National Association of Benefits and Insurance Professionals
NABIP
Shaping the *future* of healthcare

October 15, 2023

Health Care Task Force
Committee on the Budget
204 Cannon House Office Building
Washington, DC 20515

Dear Chairman Burgess,

I am writing on behalf of the National Association of Benefits and Insurance Professionals (NABIP), formerly NAHU, a professional association representing licensed health insurance agents, brokers, general agents, consultants and employee benefits specialists. The members of NABIP help millions of individuals and employers of all sizes purchase, administer and utilize health plans of all types.

The health insurance agents and brokers that NABIP represents are a vital piece of the health insurance market and play an instrumental role in assisting employers and individual consumers with choosing the health plan or plans that are best for them. Eighty-two percent of all firms use a broker or consultant to assist in choosing a health plan for their employees[1] and eighty-four percent of people shopping for individual exchange plans found brokers helpful -- the highest rating for any group assisting consumers.[2] During the 2023 open enrollment period, agents and brokers assisted 71 percent of those who enrolled through HealthCare.gov or a private direct enrollment partner's website. Consequently, the NABIP membership has a vested interest in ensuring that consumers have access to the most affordable health coverage that is the correct fit for their clients. We are pleased to have the opportunity to submit recommendations to the committee regarding your request for information on how to best lower healthcare costs while simultaneously improving health outcomes.

More than 175 million Americans, over half of the country's total population, are enrolled in health insurance coverage from their employer. Recent surveys indicate that most adults are satisfied with their current health coverage, with 63 percent those enrolled in employer-sponsored coverage "extremely satisfied" with their benefits.[3] Further, 76 percent of workers see health insurance as a primary or important factor for continuing to work at their current employer.[4]

While employer-sponsored coverage remains one of the most popular forms of healthcare coverage in the United States, one in three employees saw their healthcare costs increase over the last two years. As a result of higher healthcare costs, surveys show that some employees have reduced their contributions to retirement savings plans and delayed going to the doctor, among other cost issues.[5] Healthcare is highly individualized so it is vital that Americans have a wide range of healthcare options,

[1] Kaiser Family Foundation. Employee Health Benefits Annual Survey. October 2013.
[2] Blavin, Fredric, et al. Obtaining Information on Marketplace Health Plans: Websites Dominate but Key Groups Also Use Other Sources. Urban Institute. June 2014.
[3] Employee Benefit Research Institute. Worker Satisfaction with Health Benefits is Higher, but Costs Remain a Concern. 6 January 2022.
[4] Accenture. Employer Beware: Workers Demand Health Coverage. June 2015.
[5] Employee Benefit Research Institute. Worker Satisfaction with Health Benefits is Higher, but Costs Remain a Concern. 6 January 2022.

and today, there are a great variety of plan options available to employees across the country. tTo improve these options, there are actions that Congress can take to control costs for employers and employees and, more broadly, to strengthen and preserve the popular employer-sponsored system.

A key component to keeping healthcare costs low – especially for those covered by their employer – is to maintain the employer tax exclusion. The employer-based system is highly efficient at providing workers and their families with affordable coverage options through group purchasing and its associated economies of scale by spreading risk and avoiding adverse selection. There is more than a 4-to-1 return for the federal government because of the exclusion; for every dollar of tax expenditure, employers paid $4.64 to finance health benefits.[6] The success of this system is possible because of the preferential tax treatment of employer-sponsored insurance coverage, where employer-paid contributions for an employee's health insurance are excluded from that employee's compensation for income and payroll tax purposes.

While eliminating or capping the exclusion could increase federal revenue, it would also eliminate the efficiency of employer-sponsored insurance. Employers provide a natural pool of people who are generally healthy for spreading risk. Healthier individuals would be likely to forego coverage if faced with a new tax burden, leading to adverse selection and a death spiral for those remaining in the insured pool. Small business owners would be especially hard-hit, finding themselves paying thousands of dollars in new taxes on their insurance premiums, making it even more difficult to offer comprehensive coverage for their employees. It would also remove the most important employee benefit, used to attract and retain talented employees. It is likely that, if a small business owner is compelled to drop coverage due to costs, over one-third of their workforce may quit within 12 months.[7] Workers would also be less likely to have their employer as an advocate in coverage disputes, and employers would be less likely to involve themselves in matters of quality assessment and innovation for their employees.

