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**CENTER ON
HEALTH INSURANCE
REFORMS**

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**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.

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, 2021. 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.

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;

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.