Offer of Comprehensive and Affordable Coverage Through an AHP*

Our Coalition's membership-based organizations represent over 1 million small employers, and millions more who are employees of these small employer-members or who are self-employed with no employees, the majority of whom would be eligible to obtain health coverage through an AHP if Federal law allowed AHPs to cover (1) employers in *different industries* and (2) *self-employed individuals with no employees*. Our Coalition's membership-based organizations with employers in the *same industry* **ALREADY** provide comprehensive and affordable health coverage to tens of thousands of employees through an AHP in accordance with existing law.

A. Voluntary Coverage of the "Essential Health Benefits"

All of our AHP Coalition members that offered an AHP to (1) employers in *different industries* and (2) *self-employed individuals with no employees* during the 2019 plan year – along with all of our AHP Coalition members that **CURRENTLY** offer an AHP to employers in the *same industry* – *voluntarily* covered all ten of the ACA's EHBs.

It is important to emphasize that the tenth EHB requires "pediatric services, including oral (i.e., dental) and vision care." Every AHP in our Coalition provided "pediatric major medical health coverage," as well as "pediatric dental and vision care." Some AHPs covered "pediatric dental and vision care" through the AHP insurance contract itself, while others provided "pediatric dental and vision care" through stand-alone products. In both cases, *all* ten of the EHBs were covered.

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[7] *See* Small Business Trends, *Key Trends at Sole Proprietorships Over the Past 30 Years*, Dec. 4, 2015 at https://smallbiztrends.com/2014/09/key-trends-sole-proprietorships-past-30-years.html (reporting that the Internal Revenue Service found that sole proprietorships nearly doubled from 1980, when there were 39.2 for every thousand Americans to 76.7 sole proprietors for every thousand Americans in 2007).

Those AHPs that offered "pediatric dental and vision care" through a stand-alone product chose to do so because the Board governing the AHP determined that pediatric dental and vision benefits can be provided through a stand-alone product at a lower cost, while providing the same – if not a better – level coverage than if these services were offered through the AHP insurance contract itself. It is important to point out that the "control" test applicable to an AHP imposes a fiduciary duty on the Board governing the AHP, requiring the Board to "act solely in the interest" of the AHP participants and "for the exclusive purposes of providing benefits to participants and their beneficiaries…and…defraying reasonable expenses of administering the plan…"[8] The requirement to adhere to these fiduciary duties drove the Board's decision-making (to do otherwise would result in a fiduciary breach under ERISA).

B. Broader Provider Networks Than "Individual" and "Small Group" Market Plans

In addition to *voluntarily* covering the EHBs, our Coalition member's AHPs offer/offered broader "health care provider networks" relative to many existing ACA "small group" and "individual" market plans.

It is well-established that ACA-compliant "small group" and "individual" market plans primarily have "narrow networks."[9] In fact, the Congressional Budget Office (CBO) has explained that "individual" market plans generally have narrower provider networks than employment-based plans.[10]

For those employees currently covered by an AHP (which as stated, is an employment-based large group plan) – and for those employees and self-employed individuals covered by an AHP during the 2019 plan year – their plan's broader provider network means/meant that AHP participants are/were no longer required to drive hours to and from a physician's office or a hospital that are/were in-network to receive medical treatment or to even get a routine medical check-up.

C. AHPs Offer Lower Deductible Plans for the Same Level of Coverage Offered Through "Individual" and "Small Group" Market Plans

For the 2022 plan year, the average deductible for a single "silver metal" plan in the "individual" market was $4,890, while the average deductible for a single "small group" market plan was $2,543.[11] However, employees and self-employed individuals who were covered by an AHP during the 2019 plan year enjoyed *lower* deductibles for the same level of coverage as they would receive under an ACA-compliant "small group" or "individual" market plan. Same for employees **CURRENTLY** covered by an industry-based AHP.[12]

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[8] Section 404(a)(1)(A) of the Employee Retirement Income Security Act ("ERISA").
[9] Industry studies confirm that ACA-compliant small group and individual market plans primarily have "narrow networks." *See Plans with More Restrictive Networks Comprise 73% of Exchange Market*, Avalere Health, Nov. 30, 2017.
[10] Congressional Budget Office, *A Public Option for Health Insurance in the Nongroup Marketplaces: Key Design Considerations and Implications*, April 2021, page 7-8 at https://www.cbo.gov/system/files/2021-04/57020-Public-Option.pdf.
[11] *See* Healthinsurance.org, *What is a health insurance deductible* at https://www.healthinsurance.org/glossary/health-insurance-deductible/#:~:text=KFF%20reported%20the%20average%202023,and%20%2445%20for%20Platinum%20plans.
[12] As stated, an AHP is a "large group" employer plan. Kaiser Family Foundation indicates that the average deductible for a single "large" employer-sponsored plan was $1,493 in 2022, which is consistent with our Coalition member's AHPs. *See* Kaiser Family Foundation, *Employer Health Benefits 2022 Annual Survey* at https://files.kff.org/attachment/Report-Employer-Health-Benefits-2022-Annual-Survey.pdf.

D. These AHPs Developed "Actuarial Fair Premiums"

Importantly, existing AHPs – and those AHPs that provided coverage to employees and self-employed individuals during the 2019 plan year – are/were priced at an "actuarially fair premium" for both young and old AHP participants. This is/was achieved through developing rate-bands based on age that did *not* exceed a 5 to 1 ratio. Alternatively, composite rates are/were developed by the average age of the employer member (not to exceed a 5 to 1 ratio among employer members), and then every employee of a particular employer member participating in the AHP is/was charged the same premium regardless of age.

Importantly, a health plan sponsored by a labor union (which is similar to an AHP because the union aggregates small employers together and offers a "large group" plan to these small employer members) ***ALSO*** develops premium rates based on a 5 to 1 age band or based on the average age of the employer member (not to exceed a 5 to 1 ratio among employer members). Why? Because the union is advised to do so by their actuaries, and the law currently allows unions to engage in this practice.

The Federal Employees Health Benefit Program (FEHBP) also develops premiums based on a 5 to 1 ratio. Why? Because based on a study cited by the Congressional Budget Office, actuaries conclude that older individuals utilize health care 4.8 times more than younger individuals, and a 3 to 1 age ratio – as opposed to a 5 to 1 age ratio – "encourages older people to enroll and discourages younger people, and because the costs of the former are greater, average premiums rise."[13]

E. Data Shows that AHPs Can Offer Lower Costing Plans While Providing Coverage That Is More Comprehensive Than ACA-Compliant "Individual" and "Small Group" Plans

Data from AHPs providing coverage to (1) employers in *different industries* and (2) *self-employed individuals with no employees* during the 2019 plan year show that there is savings that can be achieved while also covering the ACA's EHBs and offering broader provider networks and lower-deductible plans.

For example, coverage that was offered to *self-employed individuals with no employees* through an AHP that was established by five different State and Local REALTORS® – the Baldwin County Association of REALTORS® in Alabama, the Greater Las Vegas Association of REALTORS®, the Kansas City Regional Association of REALTORS®, the Nevada REALTORS®, and the Tennessee REALTORS® – produced savings relative to ACA "individual" market plans.

Specifically, participants in the Kansas City Regional Association of REALTORS® AHP averaged savings between 5 percent and 50 percent, while participants in the Tennessee REALTORS® AHP experienced 25 to 50 percent savings. The Nevada REALTORS® AHP participants saw savings from 2 percent up to 32.5 percent, while participants in the Baldwin REALTORS® AHP realized savings ranging from $150 to $15,000 per year. Unfortunately, these AHPs have been discontinued due to the legal uncertainty surrounding AHPs.[14]

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[13] Congressional Budget Office, *Private Health Insurance Premiums and Federal Policy,* February 2016, page 22 at https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/51130-Health_Insurance_Premiums.pdf.

[14] On March 28, 2019, the District Court for the District of Columbia ruled that the Department of Labor's ("DOL's") final regulations issued on June 18, 2018 that allowed AHPs to cover (1) employers in *different industries* and (2) self-employed individuals with no employees are invalid. The U.S. Department of Justice appealed the ruling to the Court of Appeals for the District of Columbia Circuit. On May 10, 2019, the Circuit Court granted an expedited review of the District Court ruling. Four years later, a final ruling from the Circuit Court has yet to be released.

Similarly, an AHP offered by the Nebraska Farm Bureau to self-employed farmers produced savings of up to 25 percent relative to "individual" market rates in Nebraska. This AHP has also been discontinued.

Another AHP jointly sponsored by the Small Business Association of Michigan and the Michigan Business and Professional Association – called Transcend AHP – covered both small employers and self-employed individuals. Although this AHP has been discontinued as of December 31, 2019, below are some statistics showing savings during the 2019 plan year:

- 22 employee investment manager – 35% savings - $100,000/year and composite rates.
- 15 employee architecture firm – $3,700 savings and composite rates.
- 27 employee managed service provider – 27% savings - $53,000/year.
- 3 employee law firm – 5% savings from comparable BCBSM "small group" plan.
- Sole proprietor, health insurance agent – 17% in savings - $2,400/year in savings vs. an ACA Exchange plan.
- 16 employee light manufacturer – 11.3% savings - $16,000 a year and lower deductible.
- 7 employee refrigeration company – $2,400/year savings and composite rates.
- 15 employee manufacturer – 27% savings - $59,500/year savings.
- Sole proprietor, investment manager – 10% savings and a more robust plan design vs. an ACA Exchange plan.
- 16 employee small municipality – 10% savings - $18,400/year.
- 24 employee construction company – 8.66% saving and cut deductible in half to $1,000.
- 9 employee credit union – 18.5% savings - $15,600/year in savings and a lower deductible.

VI. *AHPs Are Not the Same As Short-Term Health Plans; AHPs Provide Comprehensive Coverage As Required Under the ACA, ERISA, HIPAA, COBRA, and State Law*

It is important to emphasize that AHPs are *not* the same as short-term health plans. We believe it is paramount to make this distinction because the media and critics of short-term health plans have inaccurately explained the rules applicable to AHPs. In short, the media and these critics have conflated AHPs and short-term health plans, and they have described these health plans as being one-in-the-same. AHPs and short-term health plans are *vastly different*.

A. Short-Term Health Plans Are Exempt from the ACA, While AHPs Are Subject to the ACA's Coverage Requirements

Under existing law, short-term health plans are *not* considered "health insurance" offered in the individual insurance market,[15] and therefore, short-term health plans are *not* subject to the Affordable Care Act's ("ACA's") insurance and coverage requirements.[16] As a result, short-term health plans *can* deny a person coverage with a pre-existing condition (because the ACA's pre-existing condition protections do *not* apply). Also, a short-term health plan *can* develop premiums based on a person's health condition (because the prohibition against developing premiums based on health status does *not*

[15] Section 2791(b)(5) of the Public Health Service Act section ("PHSA"), providing that the term "individual health insurance coverage" means health insurance coverage offered to individuals in the individual market, but does not include short-term limited duration insurance.

[16] Section 1551 of the Affordable Care Act ("ACA") incorporates the definitions under the PHSA – including PHSA section 2791(b)(5) – into the ACA's insurance and coverage requirements.

apply). And, a short-term health plan *can* impose annual and lifetime limits on benefits and medical services covered under the plan (because the prohibition against imposing annual and lifetime limits does *not* apply).

On the other hand, AHPs – as a "group health plan"[17] – *are* subject to the ACA's coverage requirements.[18] Again, this distinction is important to understand because – under current law – AHPs (1) *cannot* deny a person coverage if they have a pre-existing condition, (2) *cannot* develop premiums based on a participant's health condition, and (3) *cannot* impose annual and lifetime limits on the EHBs covered under the plan.

According to the ACA, a fully-insured "large group" and self-insured AHP – as a "group health plan" – *must*:

- Eliminate all pre-existing condition exclusions for all plan participants.[19]
- Stop imposing annual and lifetime limits on the "essential health benefits" covered under the plan.[20]
- Provide coverage for certain preventive health services with no cost-sharing.[21]
- Cover "adult children" up to age 26.[22]
- Stop rescinding coverage absent fraud or misrepresentation.[23]
- Include new internal and external appeals processes (and provide notice).[24]
- Allow participants a choice of primary care physician/pediatrician/OB/GYN.[25]
- Provide direct access to emergency services.[26]
- Refrain from establishing rules for eligibility based on, among other things, health status, medical condition, claims experience, medical history, or genetic information.[27]
- Limit the plan's cost-sharing to the maximum out-of-pocket limits for a high-deductible health plan defined under the health savings account ("HSA") rules for 2014.[28]
- Eliminate waiting periods that exceed 90 days.[29]
- Cover the cost of clinical trial participation.[30]
- Provide participants with a summary of benefits and coverage.[31]
- Provide annual reports describing the plan's quality-of-care provisions.[32]

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[17] ERISA section 733(a)(1) and PHSA section 2791(a)(1) provide that a "group health plan" is generally any plan, fund, or program established or maintained by an employer (or employee organization or both) for the purpose of providing medical care to employees or their dependents…directly, or through insurance, reimbursement, or otherwise.
[18] ERISA section 715 incorporates by reference the ACA's coverage requirements applicable to a "group health plan" into ERISA.
[19] *See* PHSA section 2704.
[20] *See* PHSA section 2711.
[21] *See* PHSA section 2713.
[22] *See* PHSA section 2714.
[23] *See* PHSA section 2712.
[24] *See* PHSA section 2719.
[25] *Id.*
[26] *See* PHSA section 2719A.
[27] *See* PHSA section 2705.
[28] *See* PHSA section 2707(b).
[29] *See* PHSA section 2708.
[30] *See* PHSA section 2709.
[31] *See* PHSA section 2715.
[32] *See* PHSA section 2717.

B. Consumer Protections Under ERISA, HIPAA, and COBRA Apply to AHPs

Under ERISA, there are specific notice and disclosure requirements that a fully-insured "large group" and self-insured AHP must comply with.[33] In addition, ERISA's fiduciary responsibilities apply,[34] requiring the AHP and its employer members to act in the best interest of the plan participants. AHP plan participants also have a private right of action to sue the AHP if there is wrong-doing,[35] and there are detailed procedures for filing health status.[36]

According to COBRA, a plan participant terminating coverage under an AHP has a right to continuation of coverage,[37] and according to HIPAA, premiums for an AHP participant *cannot* be developed based on the participant's health condition.[38]

C. State Benefit Mandates Apply to Fully-Insured "Large Group" AHPs

Another important layer of coverage requirements that is often times overlooked by critics of AHPs is this: A fully-insured "large group" AHP will be subject to State benefit mandates. State benefit mandates require an insurance contract sold within a particular State to cover specified benefits and medical services. The State benefit mandates applicable to fully-insured "large group" plans in most States are as good as the ACA's EHBs. Even in States where their benefit mandates do not cover all of the ten medical services that make up the EHBs, the drafters of the ACA observed that most if not all fully-insured "large group" plans were already covering the EHBs, which led Congress to exempt fully-insured "large group plans" from the EHB requirement entirely.

D. State MEWA Statutes Apply to Self-Insured AHPs

In the case of a self-insured AHP, this arrangement is by definition a "multiple employer welfare arrangement" (MEWA).[39] In the case of a self-insured MEWA, Congress specifically amended ERISA's preemption provision to give States the explicit authority to regulate self-insured MEWAs operating within the State.[40] Since that time, many States have enacted their own State MEWA laws with varying degrees of regulation – ranging from restrictive to permissive. These laws often times impose specific coverage and/or premium rating requirements on self-insured MEWAs. In addition, State MEWA laws typically impose the same solvency – or reserve – requirements that apply to insurance companies operating within the State. Other States outright prohibit self-insured MEWAs. States that have yet to enact a State MEWA statute are not prohibited from doing so in the future. In addition, States with existing State MEWA statutes are free to amend those statutes to impose specific coverage, rating, and/or solvency requirements on self-insured AHPs.

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[33] ERISA, Title I, Subtitle B Part 1.
[34] ERISA, Title I, Subtitle B Part 4.
[35] ERISA section 502.
[36] ERISA section 503.
[37] ERISA, Title I, Subtitle B Part 7.
[38] ERISA section 702.
[39] *See* ERISA section 3(40).
[40] ERISA section 514(b)(6)(A)(ii).

E. A Regulatory Framework Has Been Put In Place Over Time to Combat Fraud and Abuse; Our Coalition Pledges to Work With the NAIC and Congress to Fight Against Fraud and Abuse

It is important to point out that an AHP can take the form of either a fully-insured or a self-insured arrangement. This is a crucial distinction when it comes to the issue of fraud and abuse. For example, fully-insured AHPs are under-written by insurance companies, which are themselves subject to significant State regulation. In addition, States impose specific requirements on agents and brokers who sell insurance, imposing significant penalties on agents/brokers that engage in the fraudulent sale of insurance products. As result, there have been very few cases of fraud and abuse in fully-insured AHPs. And based on the current regulatory environment, it is unlikely that any fraud will occur in the context of fully-insured AHPs in the future.

While self-insured AHPs have in the past been more vulnerable to fraud and abuse, this history prompted Congress to act. Before 1983, self-insured AHPs resisted efforts at State regulation by arguing that such State regulation was pre-empted by ERISA. However – as stated above – Congress amended ERISA to give States the exclusive authority to regulate self-insured AHPs in any manner the State may choose.

Therefore, since 1983, the States have been free to regulate self-insured AHPs as they see fit, and they have exercised that authority through the enactment of State MEWA laws. For example, most States have enacted MEWA laws that set forth comprehensive certification and approval processes that an organization seeking to operate a self-insured AHP in the respective State must satisfy. Any such certification/approval must come directly from the State's Insurance Commissioner, and any such certification/approval will only be provided by the Commissioner if all of the State's MEWA law requirements are satisfied.