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

Outside of preserving the employer exclusion, there are several common-sense avenues the committee could pursue to lower costs for consumers. One way that consumers mitigate costs is by combining a

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

High Deductible Health Plan (HDHP) with a Health Savings Account (HSA), which allows consumers to pay for certain medical expenses with money free from federal taxes. However, while HSAs were created nearly 20 years ago, regulations on the structure of a qualified high deductible health plan have not kept pace in today's changing benefits landscape. One vital change to consider would be to allow pre-deductible coverage for primary care. This would allow many more people the opportunity to take advantage of the benefits of an HSA plan.

Access to a primary care physician can drive down costs and increase patient utilization of preventive care. States with higher ratios of primary care physicians to population have better health outcomes, including lower rates of all causes of mortality (even after controlling for sociodemographic measures and lifestyle factors).[10] For those suffering from chronic conditions specifically, having regular access to a primary care physician can lower overall health costs and improve health outcomes.[11] While we want as many consumers as possible to have access to a primary care physician, there are some barriers to care in the current system.

When it comes to primary care, there are three options: direct primary care (DPC), traditional primary care and concierge medicine. A traditional primary care provider's main source of revenue is third-party reimbursement billed through each patient's health insurance issuer. "Concierge providers" bill a patient's health insurance issuer for payment for services rendered as well; however, concierge doctors also charge patients an annual fee (typically in the $2,000 to $3,000 range) for expedited access to the provider. Finally, the DPC model involves a fully independent provider who does not accept any type of third-party reimbursement. Instead, DPC payments all come directly from individual patients or families.

Effective primary care, including direct primary care, is well-known to be one of the critical components of overall personal wellness. The DPC model has gained popularity over the past 10 years, with both individual patients and employers interested in helping employees gain access to higher quality care and a patient experience that exceeds what is typically available through traditional primary care practices. From 2017 to 2021, the number of active DPC clinicians per 100,000 people increased by nearly 160 percent – compared to a 6 percent increase overall in primary care providers per 100,000 people.[12] Since DPC providers maintain a much smaller patient load than the average primary care practice and have a much lower administrative burden due to the elimination of third-party reimbursement, they can spend more time on patient relationships and service. DPC providers focus on each person's comprehensive health so they can often eliminate the need for unnecessary tests and better target the need for specialty care and services. Patients in DPC practices typically have better overall healthcare utilization rates and less frequently use the emergency room or experience inpatient hospital admissions.[13]

Unfortunately for those covered by a HDHP-HSA plans, DPC is currently inaccessible. The tax code defines the medical services provided through DPC agreements as a form of health plan or insurance

[10] Starfield, B., Shi, L., & Macinko, J. Contribution of primary care to health systems and health. *The Milbank Quarterly*, 83(3). 2005.
[11] Savoy M. The Role of Primary Care Physicians in Managing Chronic Disease. *Dela J Public Health*. March 2017.
[12] Hint Health. Trends in Direct Primary Care 2022. 27 April 2022.
[13] Eskew, Philip. In Defense of Direct Primary Care. *Family Practice Management.* October 2016.

that provides first dollar coverage, and therefore prevents the 35 million Americans with HDHP-HSA plans from receiving high-quality primary care from a doctor of their choice. NABIP recommends changing this interpretation defining DPC arrangements as medical services, not health plans, thus making them compatible with HDHP-HSA plans.

In addition to the DPC interpretation, there are other changes Congress can enact to modernize HSAs. On-site employer-sponsored health clinics can provide a range of health services to employees for free or at a reduced cost. These clinics are proven to improve employee health, lower healthcare expenditures, and improve productivity related to both reduced absences and presenteeism (which occurs when employees come to work impaired by illness and are unable to work to their full ability.)[14] Employer supported on-site medical clinics for employees have been available since the 1980s. Since 2000, there has been a significant increase in the number of clinics.[15] Further expansion has been stifled, however, by regulators.

Under current IRS guidance, on-site clinics can only provide health services for free or at reduced cost to individuals with an HSA if the services in question do not provide "significant benefits in the nature of medical care" (in addition to disregarded coverage or preventive care). If the on-site clinic in question offers more significant benefits to individuals with an HSA, that individual would no longer be eligible to contribute to their account. To rectify this, NABIP recommends amending the tax code to prevent certain employment-related services from being treated as coverage under a health plan for purposes of determining eligibility for HSAs.

Telehealth is another area that must be permanently addressed in the rules for HSAs. During 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 HSA.

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. NABIP recommends making this safe harbor permanent. NABIP also recommends 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.