More extensive oversight has also come at the Federal level through the enactment of the ACA. Specifically, Congress expanded and strengthened the DOL's authority over MEWAs – and thus over AHPs – through a multi-pronged approach to eliminate MEWA/AHP abuses. These new requirements include improvements in reporting, together with stronger enforcement tools, and expanded required registration with the DOL prior to operating in a State. This additional information enhances the State and Federal governments' joint mission to prevent harm and take enforcement action. The ACA also strengthened enforcement by giving the Secretary of Labor the authority to issue a cease and desist order when a MEWA/AHP engages in fraudulent or other abusive conduct, and to issue a summary seizure order when a MEWA/AHP is in a financially hazardous condition.

This detailed State and Federal regulatory framework – which was not in place at all prior to 1983, and which has been built up over the years – provides safeguards that will largely prevent fraud and abuse, and, where such misconduct does occur, will significantly mitigate its effects. Our Coalition has also pledged to the National Association of Insurance Commissioners (NAIC) that we are ready, willing, and able to work with the State Insurance Commissioners to build on the current regulatory framework. In addition, our Coalition seeks to work with members of Congress to provide additional funding for the DOL's enforcement activities – as established under the ACA – as well as to fund State enforcement efforts.

The Alliance to Fight for Health Care
Advancing employer-provided coverage

April 26, 2023

The Honorable Bob Good
Chair
Committee on Education and the Workforce
Subcommittee on Health, Employment, Labor, and Pensions
United States House of Representatives
Washington, DC 20515

The Honorable Mark DeSaulnier
Ranking member
Committee on Education and the Workforce
Subcommittee on Health, Employment, Labor, and Pensions
United States House of Representatives
Washington, DC 20515

Dear Chair Good and Ranking Member DeSaulnier,

Thank you for the opportunity to submit the following comments for the hearing record in connection with the April 26, 2023, hearing, "Reducing Health Care Costs for Working Americans and their Families." We applaud the committee for working to address health care costs and improve coverage in the employer market for working Americans and their families

The **Alliance to Fight for Health Care** is a diverse coalition comprised of businesses, patient advocates, employer organizations, unions, health care companies, consumer groups, and other stakeholders that support employer-provided health coverage. Together, we are working to ensure that employer-provided coverage remains an available and affordable option for working Americans and their families. The Alliance is dedicated to pursuing policies that increase transparency and competition to bring meaningful change — and cost savings — to our health care system and patients everywhere.

Employer-provided health care coverage is the backbone of the U.S. health care system — covering more than 178 million people. More people receive health insurance through an employer than all other sources of coverage combined—Medicare, Medicaid, Marketplace, Tricare, and the Department of Veterans Affairs. Employer-provided coverage has always been efficient, effective, and stable, and through the COVID-19 pandemic, it has also proven to be resilient — with employers quickly stepping up to meet the health care needs of employees during the crisis.

Employer-provided coverage produces substantial return on the federal government's investment in it — both economically and when it comes to our health. Research finds that employer-provided coverage provides significant economic, social, and public health benefits. According to a National Bureau of Economic Research working paper, employer-provided coverage delivers significant value — at least $1.5 trillion in social value annually beyond the cost of insurance borne by businesses, workers, and government tax exemptions, at nearly $10,000 per person.

Despite economic uncertainty in 2022, more than 70% of large employers prioritized adding or expanding benefits or resources to meet employee needs. This included access to virtual care resources, expanded behavioral health, and alternative care arrangements, such as accountable care organizations and centers of excellence, that drive employees to high-value care.

Despite efforts, rising health care costs continue to be a top concern for both employers and employees. Health spending is increasing across all payers, and now exceeds 18% of the U.S. gross

domestic product. From 2016 to 2020, the 9.3% per person spending growth in the employer market was caused primarily by a 16% increase in average medical prices.

Health care costs continued to be a significant barrier to care for patients. A recent Morning Consult poll on health care issues conducted on behalf of the Alliance found **health care costs are the No. 1 concern among insured Americans**. What's more, 57% of insured adults said **reducing health care costs should be Congress' top priority**. But insured adults do not want to start over. Nearly 70% of insured adults, across the political spectrum, prefer to **strengthen the existing system.** Further, a majority of adults want Congress to work to lower the cost of health care for ALL Americans, not just those who receive coverage on the exchanges or in federal health care programs like Medicare and Medicaid.

The Alliance to Fight for Health care agrees. We want to work with the Committee on Education and the Workforce and Congress to improve the U.S. health care system and reduce health care costs for ALL Americans by advancing policies to reduce health insurance premiums and increase affordability. And we come to the table with bipartisan ideas, including some of the those being raised before the committee today, like expanding access to employer-provided telehealth, preserving ERISA preemption and preventing unfair hospital billing practices. Legislation to prevent unfair hospital billing practices would require hospitals to indicate the location where care is provided when they bill patients for payments. This is important because it will help expose instances where patients are being billed high prices as if they are receiving hospital level care, when in reality they are in a doctor's office. These small steps will benefit patients and improve transparency and accountability.

We also encourage Congress to continue the work of this committee to reduce cost and improve health outcomes for millions of American workers and their families by enacting polices to:

- **Remove restrictions preventing pro-patient competition in health care markets**
- **Protect patients from paying hospital prices for doctors' office visits**
- **Align value-based care incentives to benefit patients across all health care markets**
- **Give employers the flexibility to design programs to address chronic conditions and improve health outcomes**

Policy goal: Remove restrictions preventing pro-patient competition in health care markets

Employers want to create health plan designs that provide extra help to people with chronic or costly health conditions to improve health outcomes. Currently, "anti-tiering" and "anti-steering" clauses in contracts between providers and health plans restrict plans from creating innovative, high-value programs such as high-performance networks. Passing legislation like the Healthy Competition for Better Care Act (117th S.3139) would enable more group health plans and health insurance issuers to enter into agreements with providers that guide enrollees to high-value providers and provide incentives to encourage enrollees to seek higher-quality, lower cost care. There is significant support for such proposals. Recent polling by the Alliance indicates that 85% of insured adults feel employers should be able to give employees who have enrolled in their company's health plan a discount for seeing a high-quality provider.

Policy goal: Protect patients from paying hospital prices for doctors' office visits

The Alliance supports lowering the cost of health care services through policy proposals such as site-neutral payment reform. Current Medicare and private health insurance payment policies pay more for services provided in hospital outpatient departments (HOPDs) – in other words, provider offices owned by but not located in the hospital. According to the Medicare Payment Advisory Commission (MedPAC), this disparity is incentivizing health care consolidation and higher-health care costs. As shown in an AMA survey, currently fewer than half of physicians now work in physician-owned practices, a trend that has sharply risen since 2012.

MedPAC discussed the payment disparity in their June 2022 report to Congress, "[I]n 2022, Medicare pays 141 percent more in a hospital outpatient department than in a freestanding office for the first hour of chemotherapy infusion." As noted by MedPAC, "partly in response to these incentives, in recent years hospitals have acquired more physician practices, and hospital employment of physicians has increased." MedPAC also notes that the resulting increased reimbursements are not linked to clear benefits, such as improved quality of care for beneficiaries, but they are linked to increased costs for patients.

Congress can build on site-neutral payment reform by requiring Medicare to align payment rates for certain services across the three main sites where patients receive outpatient care—HOPDs, ambulatory surgical centers (ASCs), and freestanding physician offices. MedPAC, in its June 2022 report, estimated expanding site-neutral payment policies in Medicare could generate $6.6 billion in annual savings for Medicare and taxpayers and lower cost-sharing for Medicare beneficiaries by $1.7 billion.

The savings if voluntarily adopted by the commercial market are likely even greater. New research by University of Minnesota economist Steve Parente conducted on behalf of the Alliance estimates that expanding site-neutral payment reform in Medicare and encouraging adoption in the commercial market could result in nearly $60 billion in savings annually in the commercial market.

Requiring transparency in reporting where care is provided (i.e., a hospital or a physician's office) is another commonsense step that can help improve clarity for all consumers. Congress should consider legislation such as The Transparency of Hospital Billing Act.

These policies can all be designed to protect vulnerable rural or safety net hospitals, while protecting patients from climbing costs and consolidation. There is significant support for site-neutral payment reform. The Alliance's recent Morning Consult poll found 86% of insured adults, across political parties, believe health care costs should remain the same regardless of where the service is received.

Policy goal: Align value-based care incentives to benefit patients across all health care markets

The Alliance believes that federal cost reduction and quality improvement efforts should seek to improve the health care market for *all* beneficiaries. Encouraging collaboration between public and private providers and payors could accelerate beneficial changes for all participants. Creating pathways to engage the group health market in CMS Innovation Center (CMMI) models more meaningfully will promote multi-payer collaboration and encourage public-private partnerships that improve quality, reduce costs, and advance the system as a whole.

All patients should have a seat at the table in advance of future model development and be part of an open dialogue to promote coordination and learning to help improve the system together.

Policy goal: Give employers the flexibility to design programs to address chronic conditions and improve health outcomes

The Alliance also supports policies that reduce barriers to high value care, including enabling plans and employers to offer more high-value care pre-deductible. Laws and rules limiting pre-deductible coverage for chronic disease prevention, onsite medical clinics and telehealth inhibit employers' ability to offer high-value and potentially life-saving care to their employees on an equitable basis. Because of this, the Alliance supports legislation, including:

- The Chronic Disease Management Act (117th H.R. 3563/S. 1424), which allows greater flexibility to offer pre-deductible coverage for chronic disease prevention.
- The Telehealth Expansion Act (117th S. 1704), which makes permanent the flexibility for plans to offer telehealth pre-deductible.
- Legislation that allows employers to provide more robust services (like chronic disease management and primary care) at onsite medical clinics pre-deductible without charging cost-sharing.
- Legislation that permits plans below a specified actuarial value to make and plan participants to receive contributions to Health Savings Accounts (117th S. 2099).

The Alliance supports meaningful steps toward introducing the necessary transparency, accountability, and consumer protections into our health care system to meaningfully reduce costs, improve outcomes, and drive towards value.

You can find a longer list of our recommended policies – including the barriers they aim to address – on our website at www.fightforhealthcare.com.

We look forward to working together on a bipartisan basis to increase transparency and competition that makes health care more affordable, supports continued innovation, improves job-based coverage, and advances the health care system for all patients.

Respectfully,

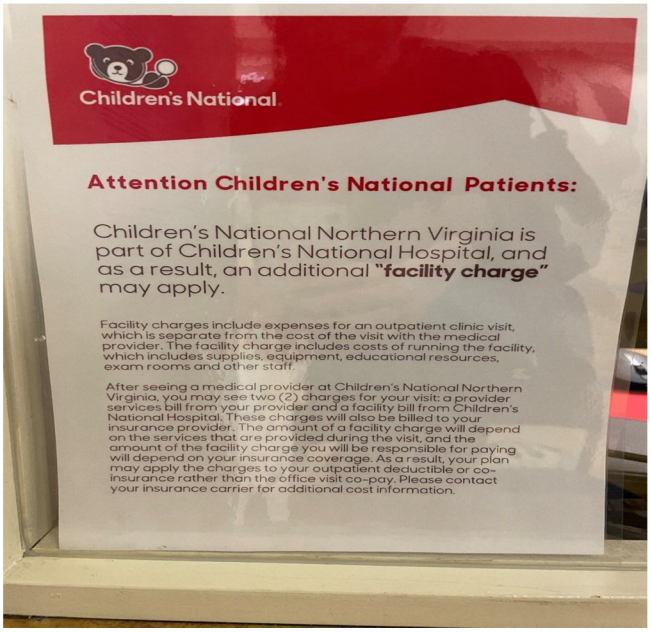
The Alliance to Fight for Health Care

APPENDIX

Same doctor. Same office. Should baby April pay more when they change the sign on the door?

When a physician's practice is bought by a larger hospital and the sign on the door changes, patients should not be forced to pay more. While the **Alliance to Fight for Health Care** appreciates the critical work hospitals do to care for patients and recognizes the challenges all sectors are facing given record-level inflation, patients should not be forced to pay hospital prices and hospital add-on fees for care that can be safely provided in doctors' offices. Site-neutral payment policies would reduce the incentives for hospitals to buy up physician practices, which will lower costs for patients.

This is an example of what happens to patients when a hospital buys their doctor's office. It shows a recent notice that baby April and her mom saw posted while checking in for their usual office visit last month. The office is over 11 miles from the hospital.



In case you missed it!
The News & Observer: "The health care didn't change. The office hasn't moved. Why is UNC now charging more?"

Sneaky fees are driving up health care costs for patients. A recent News & Observer article, "The health care didn't change. The office hasn't moved. Why is UNC now charging more?" highlights a growing trend of hospitals purchasing independent physician practices and clinics and charging patients more by adding so-called "facility fees."

The article describes how some UNC patients received a letter informing them that their dermatology clinic would be converted into a hospital-based clinic: "Almost everything about the health care at those clinics would stay the same, the letter assured patients. The location of the clinics, the doctors working there and the care they provided would not change." In fact, the only clear change, according to the letter, was an "additional 'facility fee' from UNC hospitals."

The article explains, "Health policy experts say this is an increasingly popular way for hospitals to get more money for providing the same care. By declaring free-standing clinics to be part of the hospital, they are able to tack on a facility fee, boosting their revenue."

The article quotes Ge Bai, a health policy researcher at the Johns Hopkins Bloomberg School of Public Health, who said, "It squeezes dollars from the pockets of patients and payers and channels them to the hospital's bank account."

The ***Alliance to Fight for Health Care*** **opposes hospital tactics that increase the financial burden on the patient and encourages Congress to expand site-neutral payment policy, which aims to align payment rates for certain services that are commonly and safely provided in lower-cost care settings.**

- The News&Observer

The health care didn't change. The office hasn't moved. Why is UNC now charging more?

By Teddy Rosenbluth

Published online March 13, 2023

Last month, some UNC Health patients received a letter informing them that three outpatient dermatology clinics would be converted into "hospital-based clinics."

Almost everything about the health care at those clinics would stay the same, the letter assured patients. The location of the clinics, the doctors working there and the care they provided would not change.

What will change, the letter pointed out, is how patients are charged for that care.

Beginning on March 6, patients of the clinics have been charged an additional "facility fee" from UNC Hospitals.

This fee, which one health policy expert researcher called a "revenue-generating gimmick," will almost always result in a more expensive bill for the patient and their insurance provider, said several experts interviewed by the N&O.

Health policy experts say this is an increasingly popular way for hospitals to get more money for providing the same care. By declaring free-standing clinics to be part of the hospital, they are able to tack on a facility fee, boosting their revenue.

"It squeezes dollars from the pockets of patients and payers and channels them to the hospital's bank account," said Ge Bai, a health policy researcher at the Johns Hopkins Bloomberg School of Public Health.

A NATIONAL TREND

In North Carolina, hospital-based clinics are common.

UNC Health operates 75, Duke Health 35 and WakeMed 24, according to spokespeople from the health systems. All charge facility fees.

Hospitals argue that facility fees are necessary to afford running large medical facilities at all hours of the day and night.

But critics question whether that facility fee is necessary for some of these clinics, like UNC's dermatology offices, that keep regular hours and are miles away from a hospital. They point out that the health systems have many clinics that are not "hospital-based" and are able to operate without an added facility fee.

Hospitals have been purchasing and re-labeling independent physician clinics to boost revenues for the last decade or so, said Matthew Fielder, a health policy researcher at the USC-Brookings Schaeffer Initiative for Health Policy.

There is no statewide or national data on how many clinics have been "converted" into hospital departments in recent years.

However, a recent report to Congress found that people are increasingly seen by their doctors at places billed as hospital outpatient departments. The percentage of appointments at that type of facility rose from 9.6% in 2012 to 13.1% in 2019, the analysis found. That's a 27% increase.

For patients, the change can result in hundreds or thousands of dollars added to their bills. One Ohio woman saw her portion of the bill for her arthritis injections increase from $30 to $354 after the clinic providing the injections was converted into a hospital department, Kaiser Health News reported.

Facility fees create a strong incentive for hospitals to buy up independent clinics and flip them into hospital clinics, said Barak Richman, a researcher at the Duke-Margolis Center for Health Policy.

This is particularly problematic in North Carolina, which has one of the most consolidated health care markets in the country.

"It's a widespread phenomenon," Richman said. "It has fueled consolidation for nothing but bad reasons."

Alan Wolf, a spokesperson for UNC Health, said the billing changes were necessary to keep up with wage and pharmaceutical inflation, which he said has "far exceeded reimbursement for dermatology services."

He said the change will allow the clinics to hire more staff and cut appointment wait times.

Fielder said he's unaware of any evidence that shows this type of reclassification meaningfully improves access to care.

"There is, on the other hand, abundant evidence showing that changes like these increase providers' revenues," he said. "UNC has delivered these services in a physician office setting until now, and many other providers are continuing to do so."

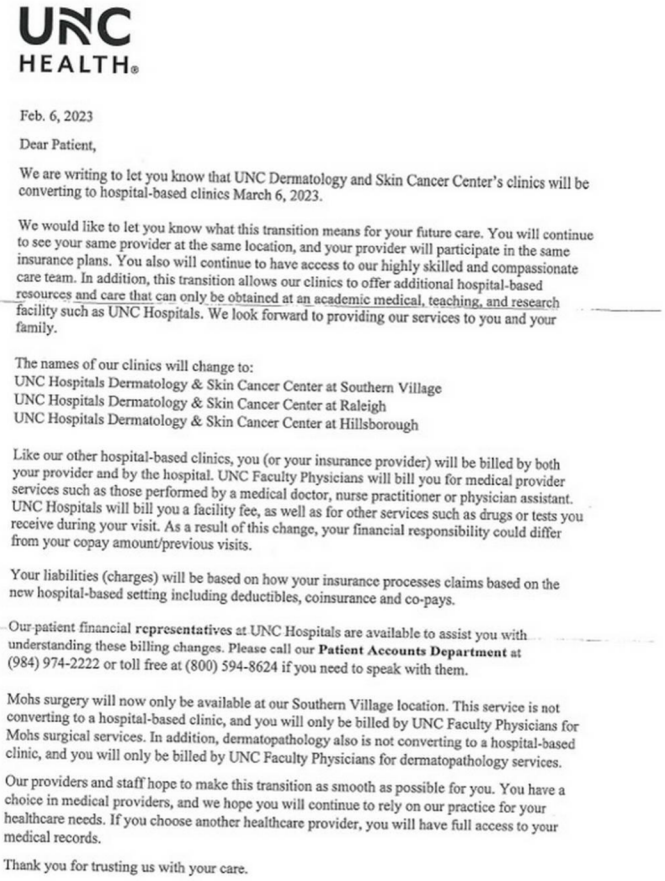
On the federal level, insurance companies have pushed for "site-neutral" Medicare billing, which would make clinic reimbursement rates the same regardless of whether they are independent or hospital-affiliated.

A report published last month by the Blue Cross Blue Shield Association found that adopting these policies could save the federal government, private health insurance companies and consumers a combined $471 billion over 10 years.

Bai said the best way to avoid facility fees at outpatient clinics is to call ahead and ask the billing department whether there will be a facility fee. If there is, she said patients could potentially find another provider.

However, she said this advice comes with an important caveat:

"The billing department might not be able to give a clear answer and patients might not have the time and energy to check when under stress."



UNC HEALTH®

Feb. 6, 2023

Dear Patient,

We are writing to let you know that UNC Dermatology and Skin Cancer Center's clinics will be converting to hospital-based clinics March 6, 2023.

We would like to let you know what this transition means for your future care. You will continue to see your same provider at the same location, and your provider will participate in the same insurance plans. You also will continue to have access to our highly skilled and compassionate care team. In addition, this transition allows our clinics to offer additional hospital-based resources and care that can only be obtained at an academic medical, teaching, and research facility such as UNC Hospitals. We look forward to providing our services to you and your family.

The names of our clinics will change to:
UNC Hospitals Dermatology & Skin Cancer Center at Southern Village
UNC Hospitals Dermatology & Skin Cancer Center at Raleigh
UNC Hospitals Dermatology & Skin Cancer Center at Hillsborough

Like our other hospital-based clinics, you (or your insurance provider) will be billed by both your provider and by the hospital. UNC Faculty Physicians will bill you for medical provider services such as those performed by a medical doctor, nurse practitioner or physician assistant. UNC Hospitals will bill you a facility fee, as well as for other services such as drugs or tests you receive during your visit. As a result of this change, your financial responsibility could differ from your copay amount/previous visits.

Your liabilities (charges) will be based on how your insurance processes claims based on the new hospital-based setting including deductibles, coinsurance and co-pays.

Our patient financial representatives at UNC Hospitals are available to assist you with understanding these billing changes. Please call our **Patient Accounts Department** at (984) 974-2222 or toll free at (800) 594-8624 if you need to speak with them.

Mohs surgery will now only be available at our Southern Village location. This service is not converting to a hospital-based clinic, and you will only be billed by UNC Faculty Physicians for Mohs surgical services. In addition, dermatopathology also is not converting to a hospital-based clinic, and you will only be billed by UNC Faculty Physicians for dermatopathology services.

Our providers and staff hope to make this transition as smooth as possible for you. You have a choice in medical providers, and we hope you will continue to rely on our practice for your healthcare needs. If you choose another healthcare provider, you will have full access to your medical records.

Thank you for trusting us with your care.

Teddy Rosenbluth covers science and health care for The News & Observer in a position funded by Duke Health and the Burroughs Wellcome Fund. The N&O maintains full editorial control of the work. This story was originally published March 13, 2023, 7:45 AM.

*The **Alliance to Fight for Health Care** is a diverse coalition comprised of businesses, patient advocates, employer organizations, unions, health care companies, consumer groups and other stakeholders that support employer-provided health coverage. Together, we are working to ensure that employer-provided coverage remains an effective and affordable option for working Americans and their families. The coalition (previously working as the **Alliance to Fight the 40**), led the successful effort to repeal the so-called 40% "Cadillac Tax" on health care coverage.*

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STATEMENT FOR THE RECORD

U.S. HOUSE OF REPRESENTATIVES

EDUCATION AND THE WORKFORCE COMMITTEE

SUBCOMMITTEE ON HEALTH, EMPLOYMENT, LABOR, AND PENSIONS

HEARING ON:

"REDUCING HEALTH CARE COSTS FOR WORKING AMERICANS AND THEIR FAMILIES"

The Partnership for Employer-Sponsored Coverage (P4ESC) commends the Subcommittee on Health, Employment, Labor, and Pensions for holding this hearing on reducing health care costs for working Americans and their families. Helping make coverage more affordable is at the core of P4ESC's mission.

P4ESC is a nonpartisan advocacy alliance of employment-based organizations and trade associations representing businesses of all sizes and sectors, and the millions of Americans and their families who rely on employer-sponsored coverage every day. Employer-sponsored health coverage is the single largest source of coverage in our nation.

P4ESC is eager to work on bipartisan legislation to permanently expand employee access to telemedicine, including first dollar coverage under Health Savings Accounts (HSAs) and enabling employers to offer a telehealth service plan to all employees regardless of their enrollment in the employer's medical coverage. Pandemic relief offered employees the ability to receive mental and behavioral health services via telemedicine, and we strongly support making this access permanent.

P4ESC strongly supports greater congressional oversight of the Federal Trade Commission (FTC) review of hospital and physician practice consolidation with emphasis on the growth of private equity acquisition of hospitals and physician practices. P4ESC also supports building on site-neutral rules to deter location-based gaming of coverage (e.g., the *Transparency of Hospital Billing Act*). Greater oversight of the high cost of medical care is long overdue.

Preserve and strengthen employer-sponsored coverage.

Employer-sponsored coverage has been the backbone of our nation's health system for more than eighty years. Businesses of all sizes contribute vast financial, administrative, and other resources to employees and their families through the employer-sponsored system and have a vested interest in health care quality, affordability, and value. Benefit offerings and coverage

plans in the employer-sponsored system are as diverse as our employers and employees themselves.

With self-insured coverage under the *Employee Retirement Income Security Act* (ERISA), employers tailor coverage to meet their workforce's specific needs across state lines. Many employers operate in multiple states with employee populations in each and self-insured coverage allows a common benefit plan for all employees no matter where they are located. These employers pay all health care claims and bear the financial risk of future claims. Employers often utilize a third-party administrator (TPA) for daily plan management, and in most cases, rent insurance carrier provider networks. Many also purchase stop loss coverage[1] to manage the risk of high-dollar claims. Most importantly, employers that sponsor self-insured health plans have a fiduciary duty under ERISA to manage plan assets prudently and in a manner that solely benefits the interests of plan participants and beneficiaries.

Under fully insured coverage, employers purchase an existing state-designed insurance plan sold and regulated on a state-by-state basis from insurance carriers. These employers do not bear the full financial risk of claims, but still hold a fiduciary interest in the cost and quality of coverage under ERISA.

Whether or not a business self-insures its coverage is largely but not entirely a question of size. In 2021, 78.1 percent of businesses with 1,000 or more employees self-insured at least one plan offering[2]. In contrast, only 17.7 percent of businesses with 25 to 99 employees self-insured their coverage[3]. More small employers would buy a fully insured plan.

Employer-sponsored coverage holds a distinct advantage over public-sponsored insurance pools. Workplace-based coverage groups together employees without regard to their health status. These pools tend to be more stable over time and more predictable leading to lower premium trends than other pooling arrangements. Younger, healthier employees offset the cost of older or less healthy employees, helping to keep coverage more affordable across the entire workforce. This natural pooling of employees in the private sector is more affordable and effective than government-created public pools in which less healthy individuals have a greater incentive to join the public pool than do healthier ones.

Employer-based coverage has been stressed by cost pressures and crises such as the COVID-19 pandemic, which tested the link between work and health care benefits. However, the number of Americans with employer-provided coverage fell only 1-2 percent despite the unemployment

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[1] Stop loss coverage is not a health plan within the meaning of the Affordable Care Act but shields a self-insured employer from the risk of the most expensive claims.
[2] Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey (MEPS) 2021. Chartbook #26: MEPS Insurance Component Chartbook 2021 (ahrq.gov).
[3] *Ibid.*

rate peaking at over 14 percent in 2020, according to the Commonwealth Fund. Employer-based insurance can and should continue to be the foundation of our nation's coverage.

Promote innovation and diversity of plan designs and offerings for employees.

Employers have led the way in benefit design and innovation for decades and will continue to do so for many decades to come. There is no one-size-fits-all employer health plan, nor should the federal government enact or implement laws to undercut ERISA and stifle an employer's ability to develop benefits offerings that meet the specific workforce's needs regardless of where that workforce is located.

A recent example is the onset of the pandemic, which presented immense challenges to the workforce. During that time, many employers expanded the ways through which enrollees could get mental health or substance abuse services, and others developed new resources, such as employee assistance programs.

All levels of government should work constructively with private sector employers to ensure that employers have the tools and flexibility to foster benefits design and innovations that provide employees with benefits that are crucial to the wellbeing of themselves and their families. We urge Congress additionally to remove barriers for employers to participate in advance payment initiatives, such as direct contracting, centers of excellence and high-performance networks.

P4ESC also urges action on bipartisan legislation to increase affordable options for patients and employers. Congress should empower and enable Americans with health savings accounts (HSAs) to better manage their health care and improve health outcomes, while lowering their out-of-pocket costs and increasing access to innovative care options.

HSAs were created nearly 20 years ago, but regulations about how individuals can use their HSA dollars have not kept pace in today's changing benefits landscape. One very important change to consider would be to provide pre-deductible coverage for primary care. We acknowledge that HSAs are not within this Committee's jurisdiction.

Address medical costs and challenges.

The fiscal viability and rising cost of our nation's health care system have long been debated, even before the COVID pandemic. Though many proposals have sought to address the ***demand side*** of health care spending by discouraging utilization, the better approach would be to address the ***supply side*** of health care spending. The rising cost of hospitalizations and prescription drugs are unsustainable in the long-run, and are a major factor driving the increase in cost of employer plans. We urge Congress to address the supply side of health care spending.

Rising health care costs are the greatest challenge in employer-sponsored health coverage. Small business owners have cited this as a leading challenge for more than 30 years.[4] Medical care from doctors, hospitals, and other medical providers is too expensive as are prescription drugs and biologics.

Pharmaceutical manufacturers, Pharmacy Benefit Managers (PBMs), and others are wrapped up in a convoluted and mutually dependent web that adds needless cost to coverage. Greater transparency of the pharmaceutical supply chain has helped to a degree, but the market has ultimately proven to be an insufficient governor of supply and cost. Additional steps to improve transparency and greater oversight and regulation of the pharmaceutical supply chain are needed. We also urge other committees of this Congress to investigate the current patent approval process and the apparent gaming of patents by incremental changes to extend patent exclusivity.

Health sector consolidation

P4ESC and businesses of all sizes long have been concerned by health sector consolidation and limited access to certain provider groups. The growth of private equity involvement in health care has fueled increased consolidation and higher health care costs. Congress should encourage the FTC to examine consolidation of hospitals and physician practices by private equity more closely and continue oversight on its progress.

Employers and employees face particular challenges in finding available and affordable mental and behavioral health care, especially with the severe provider shortage in the U.S. According to HHS, 129.6 million Americans live in areas designated as "Mental Health Professional Shortage Areas"[5] and 6,559 additional behavioral health providers[6] are needed to fill these provider gaps[7]. Moreover, some mental health providers decline to participate in health insurance networks at any price. Because many mental and behavioral health providers choose not to go in-network, employees can face large out-of-network bills for care sought and experience trouble finding available providers. It will take the efforts of all stakeholders to resolve this vexing issue.

It is important to stress that efforts to evaluate provider availability in health insurance networks must also consider whether these providers make themselves available and affordable to employees. Coverage requirements and civil monetary penalties on employers are counterproductive unless there is a countervailing requirement for providers to participate in one

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[4] National Federation of Independent Business, www.nfib.org
[5] Bureau of Health Workforce Health Resources and Services Administration, U.S. Department of Health & Human Services, "Designated Health Professional Shortage Area Statistics." September 30, 2021, available at https://data.hrsa.gov/Default/GenerateHPSAQuarterlyReport.
[6] Behavioral health providers are health care practitioners or social and human services providers who offer services for the purpose of treating mental disorders including: psychiatrists, clinical social workers, psychologists, counselors, credentialed substance use specialists, peer support providers, and psychiatric nurse providers.
[7] Bureau of Health Workforce Health Resources and Services Administration, U.S. Department of Health & Human Services, "Designated Health Professional Shortage Area Statistics." September 30, 2021.

or more networks. We strongly urge mental health care providers to join our networks to provide needed care to our employees and covered dependents.

Uphold the tax treatment of employer-sponsored coverage.

The exponential growth in our nation's employment-based health coverage system can be traced back to a cap on wages initiated during World War II to stifle inflation. Employers began offering so-called fringe benefits – such as health coverage – to offset the limit on wages and attract employees. For decades, employees and employers have benefited from the preferences in the federal tax code that: exclude the value of employment-based health coverage from an employee's income; allow for the pre-tax payment of an employee's premiums for employment-based health coverage; and enable employers to deduct the cost of health coverage as a business expense.

The direct benefits and federal spending offsets of employer-provided coverage result in an annual net social impact of $1.5 trillion, driven by increased labor participation, business formation, increased health coverage, and reduced federal health subsidies. Each dollar of federal expenditure – the tax revenue foregone for employer-provided coverage – yields approximately $5.34 in benefits for covered employees and their families, according to the National Bureau of Economic Research.

Provide employers with compliance relief from burdensome regulations.

The ability to offer coverage to employees and the capacity to operate a business for its core purpose are not mutually exclusive functions. An employer's offer of coverage is not merely a transaction in which an employee fills out paperwork, enrolls in coverage, and receives an insurance card. It is a multifaceted fiscal and operational commitment at the core of any business. As employers are making the decision to offer coverage and determine which type of coverage to offer their employees, the administrative compliance costs and complexities associated with coverage are critical to their consideration.

The compliance requirements under the *Affordable Care Act* (ACA) have always been complex and administratively burdensome on employers. P4ESC has long advocated bipartisan legislation to provide a more streamlined approach to the IRS employer information reporting requirements, the employer mandate definitions of full-time and seasonal employment, and the large business threshold. The ACA tax-policy rules fundamentally altered business operations and continue to be costly and burdensome. Reforming the reporting requirements (e.g., the *Commonsense Reporting Act*) would provide a more consumer-friendly process for individuals, and a less burdensome and costly compliance process for employers, the federally facilitated and state-based Exchange systems, and the IRS alike.

Altering the definitions of an applicable large employer and the definition of a full-time employee under the employer mandate would enable employees to pick up extra hours, provide consistent federal definitions across different laws, and enable businesses to hire more employees and grow their operations.

Conclusion

As a coalition representing businesses of all sizes, the Partnership for Employer-Sponsored Coverage appreciates the opportunity to provide these comments to members of the Subcommittee. P4ESC represents employers across the spectrum of the employer system – from the smallest family-owned business to the largest corporation. Employers have a significant stake in developing and implementing health care policies, and we look forward to working with you and your colleagues in a bipartisan manner throughout the 118th Congress. If you or your staff would like to meet to discuss the issues raised in our statement, please have your staff contact P4ESC's Executive Director Neil Trautwein at neil@trautweinstrategies.com.

careviso

April 26, 2023

Chair Virginia Foxx (R-NC)
House Committee on Education and the Workforce
2176 Rayburn House Office Building
Washington, D.C. 20515

Ranking Member Robert C. "Bobby" Scott (D-VA)
House Committee on Education and the Workforce
2101 Rayburn House Office Building
Washington, D.C. 20515

Subject: Reducing Health Care Costs for Working Americans and Their Families

Dear Chair Foxx and Ranking Member Scott:

Thank you for the committee's current focus affordability and transparency in the delivery of health care.

careviso's mission is to remove barriers and improve patient access to their health care, with a focus on diagnostic testing. For the last five years, careviso has built a technology platform that works with physicians, facilities, and payors. The platform can tell a patient what the out-of-pocket price is expected to be for a test or service, along with any medical management – such as prior authorization requirements. Our goal is to have patients and physicians focus on treating their condition or disease and having a platform available, such as careviso's, to be able to complete necessary administrative tasks associated with accessing health care and understanding the costs that will be paid by individual and their health plan.

As members of the health care technology community, and consumers of health care ourselves, we are encouraged that members of Congress are working to improve affordability and transparency so that patients and physicians have the information necessary to navigate the complexities of the current system.

careviso's health care provider-facing tool will help patients make informed decisions before receiving a treatment or service, without delaying care or creating unnecessary anxiety for an individual or family about a future surprise bill for a past treatment or service.