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[14] O'Keefe, L.C., Anderson, F. "Benefits of On-Site Clinics" *OJIN: The Online Journal of Issues in Nursing Vol. 22, No. 2*. May 2017.

[15] Tu, H.T., Boukus, E.R., & Cohen, G. R. (2010). Workplace clinics: A sign of growing employer interest in wellness. *HSC Research Brief, 17. 113*.

Another outdated restriction on the use of HSAs is the inability for seniors over age 65 to contribute to an HSA. Seniors are now working longer than ever and deserve to be able to access the tax advantages of contributing to an HSA. Under current rules, Medicare beneficiaries may use funds from an HSA created prior to going on Medicare; however, beneficiaries may not open or continue to contribute to an existing HSA. This is a form of discrimination against working seniors and creates a barrier for them to be able to use pre-tax dollars to pay for out-of-pocket medical expenses or for dental and vision care which are not currently covered under Medicare. Since HSA funds remain in the account and are not "use it or lose it" type programs like flexible spending accounts, the use of HSAs encourages seniors to continue to save funds in an interest-bearing account for future healthcare expenses. NABIP recommends allowing seniors the ability to contribute to an HSA.

Another way to lower costs and improve outcomes is through value-based insurance design (VBID) and other innovation techniques. For example, as of August 2023, over 60 million individuals were enrolled in one or more parts of the Medicare program; over 30.8 million Medicare beneficiaries were covered by Medicare Advantage (MA) coverage.[16] Medicare Advantage focuses on primary care, early intervention, care coordination, and wellness programs to slow disease progression and improve health status, particularly for beneficiaries with chronic conditions.

The share of the Medicare population enrolled in MA plans grew from 24 percent in 2013 to 51 percent in 2023 – a 112 percent increase in enrollment over ten years. About 85 percent of 2013 MA enrollees remained in MA through 2019, compared to the 81 percent retention rate of fee-for-service Medicare beneficiaries. Medicare Advantage beneficiaries also include a higher percent of Black and Latino beneficiaries than in fee-for-service Parts A and B; fifty-three percent of Latino Medicare beneficiaries and 49 percent of Black Medicare beneficiaries are enrolled in MA. While approval of MA coverage is high across all populations, non-white beneficiaries report an even higher level of satisfaction, with 99 percent reporting that they were satisfied with their coverage.[17] Today, 96 percent of Medicare Advantage beneficiaries are satisfied with their quality of care.[18] Although NABIP supports continued choice for Medicare beneficiaries in the type of coverage they are able to select, MA plans have some advantages when it comes to overall management of health care.

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

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[16] Ochieng, Nancy. Medicare Advantage in 2023: Enrollment Update and Key Trends. *Kaiser Family Foundation*. 9 August 2023.
[17] Better Medicare Alliance. Medicare Advantage Satisfaction Hits New High Amid COVID-19 Crisis. 21 January 2021.
[18] Jacobson, Gretchen, et al. Medicare Advantage vs. Traditional Medicare: How Do Beneficiaries' Characteristics and Experiences Differ? Commonwealth Fund. 14 October 2021.

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

As a result, analysis shows that each dollar spent by the federal government on MA provides beneficiaries with additional benefits and lower cost sharing than they would otherwise receive under traditional Medicare; for every dollar of costs for Medicare-covered services, the government's payment covers 89.5 cents of the costs for MA beneficiaries but only 85.2 cents of the costs for fee-for-service Medicare beneficiaries, with the MA and FFS beneficiary paying for the remaining 10.5 cents and 14.8 cents, respectively.[19] In recent years, MA plans have also turned their attention to addressing their beneficiaries' social determinants of health (SDOH), the non-medical factors that influence health outcomes.[20] NABIP has long supported efforts to improve upon and expand the use of VBID and increase focus on social determinants of health throughout the healthcare system.

NABIP also encourages CMS and the CMS Innovation Center to make aggregate data available to health plans outside of the MA program. If CMS is able to share data from its innovation models with the private sector, then health plans, agents, brokers and other private stakeholders can better identify potential quality measures related to addressing SDOHs and general inefficiencies in care delivery within the entire healthcare system.

We appreciate the opportunity to provide these comments and would be pleased to respond to any additional questions or concerns of the committee. If you have any questions about our comments or if NABIP can be of assistance as you move forward, please do not hesitate to contact me at jgreene@nabip.org or (202) 595-3677.

Sincerely,

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

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