As we continue to work towards our shared goal of improving affordability and increasing transparency, please let careviso know if we can provide technological background or compliance expertise to inform the legislative process.

info@careviso.com
careviso.com

Sincerely,

Andrew Mignatti, President & CEO

BlueCross BlueShield Association

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April 26, 2023

The Honorable Virginia Foxx
Chair
House Education and Workforce Committee
Washington, DC 20515

The Honorable Bobby Scott
Ranking Member
House Education and Workforce Committee
Washington, DC 20515

The Honorable Robert Good
Chair, Subcommittee on Health, Employment, Labor, and Pensions
House Education and Workforce Committee
Washington, DC 20510

The Honorable Mark DeSaulnier
Ranking Member, Health, Employment, Labor, and Pensions Subcommittee
House Education and Workforce
Washington, DC 20515

Dear Chairman Foxx, Ranking Scott, Chairman Good, and Ranking Member DeSaulnier:

Every American deserves peace of mind when it comes to their health care, but too many are struggling to afford the health coverage and care they need. The Blue Cross Blue Shield Association (BCBSA) is committed to advancing common-sense solutions that can make a meaningful impact to improve care and lower costs for every American family, and we appreciate your leadership in holding today's hearing, **"Reducing Health Care Costs for Working Americans and Their Families."**

BCBSA is a national federation of 34 independent, community-based and locally operated Blue Cross and Blue Shield (BCBS) companies that collectively cover, serve, and support 1 in 3 Americans in every ZIP code across all 50 states and Puerto Rico. Our mission is simple: we want every single American to have affordable access to high-quality care. BCBS companies across the country work every day with local and national partners to tackle high costs so everyone can access the care they need regardless of how they get their coverage. As the underlying prices for medical care, health care services and prescription drugs continue to rise at unsustainable rates, we know we cannot address this affordability crisis alone. We have developed a comprehensive set of policy recommendations – **Affordability Solutions for the Health of America** – that, together, would save patients, consumers, and taxpayers **$767 billion in over ten years**.

A critical step in reducing health care costs is to advance solutions that will protect patients from unreasonable and unwarranted cost increases for the care they receive. We applaud the committee for considering legislation that would require **fair and transparent billing for professional health care services.** All too often, after a big hospital or dominant health system acquires a community physician practice, the practice begins billing health insurance as if the patient's care was delivered at the hospital.

Blue Cross Blue Shield Association is an association of independent Blue Cross and Blue Shield companies.

Fair and transparent billing would ensure that payments for patient care accurately reflect where the care was delivered, not where reimbursement can be maximized. That is why CMS should require off-campus hospital sites to obtain and bill using a different national provider identifier (NPI) than the main campus. Additionally, hospitals should be required to use the correct professional paper and electronic billing forms when billing for their off-campus outpatient sites. When these appropriate billing protections are in place, health insurance providers can accurately differentiate between care settings and apply the correct payment rates – which in turn would lower premiums and out-of-pocket costs for consumers.

Thank you again for your leadership and commitment to lowering health care costs for all Americans. We look forward to continuing to work with you to advance solutions that deliver real results for every American and every community. If you have any questions regarding our Affordability Solutions, please contact me or my colleague, Keysha Brooks-Coley, vice president of advocacy, at Keysha.Brooks-Coley@bcbsa.com.

Sincerely,

David Merritt
Senior Vice President, Policy and Advocacy
Blue Cross Blue Shield Association

Blue Cross Blue Shield Association is an association of independent Blue Cross and Blue Shield companies.

PARAGON HEALTH INSTITUTE
POLICY BRIEF

April 26, 2023

Small Business Health Insurance Equity Through Association Health Plans

Federal policymakers can lower insurance costs for small businesses and their workers by expanding access to large group health plans.

By Kev Coleman

Background on Small Business Health Care Costs

Back in 2002, the government's Medical Expenditure Panel Survey estimated that 44.5 percent of private sector firms (with fewer than 50 employees) offered health insurance. This percentage fell to 31.9 percent by 2021, a decline of 28 percent. During the same period, the average premium for a single employee rose over 118 percent, while the average family premium grew 140 percent.[3]

High costs threaten the availability of health benefits across the small firm landscape. A 2022 survey of 1,209 small firms found that 53 percent have considered ending health coverage due to rising cost.[4] The same survey found that 74 percent have considered reducing employer contributions to employee health insurance costs.

Unaffordable health benefits adversely affects many dimensions of the small business market. A variety of U.S.-based surveys have observed health insurance expenses leading small businesses to:

- Cancel Raises and Reduce Hiring – Due to high health insurance costs, 45 percent of small firms could not increase salaries, and 37 percent could not expand their workforces[5]
- Increase the Price of Goods and Services – 41 percent of small firms raised prices because of health insurance costs[6]
- Convert Positions to Part-Time or Lay-Off Workers – Health insurance was the most common cause of unexpected expenses causing job conversions to part-time work or the layoff of workers[7]

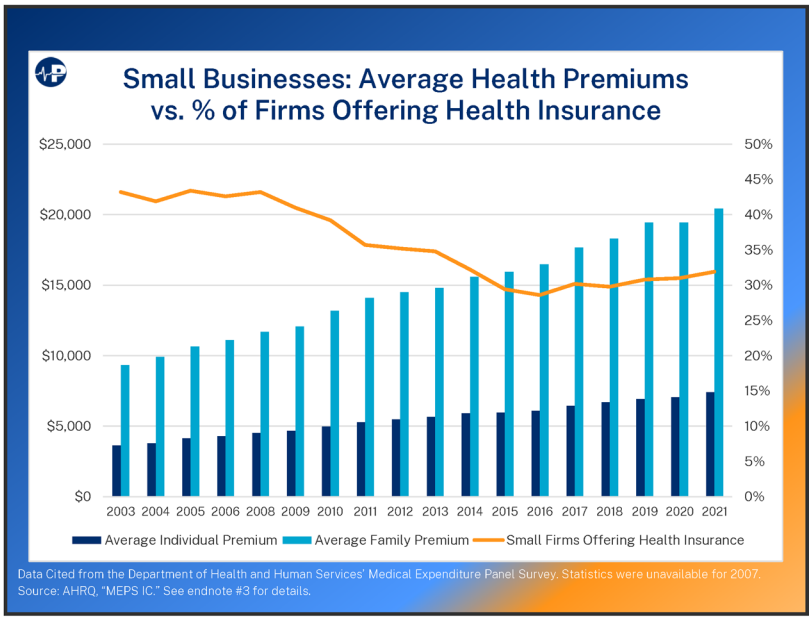
Small Businesses and Health Insurance

*According to 2022 data from the Kaiser Family Foundation, the average annual premium for employers with 50 or fewer workers is **$8,012** in annual premiums for single worker coverage, with family average exceeding **$22,000**.*[1]

Post-COVID Small Business Environment

The aftermath of COVID has been devastating to the small business community. A combination of lockdowns, inflation, and supply chain problems have led to widespread business closures.

An accompanying labor shortage has led to higher salary expenses while general inflation hit a four-decade peak during 2022. Unsurprisingly, a poll of 6,000+ small firms by the small business network Alignable found that 41 percent couldn't pay rent on time or in full for November 2022.[2]



Small Business Insurance Premiums

2002-2021

The above chart displays small business health insurance premium growth over the past two decades. Family premiums for employees of small businesses increased an average of 7 percent from 2002's baseline for 20 years, bringing the average family premium to $20,406 in 2021 from 2002's $8,502.[8] Individual coverage experienced a similar escalation: from $3,375 in 2002 to $7,382 in 2021. This is a rise of nearly 119 percent, which represents an additional 5.9 percent of expense each year during this period.[9]

Economists widely agree that the full cost of employer health coverage is borne by the employee (which includes the employer contribution that might otherwise go toward worker wages). However, the explicit contributions employees make in premiums may affect coverage participation. In 2002, the average employee contribution toward family health premiums was a quarter of its total cost.[10] By 2021, the percentage exceeded a third of cost.[11] This upward cost trend has coincided with a downward trend in health plan

participation. Employee enrollment within small firms offering health coverage has declined from 61.3 percent to 53.8 percent over the past two decades.[13]

Gig Workers: The Overlooked Small Businesses

Gig work is a phrase often used to describe a variety of labor performed outside the model of permanent employment for a company. This labor may be either the worker's primary income or supplemental earnings. Gig work covers independent contracting, freelancing, sole proprietorships, and other forms of incorporated and unincorporated businesses.

Given their labor performed outside permanent employment arrangements, gig workers are typically excluded from employer-sponsored health benefit plans. According to independent worker platform Stride Health, 24 percent of gig workers lack health insurance, and 58 percent of these uninsured gig workers cited prohibitive cost as the basis for why they did not purchase health coverage.[12]

Out-of-Pocket Costs Spike

Employee health care costs are more than monthly insurance premiums. Health plans engage in cost-sharing for covered medical services, where the plan members pay a portion of the health care costs directly from their own resources. These contributions are known as out-of-pocket costs and come in the form of deductibles, copayments, and co-insurance fees. While copayments and co-insurance are expenditures made alongside insurance company spending, a deductible is an amount of covered health care costs that a plan member must pay on his or her own before the health plan begins to pay for incurred health claims.

The percentage of small business employees whose health plan required a deductible contribution toward health care costs rose from 54.2 percent in 2002 to 86 percent in 2021.[14] In other words, 58.6 percent more employees had deductible obligations than had been the case 20 years prior.

The expense of deductibles themselves grew dramatically in those 20 years. In 2002, the average deductible for family coverage was $1,371. By 2021, this amount had grown 260 percent to $4,945.[15] Deductibles for single employee coverage grew even faster. The average 2002 deductible for health coverage was $602 for an individual employee with no spouse or dependents. Twenty years later, the average deductible for single employee was $2,485.[16] This 2021 average was over four times the 2022 average and represented an out-of-pocket expense increase over 312 percent.

Why Small Biz Health Care Costs Can't Be Ignored

Small businesses are a key component of the American economy. Over 5 million small businesses employ nearly 35 Americans[17] in the private sector, according to data from the Bureau of Labor Statistics. To ignore the threat insurance costs pose to employment and wage growth at small businesses is to ignore the trouble facing the employer of one in five adults in the United States.

The Inequalities of Big Business Health Plans

While health insurance costs are escalating throughout the economy, large companies have enjoyed savings advantages unavailable to small businesses. These advantages, often related to scale, have created an environment where a big business pays less than a smaller firm for the same health benefits. For example, health insurance load (i.e., the premium portion that exceeds expected medical expenditures paid by the insurer) are higher for small groups as compared to large. Multiple studies have observed loads for businesses with 100 or more employees being less than half the expense compared to small businesses with

fewer than 100 employees, with the savings growing larger for very big businesses.[18] Large companies with thousands of employees are also in a better position to negotiate with insurers, because large employers offer insurers a bigger risk pool over which health claims may be spread and moderated. In some cases, these large companies can also negotiate lower rates with health care providers (because large employers offer providers a large volume of patients to utilize their services). However, health care providers have consolidated across the nation, and the negotiating power of large group health plans has diminished.[19] Consequently, negotiation leverage may often require more covered lives than a single large company can provide within a given region. This need for greater scale, as the next section will demonstrate, can be addressed through an instrument **analogous to cooperative purchasing**.

A second advantage of large group health plans is overhead expenses. Among the areas in which large businesses have cost advantages is the percentage of premiums that can legally be used for profit and administration within a fully insured health plan. Small group plans devote 20 percent of their premiums to profit and overhead. Large group health plans, in contrast, are restricted to 15 percent for the same items, giving them a 5 percent savings advantage.[20] Another cost efficiency for large group plans derives from the absence of a "user fee." This fee, ranging from 2.25 percent to 2.75 percent of premiums, is charged to insurers selling "individual" coverage on an Affordable Care Act (ACA) exchange to self-employed businesses. In a state-based exchange such as Covered California, the charge is 5.2 percent for small group plans for businesses with multiple employees.[21]

A third advantage of large group health plans is the ability to customize the health plan's benefit design to include features that can potentially lower premiums such as programs incentivizing positive health outcomes and economic value in medical treatment. While large group health plans do have benefit requirements, these mandates are not as costly as those mandates applicable to individual and small group market plans. Large group plans can also reduce costs by unbundling supplemental benefits such as vision and dental care into separate group plans. Accordingly, those who don't desire such coverage do not pay for it, while those with such preferences still benefit from group rate savings.

Another advantage of large group health plans is their compatibility with self-insurance models where the employer pays for medical claims as opposed to a third-party insurer. Fully insured health plans, unfortunately, have a disincentive to control costs. Medical loss ratios constrain insurer earnings to a portion of premiums, so an efficient plan with less expensive medical claims reduces insurer revenue.

While small businesses may self-insure, it is difficult due to cash reserve requirements as well as the greater medical claims fluctuations of small risk pools. For large companies, self-insuring eliminates the cost of insurer profits and state premium taxation. More savings are afforded by claims analyses that identify billing errors and service "upcoding" by health care providers. Insurance companies, in contrast, are generally resistant to sharing claims data for analysis and may insist on quick claims payment even when the billing lacks proper Current Procedural Terminology (CPT) itemization. Another important self-funded savings advantage is the option of using a pharmacy benefits manager with a cost-plus pricing model (where rebating and spread-pricing schemes are prohibited). Fully insured health plans, unfortunately, have a disincentive to control costs in the manner outlined above for self-insured plans given rules around medical loss ratios.

Fairness for Small Business

Since **large group health plans have innate cost savings, and they cover 78 million Americans**[22] (which is more than covered by the entire Medicare program) with high rates of satisfaction, federal policymakers should implement a framework extending these advantages to small businesses while retaining appropriate consumer protections. Essentially, the Department of Labor (DOL) should:

- Promote a legal instrument that allows small businesses to band together within a single employer group to obtain affordable large group health insurance coverage
- Preserve existing federal and state regulations enforcing consumer protections for large group health insurance plans
- Prevent a third party, including but not limited to insurance companies, from owning or controlling the health plan sponsored by an employer group

The DOL has a pre-existing tool—**association health plans (AHPs)**—that can be improved through regulatory changes to accomplish the above goals and bring equity to small business health insurance. An AHP is an organization composed of companies working together to provide their employees health coverage through a single large group health plan. While AHPs have existed for decades, suboptimal regulatory design and market access restrictions have prevented AHPs from widely transforming small business health coverage.

Recommended Improvements

The core savings mechanism of an AHP is the consolidation of many companies into a single buying unit. There is considerable precedent for this practice as seen in **group purchasing organizations**, **professional employer organizations**, **group captives**, and **cooperatives** (such as ACE Hardware). In each of these examples, organizations employ a similar strategy where demand for products/services is pooled among multiple businesses to secure lower prices from suppliers.

AHPs are regulated primarily under the Employee Retirement Income Security Act of 1974, though their operation is also governed by provisions within many other laws such as the Health Insurance Portability and Accountability Act (HIPAA) and the ACA. Legacy regulations for AHPs have deficiencies needing improvement if employer groups are going to share in the health care savings already enjoyed by big companies. These improvements fall into three categories:

1. Reducing the barriers small businesses face when trying to band together to sponsor a single large group health plan

Large Group Requirements Applicable to AHPs

An AHP is considered a "group health plan" for purposes of the ACA and, thus, is subject to the ACA's "group health plan" requirements, which include:

- *Covering pre-existing conditions*
- *Covering government-specified preventive care without copays*
- *Prohibiting annual/lifetime spending limits for all care coinciding with Essential Health Benefits*
- *Offering internal and external benefit determination appeals*
- *Retaining enrollment for eligible dependent children up to age 26*
- *Prohibiting benefit waiting periods beyond 90 days from the day of employee hire*

Other legal requirements for AHPs outside the ACA include:

- *HIPAA nondiscrimination rules (see discussion on next page)*
- *Covering maternity and newborn care similarly to other plan services*
- *Covering childbirth hospital stays of at least 48-hours*

Complying with COBRA obligations allowing participants to continue in the health plan for 18–36 months despite termination (or hours reduction)

2. Extending large group health plan savings to workers laboring within the gig economy

3. Protecting AHPs from "bad actors" who misrepresent benefits or make false/misleading claims

These improvements would provide small businesses with lower cost health coverage, a stable insurance market, and sensible consumer protections. Moreover, the above goals can be accomplished **without** billions in new government premium and cost-sharing subsidies (the type of subsidization in the "individual" market) or further taxpayer spending for online marketplaces (i.e., the ACA exchanges) and tens of millions in grants and marketing for organizations assisting individuals with health insurance shopping and enrollment (i.e., the ACA's Navigators).

Improvement Details for Employer Groups

Under current law, for a group of small businesses (50 or fewer employees) to form a single large group health plan, the group must qualify as a **bona fide group or association of employers** as defined in DOL guidance. If the employer group is not "**bona fide**," each business within the group will be treated independently by regulators and forced into the more expensive small group market.[23] Current **bona fide** requirements exclude employer groups that lack a narrowly defined professional commonality. Hence, a group of carpentry firms may qualify as **bona fide**, but a homebuilder group composed of carpenters, electricians, plumbers, and painters would not. Since considerable scale is needed to extract health care price concessions, regulatory betterments should (1) broaden the commonalities by which sizable employer groups may grow and (2) allow associations to form based on a shared need for affordable health insurance without this motivation invalidating their satisfaction of other **bona fide** requirements.

With respect to the first issue, federal policymakers should expand **bona fide associations** to encompass the government's existing North American Industry Classification System.[24] In addition, associations that combine a valid professional grouping with secondary membership considerations (e.g., minority-owned, veteran-owned, carbon-zero, etc.) should be permitted.

Federal policymakers should also consider groups of employers that do not share the same industry, trade, or profession as **bona fide**, provided that the group:

- Has been actively in existence for at least two years

HIPAA Non-Discrimination Provisions

*AHPs are governed by the consumer protections within HIPAA. Under HIPAA, an individual may not be denied eligibility or continued eligibility to enroll in a group health plan based on health factors. Specifically, an AHP is **prohibited** from denying coverage based on:*

- *Health status (e.g., obesity, a physical disability, etc.)*
- *Pre-existing medical conditions (e.g., diabetes, high blood pressure, etc.)*
- *Pre-existing mental illnesses (e.g., depression, bipolar disorder, etc.)*
- *Medical claims history (e.g., expensive health care bills resulting from an accident)*
- *Medical history*
- *Genetic information*
- *Disability*

HIPAA's nondiscrimination rules prohibit an AHP from charging an individual enrollee higher premiums due to health factors. Likewise, the AHP benefits cannot be limited or excluded for an individual enrollee based on health factors.

- Was formed and maintained in good faith for purposes other than providing medical care through the purchase of insurance or otherwise
- Does not condition membership in the group on any health-status-related factor relating to any individual (including an employee of an employer member of the group or a dependent of an employee)
- Makes health coverage through the AHP available to all employer members of the group regardless of any health-status-related factor relating to its employer members (or individuals eligible for coverage through an employer member)
- Does not provide health coverage through the AHP to any individual other than an employee of an employer member of the group

Improvement Details for Gig Workers

Currently, a group or association is not considered **bona fide** if it includes self-employed individuals (e.g., gig workers). Gig workers are sole proprietors representing a sizable portion of the workforce, but one in four gig workers is uninsured. Given that a gig business operates simultaneously as employer and employee, gig workers should be allowed to access large group health coverage through an AHP, provided that:

- The group/association permits sole proprietor membership
- The gig workers satisfy the association's membership criteria
- Each gig worker's labor represents a true business as evidenced by at least 40 hours of gig work per month

This combination of individuals and employers within a single **merged market** is not novel. For example, in 2022 the government approved Maine's 1332 waiver request for the merger of their ACA individual and small group markets.[25] In the waiver, Maine justified the merger request by the premium reductions afforded by the merger as well as Massachusetts `operation of a merged since 2007.[26]

Guidance for AHPs Wanting to Self-Insure

While fully insured AHPs have been a reliable feature of employer insurance for decades, self-insured versions have had a more spotty record, and there have been instances of insolvencies due to inadequate funding. It should be noted that self-insurance, otherwise known as self-funding, isn't an inferior coverage model. Self-insured group health plans cover 36 million Americans (2019) and hold more than $102 billion in assets.[27] In addition, mixed insurance models combining self-funding with insurance provide health benefits to another 28 million Americans.[28] However, given that self-insurance is not the right option for many employer groups, it is recommended that federal policymakers should:

- Refrain from new AHP regulation that directly preempts state laws and regulation developed over decades to govern self-insured health plans (including reserve and contribution requirements), as these rules reflect individual state experience with self-funding arrangements
- Encourage a "level-funded" plan (with specified consumer protections) for two years prior to pure self-funding for new AHPs with no prior plan history. This would allow the AHP to collect meaningful claims data while eliminating health plan insolvency risks during this period

1. Claims data analysis provides cost-savings opportunities as well as a sound actuarial basis for self-funded premium setting. Claims data can also reveal costly pricing differences inside a provider network that can be corrected alongside overbilling and inappropriate medical utilization. Some studies have found some form of error in four out of five medical bills, including errors that can inflate medical costs

- Require both "specific" and "aggregate" stop-loss insurances for AHPs committed to self-funding in order to protect these AHPs from medical claims in excess of actuarial projections. Specific stop loss is insurance for excessive medical claims of a single plan participant; aggregate stop loss insures excess claims for the group.

Anti-Fraud and Good Governance Provisions

Current federal regulation seeks to prevent AHP fraud by requiring the employers sponsoring an AHP to "control" the health plan in form and substance. Most if not all states include similar "control" requirements. Here, the employer group must establish a governing board with bylaws or other similar indications of formality. A majority of the board members must be made up of the group's employer members participating in the plan that are duly elected by each participating employer member casting one vote during a scheduled election. Importantly, this board is considered a "fiduciary" and is required to operate the plan solely in the interests of participants and beneficiaries. No amounts paid into the plan by participating employer members and their employees may ever revert back to an employer member, a board member, a service provider, or any other third-party entity. To further protect the new AHP market, the DOL should:

- Allocate sufficient resources to identify and prosecute bad actors entering the market
- Establish penalties to deter those who would make false compliance representations within the improved AHP market

Federal policymakers should also update marketing rules to deter bad actors from entering the new market. If an AHP uses a third party for marketing, the AHP should be held responsible for advertisement accuracy.

Additional Guidance

The brief period of AHP reform in late 2018 through early 2019 demonstrated small employers' health coverage strategy. Contrary to what the critics suggested, the new AHPs offered comprehensive major medical coverage, and that trend persists in today's legacy AHP market. In many cases, current AHP coverage is more comprehensive than ACA-compliant "small group" and "individual" market plans. In addition, AHPs offer broader "health care provider networks" relative to many existing ACA small group and individual market plans and are priced at an "actuarially fair premium" for both young and old participants. AHPs are also subject to specific rules that prevent them from discriminating against individuals/employees based on health conditions. Most importantly, AHPs are prohibited from denying people coverage if they have pre-existing conditions.

However, in certain cases, organizations offering benefits through what they may call AHPs may not necessarily provide comprehensive major medical coverage (e.g., the arrangement is offering limited-benefit-type coverage such as indemnity, disability, or specified disease coverage). In these cases, the AHP should be required to explain clearly that its benefits are considered "excepted benefits" or other limited benefit designs—not major medical coverage—so there is no confusion among employees regarding what medical services are insured.

Much of what has been discussed in this brief are improvements to the law that can be performed through agency-level regulatory updates. Congress can take legislative measures to codify these improvements into law to protect the long-term health and stability of the AHP market. In addition, Congress may wish to consider codifying additional changes such as:

- Allowing an AHP to prevent a business from rejoining the AHP for two years after leaving the plan. This would discourage businesses from trying to "game" AHPs by leaving when medical claims are anticipated

to be low and returning when they expect medical claims to rise.

- Allowing an AHP to establish base premium rates formed on an actuarially sound, modified community rating methodology (that considers the pooling of all plan participant claims) and use each employer's specific risk profile to determine the employer's contribution rates for its share of the AHP premium (by actuarially adjusting above or below the established base premium rates).

Among the benefits of congressional legislation (as opposed to agency rule-making alone) is the stability it communicates to the AHP market. Organizations would invest technology and marketing in the improved AHP market if there is not the fear of their capital being lost. If AHP improvements rest solely on regulation, they may be reversed quickly by a later administration.

Key Issues Raised by Critics

Critics of AHPs have rejected entering into a dialogue on the reform and betterment of the AHP market despite the continued decline of the "small group" market, unpopular consumer mandates, and escalating government spending. Unfortunately, these critics have:

- **Ignored** the financial stability of fully insured and level-funded AHPs and implied that all AHPs have the solvency risks that can attend self-funded plans lacking adequate cash reserves and stop loss coverage
- **Obscured** the material differences between third-party-controlled Multiple Employer Welfare Arrangements (MEWAs) and employer-controlled association health plans
- **Concealed** that AHPs are an instrument for small businesses to access quality and affordable large group health coverage while incorrectly arguing that AHPs are an "end run" around the ACA
- **Disregarded** five decades of state and federal laws that have been developed to improve oversight of AHPs
- **Misrepresented** AHP premium savings as possible only through younger and healthier risk pools.

The brief period of September 2018 through March 2019—during which several of the regulatory changes outlined in this brief were allowed in the market before legal challenges suspended their operations—saw AHP premium savings reaching into double digits. These savings materialized without the market segmentation and adverse individual and small group market effects that critics claimed would occur. In reality, in the absence of these improved AHPs, the small group health insurance market has continued to decline. In 2022, two-thirds (68.1 percent) of private sector firms (with fewer than 50 workers) **did not offer** health insurance.[29] A study by the Commonwealth Fund found that enrollment in the small group health insurance market declined over 27 percent, from 18.1 million enrollees in 2012 to 13.1 million by 2018.[30] If the existing small group insurance market was an economical and compelling solution for small businesses, how do we explain these statistics?

This policy brief promotes AHP changes to benefit small businesses and welcomes debate on the merits of its proposals. Unfortunately, some critics refuse to discuss improvements in good faith. Instead, their efforts focus on smearing AHPs and associating them with every historical MEWA violation, even in cases where the MEWA violation concerned welfare benefits that were neither AHPs nor major medical plans.

About the Author

This policy brief was authored by Kev Coleman. Mr. Coleman combines years of health care research with experience in health care technology design and implementation.

Special Thanks

The author thanks Christopher Condelucci for his helpful review and comments.

[1] Gary Claxton et al., "Employer Health Benefits 2022 Annual Survey," Kaiser Family Foundation, October 2022, https://files.kff.org/attachment/Report-Employer-Health-Benefits-2022-Annual-Survey.pdf.
[2] Chuck Casto, "Rent Crisis Breaks '22 Record: 41% in U.S. Couldn't Pay in Nov., Up 4%," Alignable.com, November 23, 2022, https://www.alignable.com/forum/rent-crisis-breaks-new-22-record-41-couldn-t-pay-in-nov-up-4.
[3] Data on the percentage of private sector small businesses offering health insurance is taken from Agency for Healthcare Research and Quality (AHRQ), "Medical Expenditure Panel Survey (MEPS) Insurance Component (IC)," "Percent of private-sector establishments that offer health insurance by firm size and selected characteristics, 1996 to 2021," Firm size: fewer than 50 employees, https://datatools.ahrq.gov/meps-ic?type=tab&tab=mepsich3ntl. Data on average single and family premiums for small businesses is also taken from the MEPS IC. See "Average total single premium (in dollars) per enrolled employee at private-sector establishments that offer health insurance by firm size and selected characteristics, 1996 to 2021" and "Average total family premium (in dollars) per enrolled employee at private-sector establishments that offer health insurance by firm size and selected characteristics, 1996 to 2021." The average single coverage premium for employees in private sector businesses with fewer than 50 workers was $3,375 in 2002, rising to $7,382 in 2021. The average family premium for the same business class was $8,502 in 2002 and $20,406 in 2021.
[4] Small Business for America's Future, "Survey: Healthcare Costs Putting Financial Pressure on Small Business," October 2022, https://irp.cdn-website.com/b4559992/files/uploaded/SBAF%20National%20Healthcare%20Survey%20Oct.%202022.pdf.
[5] A July 2021 small business survey by insurance companies Cigna and Oscar found that 45 percent of respondents "said they couldn't increase salaries because of health-insurance costs." Oscar, "Many Small-Business Owners Want to Offer Employees Health Insurance but Don't. Here's What's Holding Them Back," last updated October 1, 2022, https://www.hioscar.com/blog/many-small-business-owners-want-to-offer-employees-health-insurance-but-dont-heres-whats-holding-them-back. The same survey effort reported that 37 percent of respondents said "they felt they couldn't expand their workforce because of the cost of health coverage for workers." Oscar, "Small Businesses Face Hiring Challenges after the Great Resignation of 2021—and Healthcare Costs Can Make It Harder," https://www.hioscar.com/blog/small-businesses-face-hiring-challenges-after-the-great-resignation-of-2021-and-healthcare-costs-can-make-it-harder.
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[7] Skynova, "Hidden Costs of Employment," https://www.skynova.com/blog/hidden-costs-of-employment.
[8] AHRQ, "MEPS IC," "Average total family premium (in dollars) per enrolled employee at private-sector establishments that offer health insurance by firm size and selected characteristics, 1996 to 2021," Firm size: fewer than 50 employees.
[9] Ibid.
[10] AHRQ, "MEPS IC," "Percent of total premiums contributed by employees enrolled in family coverage at private-sector establishments that offer health insurance by firm size and selected characteristics, 1996 to 2021," Firm size: fewer than 50 employees.
[11] Ibid.
[12] Lee Hafner, "24% of Workers in the Gig Economy Are Uninsured. How Can Employers Help?," *Employee Benefit News*, November 15, 2022, https://www.benefitnews.com/news/24-of-workers-in-the-gig-economy-are-uninsured-how-can-employers-help.
[13] AHRQ, "MEPS IC," "Percent of private-sector employees that are enrolled in health insurance at establishments that offer health insurance by firm size and selected characteristics, 1996 to 2021," Firm size: fewer than 50 employees.
[14] AHRQ, "MEPS IC," "Percent of private-sector employees enrolled in a health insurance plan that had a deductible by firm size and selected characteristics, 2002 to 2021," Firm size: fewer than 50 employees.
[15] AHRQ, "MEPS IC," "Average family deductible (in dollars) per employee enrolled with family coverage in a health insurance plan that had a deductible at private-sector establishments by firm size and selected characteristics, 2002 to 2021." Firm size: fewer than 50 employees.
[16] AHRQ, "MEPS IC," "Average individual deductible (in dollars) per employee enrolled with single coverage in a health insurance plan that had a deductible at private-sector establishments by firm size and selected characteristics, 2002 to 2021." Firm size: fewer than 50 employees.
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[21] Robert King, "CMS Final Rule Boosts Insurer User Fees and Extends ACA Open Enrollment Period for 2022 Coverage Year," *Fierce Healthcare*, September 27, 2021, https://www.fiercehealthcare.com/payer/cms-final-rule-boosts-insurer-user-fees-and-extends-aca-open-enrollment-period-for-2022. See also Covered California, "Covered California for Small Business Qualified Health Plan Issuer Contract for 2023–2025 for the Small Group Market," August 1, 2022, https://hbex.coveredca.com/insurance-companies/PDFs/2023-2025_QHP_CCSB_Model-Contract_8-1-22.pdf.
[22] "In 2019, 56,348 large health plans covered 78.8 million participants." Large plans, in this context, are plans with at least 100 enrollees, despite the fact that in most states the definition of *large group health plan* starts at 51 plan participants. Constantijn W. A. Panis and Megan Yeretsian, "Self-Insured Health Benefit Plans 2022 Based on Filings through 2019," Advanced Analytical Consulting Group, September 24, 2021, https://www.dol.gov/sites/dolgov/files/EBSA/researchers/statistics/

retirement-bulletins/annual-report-on-self-insured-group-health-plans-2022-appendix-b.pdf.

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See also:

- The Employee Retirement Income Security Act of 1974 (ERISA)
- The Health Insurance Portability and Accountability Act of 1996 (HIPAA)
- The Civil Rights Act
- The Women s Health and Cancer Rights Act
- The Public Health Service (PHS) Act
- The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)
- The Genetic Information Nondiscrimination Act
- The Affordable Care Act
- The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)

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June 23, 2023

Sabrina Corlette
Research Professor
Georgetown University McCourt School of Public Policy
600 New Jersey Ave., NW
Washington, DC 20001

Dear Ms. Corlette:

Thank you again for testifying at the April 26 Subcommittee on Health, Employment, Labor, and Pensions hearing on "Reducing Health Care Costs for Working Americans and Their Families."

Enclosed are additional questions submitted by Subcommittee members following the hearing. Please provide written responses no later than July 14, 2023, for inclusion in the hearing record. Responses should be sent to Michael Davis of the Committee staff who can be contacted at (202) 225-7101.

We appreciate your contribution to the work of the Subcommittee.

Sincerely,

Bob Good
Chairman
Subcommittee on Health, Employment, Labor, and Pensions

Enclosure

Questions for the Record for Sabrina Corlette

HELP Subcommittee Hearing
"Reducing Health Care Costs for Working Americans and Their Families"
April 26, 2023
10:15 a.m.

Rep. Lucy McBath (D-GA)

1. As a breast cancer survivor, I know firsthand how getting the right prescription drug at the right time can make a difference in life or death. Studies among cancer patients show that utilization management tactics like step therapy don't alter the treatment the patient ultimately gets, but it does delay the patient in accessing that treatment, reducing their chances of survival. That's why I was proud to sponsor H.R. 2630, the Safe Step Act, to ensure that plans offer an expedient step therapy exception process.

    a) How can employers, insurers, and pharmacy benefit managers work together to improve upon step therapy so that we can keep people alive and healthy while keeping costs down?

Rep. Mark DeSaulnier (D-CA)

1. Unfortunately, the final language for two of the bills discussed at this hearing was not introduced with sufficient time for careful review of the text. Now that both bills have been introduced, please provide your assessment of each:

    a) The *Association Health Plans Act* (H.R. 2868): How does this bill change current law? What concerns do you have with this language? How would it impact costs for individuals enrolled in association health plans and the broader risk pool?

    b) The *Self-Insurance Protection Act* (H.R. 2813): How does this bill change current law? What are potential concerns with the language in this bill that would preempt state authority to regulate stop-loss insurance?

2. Association health plans and multiple employer welfare arrangements have a long history of fraud and insolvencies. And I am deeply concerned that Republican proposals fail to learn this lesson. In the 1990s and 2000s, two separate reports by the Government Accountability Office found that insolvencies of these arrangements left thousands of people with hundreds of millions in unpaid medical bills.

    a) Could you talk a little about the history of fraud and insolvency with respect to association health plans?

b) Do you think that the Trump Administration's Final Rule or other Republican proposals (including H.R. 2868) to expand AHPs sufficiently address these concerns?

3. There is a growing, bipartisan recognition that we don't have enough information about costs in the health care system. In your testimony, you identify an important issue, which is the lack of transparency from companies that contract with employer-sponsored health plans to administer their benefits – such as pharmacy benefit managers (PBMs) and insurance companies that serve as third-party administrators (TPAs).

   a) What are some of the challenges that plan sponsors face when they try to get information from vendors like PBMs and TPAs? What impact does that have on health care costs?

   b) In what ways did the *No Surprises Act* and *Consolidated Appropriations Act, 2021* improve transparency and what are some of the next steps we should consider?

Rep. Susan Wild (D-PA)

1. Hospitals and hospital outpatient departments (HOPDs) play a critical role in providing many communities- including my own- with reliable access to high-quality health care. What is your response to concerns that site-neutral payment policies could lead to hospital closures and reduce patients' ability to consistently access high-quality health care services, especially in rural communities?

U.S. House of Representatives Committee on Education and the Workforce
Subcommittee on Health, Employment, Labor, and Pensions
Hearing on "Reducing Health Care Costs for Working Americans and Their Families."
April 26, 2023

Sabrina Corlette – Questions for the Record

Rep. Lucy McBath (D-GA)

1) As a breast cancer survivor, I know firsthand how getting the right prescription drug at the right time can make a difference in life or death. Studies among cancer patients show that utilization management tactics like step therapy don't alter the treatment the patient ultimately gets, but it does delay the patient in accessing that treatment, reducing their chances of survival. That's why I was proud to sponsor H.R. 2630, the Safe Step Act, to ensure that plans offer an expedient step therapy exception process.
    a. How can employers, insurers, and pharmacy benefit managers work together to improve upon step therapy so that we can keep people alive and healthy while keeping costs down?

While step therapy can be an important tool for employer health plans to encourage the use of less expensive treatment options and keep pharmaceutical costs in check, it can pose significant administrative hassles for providers and patients and may not be clinically appropriate for certain conditions. For example, many cancers can be fast-moving and time lost getting to the right treatment can be a life or death matter. Plans should thus ensure that patients have access to exemptions from a step therapy protocol, for example (a) when for a particular patient the drug is likely to be ineffective or adversely affect the patient, (b) when the patient has already gone through a step therapy process (i.e., when in a prior plan), and the initial steps failed, and (c) when the patient is already stable on a medication that is working for them. Plans should also ensure that adjudications of such exemptions are made on a timely basis, with an expedited process for patients for whom time is of the essence.

Rep. Mark DeSaulnier (D-CA)

1) Unfortunately, the final language for two of the bills discussed at this hearing was not introduced with sufficient time for careful review of the text. Now that both bills have been introduced, please provide your assessment of each:
    a. The Association Health Plans Act (H.R. 2868): How does this bill change current law? What concerns do you have with this language? How would it impact costs for individuals enrolled in association health plans and the broader risk pool?

H.R. 2868 allows small employers to band together and buy health insurance though associations. The bill effectively codifies a regulation promulgated by the Trump administration

in 2018 that has been enjoined in federal court. The bill creates an uneven playing field between AHPs and the small-group insurance market. AHPs would be able to cherry pick employer groups with relatively young and healthy employees with lower rates, but employer groups with older or less-healthy workers would facer higher rates. Over time, this adverse selection will result in higher premiums for employers in the small-group market.

Unfortunately, this bill simply re-arranges the deck chairs on the Titanic, shifting costs from the healthy to the sick. It does absolutely nothing to address the underlying reasons for the affordability challenges facing employer-based insurance: namely, the high and rising prices charged by hospitals, drug manufacturers, and other health care providers.

b. The Self-Insurance Protection Act (H.R. 2813): How does this bill change current law? What are potential concerns with the language in this bill that would preempt state authority to regulate stop-loss insurance?

H.R. 2813 would encourage the expansion of self-funded employer-based insurance exempt from key Affordable Care Act (ACA) protections and preempt states' efforts to stabilize premiums for small employers. By exempting stop-loss insurance from the definition of health insurance under federal law, and preempting states' ability to regulate in this space, the bill will encourage the proliferation of level funded plans in the small-group market. This poses three significant risks. First, level-funded plans expose small employers to financial and fiduciary risks they may not be fully aware of when they sign up. The NAIC has documented several consumer protection concerns associated with level funded products, including excluded benefits, lasering of high-risk employees, deadlines that leave employers financially responsible for late-submitted claims, and termination clauses that give the stop-loss issuer just 30 days to end the contract, without cause.

Second, if small employers with younger, healthier employees shift to level-funded products in significant numbers, it will leave employers with older, less-healthy workers in the ACA-compliant small-group market. This causes adverse selection, meaning that premium rates rise for employers who cannot pass the stop loss issuers' underwriting. For employer groups that can pass underwriting, if their claims experience worsens over time, the stop-loss issuer will then "dump" the employer group (see 30-day termination clause issue, above) into the ACA-regulated small-group market.

Third, the proposal will prevent states from trying to stabilize their small-group markets by regulating stop-loss insurance. Some states have prohibited the sale of stop-loss policies to employer groups below a certain size; others limit stop-loss policies with attachment points so low that the level-funded plans is, in effect, a fully insured group plan that should be subject to the same market rules that apply to similar products. State insurance regulators, not the federal government, are best positioned to identify and respond to problems in their insurance markets, and this bill would tie their hands.

In addition to posing the above risks, this bill does nothing to address the underlying reason why there is an affordability crisis for employer-based insurance: the prices that commercial insurers pay for provider services and prescription drugs.

2) Association health plans and multiple employer welfare arrangements have a long history of fraud and insolvencies. And I am deeply concerned that Republican proposals fail to learn this lesson. In the 1990s and 2000s, two separate reports by the Government Accountability Office found that insolvencies of these arrangements left thousands of people with hundreds of millions in unpaid medical bills.
    a. Could you talk a little about the history of fraud and insolvency with respect to association health plans?

For decades, AHPs have been used as a vehicle for selling fraudulent insurance coverage. Scams grew after Congress initially exempted AHPs from state regulation under ERISA in 1974. AHP operators would target small employers and self-employed people, collect premiums for non-existent health insurance, and then leave businesses and individuals with millions of dollars in unpaid medical bills. To escape regulatory oversight, AHP operators would set themselves up in one state with lax oversight and market policies to people in other states with more robust oversight, bypassing those states' consumer protections and benefit standards.

In 1982, Congress tried to clamp down on what had become widespread fraud by amending ERISA to allow states to regulate AHPs and MEWAs. Since then, many states have established governance, solvency and other standards for AHPs. However, fraud and insolvency among AHPs have remained a problem. For example, my Georgetown CHIR colleagues found that between 2000-2002, 144 AHP operators left over 200,000 policyholders with over $252 million in medical bills. In 2018, the U.S. Department of Labor reported that it has pursued 986 enforcement actions against MEWAs since 1985, but it admits that its "enforcement efforts often were too late to prevent or fully recover major financial losses." The agency also admits that it fails to adequately collect information about "unpaid claims or their financial impacts on patients and healthcare providers."

AHPs are also often financially unstable, and there are no federal financial standards to ensure that AHPs remain solvent, even though this proposal would significant expand the numbers of small employers and self-employed individuals who enroll. Indeed, as recently as May 2023, the Department of Labor announced a $54 million court judgment over a MEWA's unpaid claims. The Department found severe mismanagement and underfunding, leaving enrollees and providers with millions in unpaid claims.

    b. Do you think that the Trump Administration's Final Rule or other Republican proposals (including H.R. 2868) to expand AHPs sufficiently address these concerns?

No.

3) There is a growing, bipartisan recognition that we don't have enough information about costs in the health care system. In your testimony, you identify an important issue, which is the lack of transparency from companies that contract with employer-sponsored health plans to administer their benefits – such as pharmacy benefit managers (PBMs) and insurance companies that serve as third-party administrators (TPAs).
    a. What are some of the challenges that plan sponsors face when they try to get information from vendors like PBMs and TPAs? What impact does that have on health care costs?

My colleagues and I at Georgetown's Center on Health Insurance Reforms recently completed a survey of 50 state employee health plans, and we asked about their experiences working with third-party vendors such as TPAs. Although state employee plans often the largest commercial purchasers of insurance in their states, and thus should have considerable influence over the vendors who seek their business, these plans report frustration with their TPAs. Plan administrators observe that these entities often drag their feet or even actively resist cost containment initiatives and greater transparency. This is likely due to misaligned incentives and a lack of accountability for cost growth. Furthermore, although the CAA of 2021 should have improved the sharing of claims data with plan administrators, reports suggest that many TPAs continue to place limits on employer use of that data.

    b. In what ways did the No Surprises Act and Consolidated Appropriations Act, 2021 improve transparency and what are some of the next steps we should consider?

The NSA/CAA included important policies to improve transparency for employers who purchase health benefits. In particular, the law prohibits gag clauses in provider-payer contracts, and requires brokers and other vendors to disclose financial transactions over a specified threshold. However, more could be done to ensure compliance with the ban on gag clauses, and to incentivize TPAs to lift restrictions on claims and pricing data for plan administrators (with appropriate privacy and security safeguards of personally identifiable information). In addition, Congress should continue to push the Department of Labor to clarify that the CAA's vendor disclosure requirements include TPAs and PBMs.

Rep. Susan Wild (D-PA)

4) Hospitals and hospital outpatient departments (HOPDs) play a critical role in providing many communities- including my own- with reliable access to high-quality health care. What is your response to concerns that site-neutral payment policies could lead to hospital closures and reduce patients' ability to consistently access high-quality health care services, especially in rural communities?

Depending on the payer and the state where a patient seeks services, hospitals can charge more, and insurers will typically pay more, for the same service provided in a hospital setting, such as an HOPD, than in a clinician's office. Some payers, like Medicare, have limited payments for these charges to certain facilities, practice locations and/or services, and some states have similarly restricted hospitals' ability to bill these higher charges. Higher prices for HOPD-based care result in higher health care spending for services that can be safely provided in a clinician's office, which ultimately translates into higher costs for health care consumers, employers, insurers, and public payers. These higher payments are also one factor (among many) incentivizing hospitals to acquire clinician practices and driving greater consolidation in our health care system. Site-neutral payment, in general, would instead equalize payments for ambulatory services across settings – whether the setting is an independent physician's office, a clinic, an HOPD, an ambulatory surgical center, or another setting.

To the degree that rural hospitals and other hospitals depend on higher payments for ambulatory care, site-neutral payment proposals may appear to threaten their financial bottom-line and their ability to keep their doors open. Ambulatory care payments, however, are only one revenue stream for acute care hospitals. Further steps toward site-neutral payment may also require payers to revisit how hospitals' important fixed costs, such as costs related to maintaining helicopter pads, emergency departments, and ICU units, can be better reimbursed through payments for the care that draws upon these resources.

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June 23, 2023

Marcie Strouse
Partner
Capitol Benefits Group
9854 Colby Ave.
Clive, IA 50325

Dear Ms. Strouse:

Thank you again for testifying at the April 26 Subcommittee on Health, Employment, Labor, and Pensions hearing on "Reducing Health Care Costs for Working Americans and Their Families."

Enclosed are additional questions submitted by Subcommittee members following the hearing. Please provide written responses no later than July 14, 2023, for inclusion in the hearing record. Responses should be sent to Michael Davis of the Committee staff who can be contacted at (202) 225-7101.

We appreciate your contribution to the work of the Subcommittee.

Sincerely,

Bob Good
Chairman
Subcommittee on Health, Employment, Labor, and Pensions

Enclosure

Questions for the Record for Marcie Strouse

HELP Subcommittee Hearing
"Reducing Health Care Costs for Working Americans and Their Families"
April 26, 2023
10:15 a.m.

Chairwoman Virginia Foxx (R-NC)

1. Do you agree with Ms. Corlette's statement that "many small employers are not sophisticated purchasers of health benefits, and may not realize the financial risks and fiduciary duties they take on when they self-fund their plan"?[1] Why or why not?

Response

Small employers are the backbone of our economy. They are very sophisticated in running their business because most employers hold many roles within their company. They are not only the owner managing the aspects of getting their products out to the consumer, but they are also engaged in payroll, staffing, compliance, and benefits. The employers I work with want to know what is happening and be a part of every detail of their business. They rely on partners to provide expertise like insurance agents, CPAs, HR professionals, financial planners, and others pertinent to their day-to-day processes. They are ultimately the final decision makers, though, and pride themselves on understanding all the different aspects to make an educated decision. They know their company and their employees, so owners are very important when pulling together benefits packages. Remember that in a small employer setting, most of the employees are from within the communities where these companies are based. They feel a strong need to support their entire team, meaning they must be engaged and understand how their team will be impacted. Small employers we work closely with are more engaged and sophisticated than some large ones we work with, who can be removed from the details.

2. Your written testimony indicated that you are consistently talking to employers. What are they finding burdensome about the existing reporting requirements under the *Affordable Care Act*, and what would you recommend Congress do to alleviate some of the burdens?

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[1] *Reducing Health Care Costs for Working Americans and Their Families: Hearing Before the Subcomm. on Health, Emp., Lab., & Pensions of the H. Comm. on Educ. & the Workforce*, 118th Cong. (Apr. 26, 2023) (statement of Sabrina Corlette, Research Professor & Co-Dir., Ctr. On Health Ins. Reforms, Georgetown Univ. McCourt Sch. of Pub. Pol'y), https://edworkforce.house.gov/uploadedfiles/4.26.23_health_care_costs_hearing_corlette_testimony_final.pdf.

Response
The IRS was invited to write the section of the ACA related to employer reporting for purposes of verifying compliance with the law for providing coverage for groups over 50+. The IRS created a one-size-fits-all reporting solution that comported with IRS requests for information without respect to the employer's ability to comply.

Employer groups are not homogeneous groups. Group size matters in terms of resources and capabilities. Large group employers tend to have larger HR departments, budgets, and many self-insure, taking on the risk and most can either hire an outside firm or execute the reporting. Mid-size groups tend to have robust HR departments and are often self-insured, but some may be fully insured. Under the ACA, small groups are defined as up to 100 lives. Under 50 do not have to comply with the employer mandate. For those 50+, they must report to the IRS. They typically lack a robust HR department or in many cases, have no HR department at all. The manager may be stocking the shelves and figuring out the reporting requirements between managing the business. Agents often assist these clients with reporting.

During the legislative process, employers were never consulted to determine if the process contemplated by the federal agency would work for employers.

Employer groups spent several years in consultation with Treasury and the IRS to smooth out the process, but those changes were limited due to statutory requirements.

A voluntary prospective reporting system has been under consideration by Congress for several years. It would have allowed employers an alternative to provide employer coverage information upfront to the IRS/Exchanges in exchange for relief from some of the reporting requirements. Recently, the House of Representatives passed the Employer Reporting Improvement Act on suspension, but the prospective reporting was removed after technical assistance with Treasury.

Rep. Susan Wild (D-PA)

1. Hospitals and hospital outpatient departments (HOPDs) play a critical role in providing many communities—including my own—with reliable access to high-quality health care. What is your response to concerns that site-neutral payment policies could lead to hospital closures and reduce patients' ability to consistently access high-quality health care services, especially in rural communities?

Response
Under the federal government payment system, providers are paid for a number of procedures performed in physician offices. Those same procedures performed in a hospital setting receive an additional robust facility fee payment on top of the procedure fee.

Private equity has started moving into the hospital merger and acquisition space to take advantage of this billing loophole by purchasing physician practices and folding the physician practice under the hospital shingle, thus, allowing it to overnight charge the larger reimbursement for no additional quality or service improvement.

Patients whose copayments and deductibles are increasing at a rapid rate are feeling the price pressure. What may have been a $25 copay is now $100. Sicker patients cannot defer treatment because of the higher out-of-pocket costs and are stuck paying the higher fees.

MedPAC last summer analyzed this phenomenon and determined that there were considerable savings for the government and employers/employees. Their recommendation included redirecting some of those savings back to safety net hospitals and rural hospitals to soften the reduction of payments.

Hospitals and other providers should not find relief from low government reimbursements by reaching into the pocket of employers. Employer plans already pay a significantly higher reimbursement for all services to offset lower Medicare/Medicaid reimbursement. Taking advantage of a “loophole” in billing that allows hospitals, in this case, to artificially bill for services is harming consumers.

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June 23, 2023

Tracy Watts
Senior Partner, US Leader for Health Care Policy
Mercer
1050 Connecticut Ave., NW
Suite 700
Washington, DC 20036

Dear Mrs. Watts:

Thank you again for testifying at the April 26 Subcommittee on Health, Employment, Labor, and Pensions hearing on "Reducing Health Care Costs for Working Americans and Their Families."

Enclosed are additional questions submitted by Subcommittee members following the hearing. Please provide written responses no later than July 14, 2023, for inclusion in the hearing record. Responses should be sent to Michael Davis of the Committee staff who can be contacted at (202) 225-7101.

We appreciate your contribution to the work of the Subcommittee.

Sincerely,

Bob Good
Chairman
Subcommittee on Health, Employment, Labor, and Pensions

Enclosure

Questions for the Record for Tracy Watts

HELP Subcommittee Hearing
"Reducing Health Care Costs for Working Americans and Their Families"
April 26, 2023
10:15 a.m.

Chairwoman Virginia Foxx (R-NC)

1. What actions have employers taken to comply with the *Mental Health Parity and Addiction Equity Act*?

2. What actions have employers taken to enhance access to mental health benefits for employees and their families? What have the results been?

3. Would allowing employers to offer telehealth as an excepted benefit result in employers substituting telehealth-only benefits for a comprehensive health plan? Why or why not?

4. At the April 26 hearing, one of the witnesses expressed concerns that individuals would confuse telehealth-only benefits with major medical coverage. Do you share this concern? Why or why not?

Rep. Tim Walberg (R-MI)

1. Increased access to telehealth has transformed the way mental health professionals deliver care. How can establishing a stand-alone telehealth excepted benefit through ERISA help workers struggling with mental health conditions? Why is it important to act in light of the public health emergency ending on May 11?

Rep. Susan Wild (D-PA)

1. Hospitals and hospital outpatient departments (HOPDs) play a critical role in providing many communities- including my own- with reliable access to high-quality health care. What is your response to concerns that site-neutral payment policies could lead to hospital closures and reduce patients' ability to consistently access high-quality health care services, especially in rural communities?

Rep. Mark DeSaulnier (D-CA)

1. Mrs. Watts, the presentation accompanying your testimony discusses an issue that I know a lot of employers are taking very seriously – health equity.

    a. Can you discuss why it's so important for employer-sponsored health plans to recognize and address the diverse needs of populations, particularly people of color and members of the LGBTQ population?

    b. Can you discuss the importance of comprehensive reproductive health care for women, particularly women of color?

Questions and Answers for the Record for Tracy Watts

HELP Subcommittee Hearing

"Reducing Health Care Costs for Working Americans and Their Families"

April 26, 2023

10:15 a.m.

What actions have employers taken to comply with the Mental Health Parity and Addiction Equity Act?

In accordance with the requirements of the Mental Health Parity and Addiction Equity Act (MHPAEA), fully-insured and self-funded group health plans continue to take steps to ensure that if the plan covers mental health and substance abuse disorder benefits, it does so in parity with medical/surgical benefits covered under the plan. The numerous and complicated MHPAEA compliance rules include two key testing and evaluation requirements: (i) financial/quantitative treatment limitation testing, and (ii) non-quantitative treatment limitation (NQTL) comparative analysis. Employers that sponsor fully-insured group health plans typically rely on their carriers to ensure compliance with the parity rules as the carriers themselves are subject to the same MHPAEA rules.

Where the plan is self-funded, this generally results in the MHPAEA rules applying directly to the self-funded plan versus the third-party administrator (TPA) that generally administers the plan. Similar to fully-insured plans, employers tend to rely on their TPAs to ensure MHPAEA compliance as the TPAs are often selling benefit designs and related administrative services to employers seeking to sponsor a self-funded plan. Some of the challenges self-funded group health plans face demonstrating compliance with MHPAEA include:

- ***Financial/quantitative treatment limitation testing.*** Many plan sponsors do not have the expertise and/or data needed and must rely on third parties (e.g., third party administrators) to conduct the testing. The methodology used to conduct this testing varies significantly and most TPAs do not use plan level data because they deem the plan level data to not be credible.
- ***NQTL comparative analysis.***
    - TPAs are the entities that implement and administer most of the NQTLs in a plan and they often are the only entities that have the relevant information that must be included in a comparative analysis report.
    - The level of detail and support that TPAs are willing to provide with regard to these NQTLs varies amongst TPAs and employers can only access what TPAs are willing to share.
    - Plan sponsors generally have no way of validating or verifying the information pertaining to most NQTLs provided by the TPA.
    - The enforcing agencies (HHS/CMS, DOL/EBSA, Treasury/IRS) – despite issuing numerous MHPAEA rules and sub-regulatory guidance – have yet to clearly articulate the type and level of detail that must be included in the comparative analysis documentation for it to be deemed "sufficient" [1].

- Enforcement by DOL can be via the National Office and/or regional offices and there are instances where the same plan design/administration will be reviewed by separate offices as part of an audit/investigation, with the offices finding different levels of compliance.
- Due to the lack of prescriptive guidance from the enforcing agencies, inconsistent enforcement/audit standards across the DOL offices and the fact that almost all of the relevant information generally can only be accessed from TPAs that may not be willing to disclose such information, self-funded plan sponsors may not be able to produce a comprehensive NQTL comparative analysis that will be deemed "sufficient" by DOL/CMS despite a plan sponsor's best efforts – including engaging expert counsel – to ensure compliance with MHPAEA requirements.

1. During 2021, the Department of Labor (DOL) requested NQTL comparative analyses from more than 150 plans and issuers. Requests from the Centers for Medicare and Medicaid Services (CMS) went to four nonfederal governmental plans and nine issuers. In their 2022 MHPAEA Report to Congress regulators noted that all of the comparative analyses were insufficient when first received.

What actions have employers taken to enhance access to mental health benefits for employees and their families? What have the results been?

It is well documented that seeking out behavioral health services has historically been stigmatized, causing people to forego care due to feelings of shame or embarrassment. Over the past two years, however, demand for care has been steadily climbing. An analysis of data in MercerFOCUS, which warehouses the claims of over 1 million health plan members, found a substantial increase in the number of people accessing outpatient behavioral health services – from 73 members/1,000 in 2019 to 83 members/1,000 in 2021. It is particularly interesting that telemedicine visits for behavioral health care – essentially non-existent prior to the pandemic – were utilized by 39 members/1,000 in 2021.

Mercer's Survey on Health and Benefits Strategies for 2024 asked employers to rate the effectiveness of actions they have taken within the past few years to increase behavioral healthcare utilization and create a work environment that is supportive of mental and emotional health. Enhancing or expanding the EAP was the most common action taken — over two-thirds of survey respondents have enhanced their EAP services. The majority of employers that have recently enhanced their EAP services believe that doing so has been effective or very effective (59%). The top-rated action was adding a supplemental provider network for virtual or in-person care, which directly addresses the shortage of behavioral health providers and makes it easier for people to get care when they need it. About two-fifths of employers surveyed have added a supplemental network within the past few years; of those, 69% say it has been an effective or very effective strategy.

Effectiveness of actions taken to increase behavioral healthcare utilization or create a more supportive environment

			Of those taking action:	
		Have taken this action within the past 3 years	Has been effective or very effective	Has been fairly effective
1	Added supplemental network for virtual or in-person care	42%	69%	22%
2	Enhanced or expanded EAP	69%	59%	25%
3	Took steps to increase screenings for mental health and/or substance abuse	19%	58%	33%
4	Manager training in recognizing BH issues and steering to resources	36%	49%	30%
5	Conducted campaign to reduce stigma and encourage use of BH resources	49%	46%	33%
6	Added digital or in-person resources for managing stress/building resiliency	58%	44%	29%

Employers with 500 or more employees

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Mercer Survey on Health & Benefit Strategies for 2024

Would allowing employers to offer telehealth as an excepted benefit result in employers substituting telehealth-only benefits for a comprehensive health plan? Why or why not?

The ACA requires large employers (i.e., employers that average at least 50 full-time and full-time equivalent employees per month in the past calendar year) to offer affordable health coverage that provides "minimum value" to at least 95% of its ACA full-time employees (i.e., those working, on average, 30 or more hours per week) or potentially be subject to a shared responsibility penalty. An "eligible employer-sponsored plan" provides minimum value if the plan covers at least 60 percent of the total cost of medical services for a standard population and includes substantial coverage of physician and inpatient hospital services. Because stand-alone telehealth benefits will not meet the "minimum value" criteria under the ACA, large employers that substituted such benefits for comprehensive health plans could expose themselves to large penalties. In our experience, employers offer comprehensive medical benefits in order to recruit and retain employees, and comply with the ACA's employer-shared responsibility requirements.

At the April 26 hearing, one of the witnesses expressed concerns that individuals would confuse telehealth-only benefits with major medical coverage. Do you share this concern? Why or why not?

Have not seen any evidence to support this concern. In our experience, enrollment communications are very clear on what is covered by the program, how the programs works, including caveats regarding what is not covered. Also, after enrollment, employers typically continue to communicate to plan members about the program – encouraging them to set up an on-line account and reminding them how the benefit can be used. Even the name – telehealth, virtual care, etc. – specifies the type of care.

Increased access to telehealth has transformed the way mental health professionals deliver care. How can establishing a stand-alone telehealth excepted benefit through ERISA help workers struggling with mental health conditions? Why is it important to act in light of the public health emergency ending on May 11?

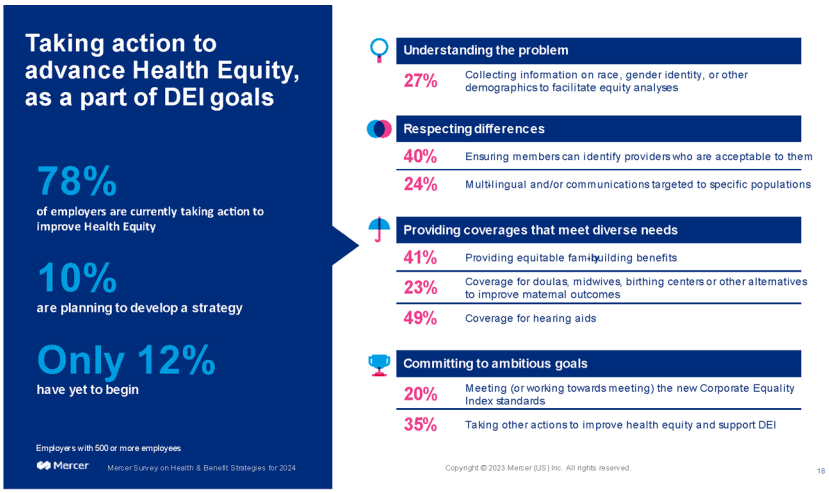
Telehealth, when offered as an excepted benefit, meets a very specific need for certain employers with large numbers of employees who are not benefit eligible – mostly part-time workers in retail, hospitality and healthcare. Because of legislative uncertainty, we saw a decline in employers using this strategy to 7% in 2023, down from 17% in 2022. This is a benefit that is valued by workers – but employers need permanent legislation for this coverage to be restored. As an example, we work with a large restaurant chain that extended telehealth to its part-time population. They view the telehealth benefit as a critical way to provide access to behavioral health services and appropriate medication when an employee who is not enrolled in the health plan gets sick.

Can you discuss why it's so important for employer-sponsored health plans to recognize and address the diverse needs of populations, particularly people of color and members of the LGBTQ population?

The existence of health disparities in the US carries significant business implications for employment. These implications include increased healthcare costs, reduced productivity, higher absenteeism rates, and challenges in attracting and retaining diverse and talented workforce The 2018 economic burden of racial and ethnic health disparities in the US was estimated at $451 billion. Given that employers provide health care benefits for approximately 50% of the American population, they have an opportunity to not only address unmet needs of employees, but to reduce costs for their organization and employees.

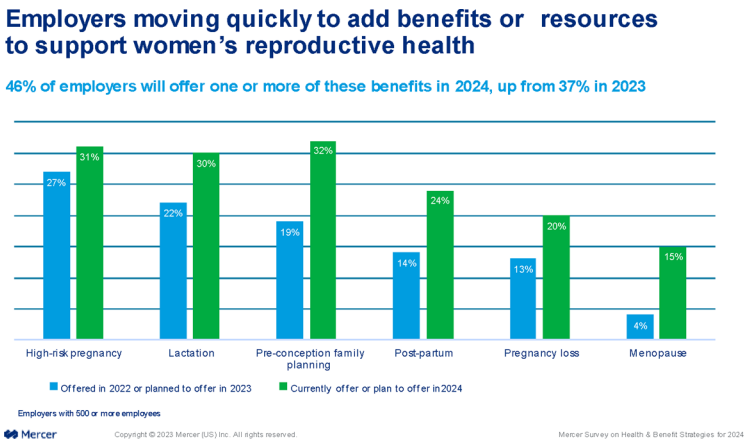
Our research over the past few years has tracked the ways employers are working to align employee benefit programs with their organizations' overarching DEI goals. For Pride month, we put together a round-up of survey results – Health benefits that matter to the LGBTQ+ community: By the numbers – relating to health and well-being benefits of particular importance to the LGBTQ+ community.

Here is a summary of what employers are doing to advance health equity from Mercer's Survey on Health and Benefits Strategies for 2024.



Can you discuss the importance of comprehensive reproductive health care for women, particularly women of color?

Female reproductive health is a big focus area for benefits leaders and companies driven by the impact of the *Dobbs* decision, the spotlight the pandemic put on health disparities and health equity, and the fact that the U.S. sadly underperforms on maternal health issues compared to other high income countries.



Black mothers in the US face disproportionate challenges and adverse outcomes of pregnancy and childbirth. Black women have a 2.9 times higher maternal mortality rate than white women. It's crucial that we shine a light on the issues and explore potential solutions to address these disparities. One example in which employers are addressing black maternal health is by expanding medical benefits to include doula support. Black women are more likely than their white counterparts to want a doula. Studies have indicated that the presence of a doula during childbirth can reduce the likelihood of intervention such as C sections and epidurals. Doulas have been shown to have a positive impact on birth outcomes, particularly for Black mothers. And furthermore, doula support is associated with higher maternal satisfaction with the birth experience. Additionally, some employers are choosing to ensure benefits include access to alternative forms of birthing support or birthing centers. This is an example of how employers are being intentional in their approach to advance health equity.

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June 23, 2023

Joel White, President
Council for Affordable Health Coverage
440 First Street NW, Suite 430
Washington, DC 20001

Dear Mr. White:

Thank you again for testifying at the April 26 Subcommittee on Health, Employment, Labor, and Pensions hearing on "Reducing Health Care Costs for Working Americans and Their Families."

Enclosed are additional questions submitted by Subcommittee members following the hearing. Please provide written responses no later than July 14, 2023, for inclusion in the hearing record. Responses should be sent to Michael Davis of the Committee staff who can be contacted at (202) 225-7101.

We appreciate your contribution to the work of the Subcommittee.

Sincerely,

Bob Good
Chairman
Subcommittee on Health, Employment, Labor, and Pensions

Enclosure

Questions for the Record for Joel White

HELP Subcommittee Hearing
"Reducing Health Care Costs for Working Americans and Their Families"
April 26, 2023
10:15 a.m.

Chairwoman Virginia Foxx (R-NC)

1. At the April 26 hearing, several Subcommittee members discussed the benefits of expanding the Medicare *Inflation Reduction Act* price controls to apply to employers. What are the costs and benefits of this approach?

2. At the April 26 hearing, several Subcommittee members discussed the benefits of applying caps on insulin costs in commercial markets. What would be the impact of this approach should Congress adopt it?

3. One of the witnesses at the April 26 hearing made several claims about association health plans (AHPs), including the following:

   - AHPs have a long history of fraudulent practices and solvency problems.[1]
   - Insurers and associations vie for employers' business by offering low 'teaser' premium rates and using underwriting or other tactics to cherry-pick and enroll the healthiest employer groups in the market (something ACA[*Affordable Care Act*]-compliant plans are prohibited from doing).[2]
   - Some AHP sponsors argue that they achieve lower premiums because they are somehow exercising market clout. This is a fallacy. If they are not engaged in risk selection, then the primary way to reduce costs is to negotiate lower reimbursement rates with providers. It is highly improbable that AHPs are able to do this better than traditional insurers.[3]

   What are your responses to these claims?

4. At the April 26 hearing, a witness testified that the *Self-Insurance Protection Act* would encourage the proliferation of level-funded plans in the small group market, posing two primary risks. The witness stated:

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[1] *Reducing Health Care Costs for Working Americans and Their Families: Hearing Before the Subcomm. on Health, Emp., Lab., & Pensions of the H. Comm. on Educ. & the Workforce*, 118th Cong. (Apr. 26, 2023) (statement of Sabrina Corlette, Research Professor & Co-Dir., Ctr. On Health Ins. Reforms, Georgetown Univ. McCourt Sch. of Pub. Pol'y), https://edworkforce.house.gov/uploadedfiles/4.26.23_health_care_costs_hearing_corlette_testimony_final.pdf.
[2] *Id.*
[3] *Id.*

> First, many small employers are not sophisticated purchasers of health benefits and may not realize the financial risks and fiduciary duties they take on when they self-fund their plan.... Second, if small employers with younger, healthier employees shift to level-funded products in significant numbers, it will leave employers with older, sicker workers in the fully insured small group market. This causes adverse selection and, in the worst cases, an insurance "death spiral," in which premium rates rise for employers whose groups cannot pass the stop-loss issuers' underwriting. Those with young and healthy workers pay less (although they could have unexpected financial liability if an employee gets sick), while employers with older, less healthy workers pay more. As with AHPs, the legislation does nothing to address the underlying reason why there is an affordability crisis for employer-based insurance: the prices that commercial insurers pay for provider services and prescription drugs.[4]

What are your responses to these claims?

5. At the April 26 hearing, a witness testified that under H.R. 824, the *Telehealth Benefit Expansion for Workers Act of 2023*,

> [T]elehealth stand-alone plans would be available to all employees (and potentially dependents), even those eligible for group health benefits. And as excepted benefits, telehealth plans would be exempt from the rules that apply to employer group health plans, including MHPAEA [*Mental Health Parity and Addiction Equity Act*]. Doing so creates the risk that employers, particularly those with lower-income workers, will substitute a telehealth-only benefit for a comprehensive group health plan.[5]

   a. Does anything in H.R. 824 exempt employers from their requirements to offer a 60 percent actuarial value plan or from their obligations under ACA Section 6055 (related to reporting of minimum essential coverage) or ACA Section 6066 (related to reporting of information about health coverage provided to full-time employees in order to administer the employer shared responsibility provisions of Section 4980H of the Internal Revenue Code)?

   b. If an employer fails to offer comprehensive qualified coverage, they are subject to penalties. Considering this, do you expect employers to drop qualified coverage in favor of standalone telehealth benefits?

Rep. Michelle Steel (R-CA)

1. Telehealth has been a critical tool to ensure patients can continue to access quality, affordable health care from their providers and to address workforce shortages

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[4] *Id.*
[5] *Id.*

throughout the COVID-19 pandemic. Increased access to telehealth has benefited a range of patients in my district, including seniors, high-risk patients, and patients located in suburban areas. While Congress has taken many steps to extend access to telehealth beyond the PHE, including by extending the CARES Act flexibility I have championed allowing Americans with health savings accounts to access telehealth services without meeting their deductible through 2024, certain populations are at risk of losing access to this life-changing modality without further action. During the PHE, the Departments of Labor, HHS, and the Treasury allowed employers to offer coverage for telehealth and other remote care services to employees who were not otherwise eligible for any group health plan offered by their employer. The Telehealth Benefit Expansion for Workers Act of 2023 (H.R. 824) would make this policy permanent. The option for employers to offer standalone telehealth coverage to their employees was not included in the Consolidated Appropriations Act, 2023 and will therefore end on May 11, 2023.

a. How do you anticipate this will impact access to care for such individuals who benefited from this policy?

b. Can you share examples of how employers have leveraged this policy throughout the pandemic and the impact it has had on their employees?

Rep. Susan Wild (D-PA)

1. Hospitals and hospital outpatient departments (HOPDs) play a critical role in providing many communities—including my own—with reliable access to high-quality health care. What is your response to concerns that site-neutral payment policies could lead to hospital closures and reduce patients' ability to consistently access high-quality health care services, especially in rural communities?

Mr. Joel White Responses to Questions for the Record
Subcommittee on Health, Employment, Labor, and Pensions Hearing on
"Reducing Health Care Costs for Working Americans and Their Families"
April 26, 2023

Chairwoman Virginia Foxx (R-NC)

1. *At the April 26 hearing, several Subcommittee members discussed the benefits of expanding the Medicare Inflation Reduction Act price controls to apply to employers. What are the costs and benefits of this approach?*

RESPONSE: Unions and employers hire PBMs to routinely negotiate price protection rebates for commercial payers that require manufacturers to refund some or all, increases in list price back to the payer. For example, research sponsored by the PBM trade association PCMA shows savings from the use of private sector management of drug prices between 20 to 30 percent. The group estimates this will result in $469 billion in savings for commercial payers over the next 10 years.[1]

Likewise, federal employees enjoy the benefits of lower prices through the private sector. The Federal Employee Health Benefits Program (FEHB) provides health insurance (and drug benefits) for 8.2 million federal employees, retirees, and their dependents by contracting with more than 200 health insurance plans and PBMs. FEHB relies entirely on the private sector to negotiate their prescription drug benefits.[2] FEHB has implemented a number of private sector tools to manage the overall costs of prescription drugs. The Biden Administration has stated these cost containment efforts have had a positive impact and should continue to be a part of any comprehensive drug management program for federal employees going forward. The Office of Personnel Management (OPM) repeatedly states and touts the "market-based competition system" as a key part of FEHB that has choices for its beneficiaries and costs that are low.

Conversely, the Inflation Reduction Act uses two primary mechanisms to control drug costs – price controls and inflation rebates (drug taxes). Unlike market based tools, price controls come with great costs.

Price controls lead to less access, long wait times, and rationing. Most European countries have drug price controls in the form of government "negotiations," which the IRA mimics, but these countries apply price controls to employees with disastrous effects. Of the 290 new medical substances that were launched worldwide between 2011 and 2018, the U.S. had access to 90 percent versus:

- France - 48%
- United Kingdom - 60%
- Japan – 50%
- Canada – 44%

In addition, European price controls delay access to new therapies by an average of 14 months. If applied to unions and employers in the U.S., the workforce will have dramatically less access to new and existing drugs. Lack of access and adherence to therapies increases health costs, leading to disease progression and increased mortality.

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[1] Pharmacy-Benefit-Managers-PBMs-Generating-Savings-for-Plan-Sponsors-and-Consumers-January-2023.pdf (pcmanet.org)
[2] Final Management Advisory Report: Federal Employees Health Benefits Program Prescription Drug Benefits Coverage (oversight.gov)

Additionally, price controls must be administered by the government and imposed on unions and employers. A government bureaucracy and law enforcement must be funded to enforce the controls. In a price control scheme, politicians and bureaucrats hold the power – competition shifts from making drugs that consumers want to political markets and their lobbyists who attempt to influence price-setting and coverage decisions. The result is government in everyone's medicine cabinet. Congress should seek to depoliticize medical decisions and give control to patients and their doctors, not government bureaucrats and politicians.

With regard to inflation rebates, the CBO has previously noted that inflation penalties in Part D and Part B "would reduce costs for prescription drug benefits offered by commercial insurance plans" even without extending them to commercial units.[3] This conclusion carried over into the CBO's final score of the IRA where the CBO recognized increased federal tax revenue from lower prescription drug costs in the commercial market, even though the Part B and D inflation penalties are confined to units dispensed within Medicare.[4]

In addition, the inflation rebate pricing metrics used for the Part B and Part D inflation penalties already capture commercial sales. The pricing metrics used for the Part B and D inflation rebates – the Average Sales Price (ASP) and Average Manufacturer Price (AMP), respectively – already capture prices paid by most commercial purchasers (e.g., large providers, group purchasing organizations, wholesalers, retail community pharmacies, etc.). Medicare already accounts for commercial price growth in the inflation penalties currently being assessed.

2. *At the April 26 hearing, several Subcommittee members discussed the benefits of applying caps on insulin costs in commercial markets. What would be the impact of this approach should Congress adopt it?*

RESPONSE: While this politically popular approach to addressing high consumer costs of insulin is appealing, the market for insulin changed faster than Congress could respond. The major manufacturers of insulin have already adopted price caps of $35 or less.

A statutory cap at $35 would lock in a higher cost than market competition might produce. Any mandated benefit will increase payer costs. This is why adding dental or vision care to Medicare costs money. When Congress mandates benefits or benefit design, it increases costs, which are typically paid by consumers in higher premiums. For example, the CBO found legislation that passed the House in 2022 to cap insulin out-of-pocket costs would increase costs and raise employer and union plan premiums.[5] Over the last decade, the cost of employer plans increased nearly 50 percent, twice as fast as wages, reducing the affordability of coverage. If a cap on insulin were adopted, premiums could increase, and wages could go down.

3. *One of the witnesses at the April 26 hearing made several claims about association health plans (AHPs), including the following:*

   - *AHPs have a long history of fraudulent practices and solvency problems.*

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[3] Expected effects on spending (cbo.gov)
[4] https://www.cbo.gov/system/files/2022-09/PL117-169_9-7-22.pdf
[5] H.R. 6833 (cbo.gov)

- *Insurers and associations vie for employers' business by offering low 'teaser' premium rates and using underwriting or other tactics to cherry-pick and enroll the healthiest employer groups in the market (something ACA[Affordable Care Act]-compliant plans are prohibited from doing).*
- *Some AHP sponsors argue that they achieve lower premiums because they are somehow exercising market clout. This is a fallacy. If they are not engaged in risk selection, then the primary way to reduce costs is to negotiate lower reimbursement rates with providers. It is highly improbable that AHPs are able to do this better than traditional insurers.*

What are your responses to these claims?

RESPONSE: Under the bill, teaser rates are not allowed, and plans must submit premiums that are actuarially sound. This claim is both false and misleading.

On the claim that these plans will have no substantive negotiating power, the claim is without basis. Current AHPs and those envisioned under the bill do and will achieve lower premiums for a variety of reasons, including:

- Workers from many employers and the self-employed form into a large group and increase the leverage these workers collectively have with respect to negotiations on insurance costs and healthcare provider reimbursement. According to the Department of Labor, such discounts may reflect a combination of (1) administrative efficiencies; (2) influence over providers' utilization decisions and practices; and (3) reduction of excess provider profits.[6] Mom-and-pops and individuals have little or no leverage currently. Scale gives them market clout.

- The legislation allows geographically based AHPs that would be In some markets, we expect entirely local AHPs, for example in a single industrial park. Not only will providers compete but the regional AHP may be able to hire its own doctor or physical therapist to treat its members.

- For self-funded AHPs, the association has access to medical claims data, allowing them to identify overpayments and providers who charge much higher rates for the same services.

- Under the bill, AHPs are not constrained by benefit mandates and can design services around member needs rather than the politically approved, expansive, and costly benefit packages under the Affordable Care Act.

- AHPs are not subject to the Marketplace User Fees paid by insurers distributing their health plans on government exchanges which are typically around 3 to 3.5% of premiums, an added cost to consumers.

According to research based on AHPs issued under the Trump Administration rule (which are different than what is envisioned in the legislation), maximum savings claims averaged 29 percent for self-funded AHPs and 23 percent for fully insured AHPs compared to a business' current non-AHP plan.[7]

Finally, with respect to the fraud claims, Congress and the Biden Administration have taken steps to protect the market. This claim is a throwback to the 1970s and 80s and is not relevant today. Under

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[6] 2018-12992.pdf (govinfo.gov)
[7] Study: First Phase of New AHPs Reveal Promising Trends | Association Health Plans

current law and the bill, AHPs would be subject to regulation, oversight and enforcement rules by the Department of Labor, the states, or both.

In 1983, Congress amended ERISA to allow states to regulate certain arrangements to promote compliance with state solvency and other rules. Likewise, the Affordable Care Act imposed a number of new policies to tighten up the market. According to the Department of Labor the ACA…:

> *"established a multipronged approach to MEWA abuses. Improvements in reporting, together with stronger enforcement tools, are designed to reduce MEWA fraud and abuse. These include expanded reporting and required registration with the Department of Labor prior to operating in a State. The additional information provided will enhance the State and Federal governments' joint mission to prevent harm and take enforcement action. The ACA also strengthened enforcement by giving the Secretary of Labor authority to issue a cease and desist order when a MEWA engages in fraudulent or other abusive conduct and issue a summary seizure order when a MEWA is in a financially hazardous condition."*

Some states already allow pooling arrangements within their state. AHPs remain subject to all federal and state laws otherwise applicable to such plans, and the provisions of H.R. 2868 are not intended to modify the application or interpretation of such laws to such plans. In particular, the rules continue to apply around who governs and controls the AHP, AHPs are required to operate the plan solely in the interests of participants and beneficiaries, and that amounts paid into the plan by participating employer members and their employees may never revert back to an employer member will protect against bad actors. The bill builds on this framework by requiring AHPs to be in existence for at least 2 years prior to establishing the benefit plan (no fly-by-night operations rule), does not condition membership in the group or coverage under the AHP on any health related factor, the AHP is not a health insurer, and has established a governing board with by-laws to manage and operate the plan, of which at least 75 percent of the board members shall be made up of employer members of the group or association participating in the plan These improvements will strengthen the existing rules governing AHPs to ensure that consumers are protected and that employers have a solid insurance option by protecting against fraud and insolvency.

Finally, the bill requires rates to be actuarially sound, which will ensure financial solvency.

4. *At the April 26 hearing, a witness testified that the Self-Insurance Protection Act would encourage the proliferation of level-funded plans in the small group market, posing two primary risks. The witness stated: First, many small employers are not sophisticated purchasers of health benefits and may not realize the financial risks and fiduciary duties they take on when they self-fund their plan…. Second, if small employers with younger, healthier employees shift to level-funded products in significant numbers, it will leave employers with older, sicker workers in the fully insured small group market. This causes adverse selection and, in the worst cases, an insurance "death spiral," in which premium rates rise for employers whose groups cannot pass the stop-loss issuers' underwriting. Those with young and healthy workers pay less (although they could have unexpected financial liability if an employee gets sick), while employers with older, less healthy workers pay more. As with AHPs, the legislation does nothing to address the underlying reason why there is an affordability crisis for employer-based insurance: the prices that commercial insurers pay for provider services and prescription drugs. What are your responses to these claims?*

RESPONSE: The Self-Insurance Protection Act does nothing to change the status quo, it simply clarifies the law to protect benefit plans that some state regulators would like to restrict or outlaw. Employers are switching to self-funded plans because the ACA market is unaffordable. SIPA protects the current right for employers to choose this option for their employees in a small group market that is already in a death spiral across the country.

4. At the April 26 hearing, a witness testified that under H.R. 824, the *Telehealth Benefit Expansion for Workers Act of 2023*,

> [T]elehealth stand-alone plans would be available to all employees (and potentially dependents), even those eligible for group health benefits. And as excepted benefits, telehealth plans would be exempt from the rules that apply to employer group health plans, including MHPAEA [*Mental Health Parity and Addiction Equity Act*]. Doing so creates the risk that employers, particularly those with lower-income workers, will substitute a telehealth-only benefit for a comprehensive group health plan.5

a. Does anything in H.R. 824 exempt employers from their requirements to offer a 60 percent actuarial value plan or from their obligations under ACA Section 6055 (related to reporting of minimum essential coverage) or ACA Section 6066 (related to reporting of information about health coverage provided to full-time employees in order to administer the employer shared responsibility provisions of Section 4980H of the Internal Revenue Code)?

RESPONSE: No. H.R. 824 does not change any of the requirements under the ACA to provide minimum essential coverage. Employers will still provide major medical benefits or face the repercussions spelled out in the law.

b. If an employer fails to offer comprehensive qualified coverage, they are subject to penalties. Considering this, do you expect employers to drop qualified coverage in favor of standalone telehealth benefits?

RESPONSE: No. Employers will not view telehealth as an equivalent benefit to major medical coverage. Defining telehealth as an excepted benefit ensures that telehealth cannot be treated as a major medical plan and has specific rules that further protect consumers. The only employers who will drop major medical coverage are those who will drop coverage regardless of the availability of telehealth as an excepted benefit.

Adding a separate telehealth benefit as an excepted benefit will have a bigger positive impact on those with significant health conditions who struggle to find providers with expertise in their medical condition. Indeed, the first telehealth services were provided in a hospital setting to ensure those suffering from a stroke had access to a specialist.

Rep. Michelle Steel (R-CA)

1. *Telehealth has been a critical tool to ensure patients can continue to access quality, affordable health care from their providers and to address workforce shortages throughout the COVID-19 pandemic. Increased access to telehealth has benefited a range of patients in my district, including seniors, high-risk patients, and patients located in suburban areas. While Congress has taken many steps to extend access to telehealth beyond the PHE, including by extending the CARES Act flexibility I have championed allowing Americans with health savings accounts to*

access telehealth services without meeting their deductible through 2024, certain populations are at risk of losing access to this life-changing modality without further action. During the PHE, the Departments of Labor, HHS, and the Treasury allowed employers to offer coverage for telehealth and other remote care services to employees who were not otherwise eligible for any group health plan offered by their employer. The Telehealth Benefit Expansion for Workers Act of 2023 (H.R. 824) would make this policy permanent. The option for employers to offer standalone telehealth coverage to their employees was not included in the Consolidated Appropriations Act, 2023 and will therefore end on May 11, 2023.

a. *How do you anticipate this will impact access to care for such individuals who benefited from this policy?*

b. *Can you share examples of how employers have leveraged this policy throughout the pandemic and the impact it has had on their employees?*

RESPONSE: Losing access to remote care through added telehealth benefits will negatively impact patient groups. Patients who have certain rare medical conditions will lose access to specialists that have expertise in managing complicated conditions that may be impacted by comorbidities. Remote workers who live in rural areas will no longer be able to access providers through video calls, and instead be forced to drive more than an hour to receive care. Families with children who have more routine medical conditions lose the ability to manage their time through telehealth visits facing the inconvenience of an unnecessary face-to-face visit.

Rep. Susan Wild (D-PA)

1. *Hospitals and hospital outpatient departments (HOPDs) play a critical role in providing many communities—including my own—with reliable access to high-quality health care. What is your response to concerns that site-neutral payment policies could lead to hospital closures and reduce patients' ability to consistently access high-quality health care services, especially in rural communities?*

RESPONSE: Between 2022 and 2031, Medicare is expected to spend $5.1 trillion on hospital services. The two site neutral provisions (parity in Medicare payments for hospital outpatient department services furnished off-campus and requiring a separate identification number and attestation for off-campus outpatient departments of a provider) adopted by the House Energy and Commerce Committee saves $4.2 billion over ten years. These modest changes amount to less than 0.0008 percent of total Medicare hospital spending over that period. To suggest hospitals will lead to closures is absurd.

It is also difficult to understand any justification for the proliferation of the use of hospital "facility fees" in the context of a visit with a physician office or clinic. In a predatory practice, hospital systems establish a monopoly on access to certain specialty practices and then use that monopoly to charge an often hidden additional fee to ensure the patient can have access to that specialty provider.

Struggling rural and critical access hospitals are not the primary practitioners of this practice - it is done primarily by large hospital systems. There is no prohibition on the hospital system-based physician from charging more for their services. This underhanded revenue trick not only costs patients more but also encourages hospital systems to buy niche medical practices, limiting competition and extending monopolies.

Chairman GOOD. Again, I would like to thank all four of our witnesses for taking the time to testify before the committee on this very important issue today. Without objection, there being no further business, the committee stands adjourned.

[Whereupon the Subcommittee on Health, Employment, Labor, and Pensions adjourned at 12:23 p.m.]

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