WHY HEALTH CARE IS UNAFFORDABLE: THE FALLOUT OF DEMOCRATS' INFLATION ON PATIENTS AND SMALL BUSINESSES

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED EIGHTEENTH CONGRESS

FIRST SESSION

MARCH 23, 2023

Serial No. 118–5

Printed for the use of the Committee on Ways and Means

U.S. GOVERNMENT PUBLISHING OFFICE
53–009 WASHINGTON : 2024

COMMITTEE ON WAYS AND MEANS

JASON SMITH, Missouri, *Chairman*

VERN BUCHANAN, Florida
ADRIAN SMITH, Nebraska
MIKE KELLY, Pennsylvania
DAVID SCHWEIKERT, Arizona
DARIN LAHOOD, Illinois
BRAD WENSTRUP, Ohio
JODEY ARRINGTON, Texas
DREW FERGUSON, Georgia
RON ESTES, Kansas
LLOYD SMUCKER, Pennsylvania
KEVIN HERN, Oklahoma
CAROL MILLER, West Virginia
GREG MURPHY, North Carolina
DAVID KUSTOFF, Tennessee
BRIAN FITZPATRICK, Pennsylvania
GREG STEUBE, Florida
CLAUDIA TENNEY, New York
MICHELLE FISCHBACH, Minnesota
BLAKE MOORE, Utah
MICHELLE STEEL, California
BETH VAN DUYNE, Texas
RANDY FEENSTRA, Iowa
NICOLE MALLIOTAKIS, New York
MIKE CAREY, Ohio

RICHARD E. NEAL, Massachusetts
LLOYD DOGGETT, Texas
MIKE THOMPSON, California
JOHN B. LARSON, Connecticut
EARL BLUMENAUER, Oregon
BILL PASCRELL, JR., New Jersey
DANNY DAVIS, Illinois
LINDA SANCHEZ, California
BRIAN HIGGINS, New York
TERRI SEWELL, Alabama
SUZAN DELBENE, Washington
JUDY CHU, California
GWEN MOORE, Wisconsin
DAN KILDEE, Michigan
DON BEYER, Virginia
DWIGHT EVANS, Pennsylvania
BRAD SCHNEIDER, Illinois
JIMMY PANETTA, California

MARK ROMAN, *Staff Director*
BRANDON CASEY, *Minority Chief Counsel*

SUBCOMMITTEE ON HEALTH

VERN BUCHANAN, Florida, *Chairman*

ADRIAN SMITH, Nebraska
MIKE KELLY, Pennsylvania
BRAD WENSTRUP, Ohio
GREG MURPHY, North Carolina
KEVIN HERN, Oklahoma
CAROL MILLER, West Virginia
BRIAN FITZPATRICK, Pennsylvania
CLAUDIA TENNEY, New York
BLAKE MOORE, Utah
MICHELLE STEEL, California

LLOYD DOGGETT, Texas
MIKE THOMPSON, California
EARL BLUMENAUER, Oregon
BRIAN HIGGINS, New York
TERRI SEWELL, Alabama
JUDY CHU, California
DWIGHT EVANS, Pennsylvania
DANNY DAVIS, Illinois

C O N T E N T S

OPENING STATEMENTS

WITNESSES

PUBLIC SUBMISSIONS

United States House Committee on
Ways & Means
CHAIRMAN JASON SMITH

FOR IMMEDIATE RELEASE
March 16, 2023
No. HL-01

CONTACT: 202-225-3625

Chairman Smith and Health Subcommittee Chairman Buchanan Announce Health Subcommittee Hearing on Why Health Care is Unaffordable: The Fallout of Democrats' Inflation on Patients and Small Businesses

House Committee on Ways and Means Chairman Jason Smith (MO-08) and Health Subcommittee Chairman Vern Buchanan (FL-16) announced today that the Subcommittee on Health will hold a hearing to examine how inflation and high health care costs have impacted patients, small businesses, and independent medical providers alike across the country. The hearing will take place on **Thursday, March 23, 2023, at 2:00 pm in 1100 Longworth House Office Building.**

Members of the public may view the hearing via live webcast available at https://waysandmeans.house.gov. The webcast will not be available until the hearing begins.

In view of the limited time available to hear the witnesses, oral testimony at this hearing will be from invited witnesses only. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit written comments for the hearing record can do so here: WMSubmission@mail.house.gov.

Please ATTACH your submission as a Microsoft Word document in compliance with the formatting requirements listed below, **by the close of business on Thursday, April 6, 2023**. For questions, or if you encounter technical problems, please call (202) 225-3625.

FORMATTING REQUIREMENTS:

The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission but reserves the right to format it according to guidelines. Any submission provided to the Committee by a witness, any materials submitted for the printed record, and any written comments in response to a request for written comments must conform to the guidelines listed below. Any submission not in compliance with these guidelines will not be printed but will be maintained in the Committee files for review and use by the Committee.

All submissions and supplementary materials must be submitted in a single document via email, provided in Word format and must not exceed a total of 10 pages. Please indicate the title of the hearing as the subject line in your submission. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.

All submissions must include a list of all clients, persons and/or organizations on whose behalf the witness appears. The name, company, address, telephone, and fax numbers of each witness must be included in the body of the email. Please exclude any personal identifiable information in the attached submission.

Failure to follow the formatting requirements may result in the exclusion of a submission. All submissions for the record are final.

ACCOMMODATIONS:

The Committee seeks to make its facilities accessible to persons with disabilities. If you require accommodations, please call 202-225-3625 or request via email to WMSubmission@mail.house.gov in advance of the event (four business days' notice is requested). Questions regarding accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Note: All Committee advisories and news releases are available on the Committee website at https://waysandmeans.house.gov/

###

WHY HEALTH CARE IS UNAFFORDABLE: THE FALLOUT OF DEMOCRATS' INFLATION ON PATIENTS AND SMALL BUSINESSES

THURSDAY, MARCH 23, 2023

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON WAYS AND MEANS,
Washington, DC.

The subcommittee met, pursuant to call, at 2:27 p.m., in Room 1100, Longworth House Office Building, Hon. Van Buchanan, [chairman of the subcommittee] presiding.

Chairman BUCHANAN. The committee will come to order.

Thank you all for being here today. I am excited to kick off the work of the Ways and Means Health Subcommittee for the 118th Congress with today's hearing about unaffordability of health care in America.

Thirteen years ago, former-President Obama signed the largest regulatory overhaul and expansion of federal health coverage since 1965.

At the time, President Obama and the Congressional Democrats made a lot of promises in the lead up to the passage and signing of Obamacare.

Then Vice President claimed that it was a "big deal." Unfortunately, he was right.

It has accelerated health care costs faster than at any point in the last 50 years and created an unworkable Federal bureaucracy that took away control from patients and doctors.

Luckily, since then, Congressional Republicans and President Trump worked to undo some of the damage that the bill created:

Repealing the disastrous "individual mandate";

Repealing the "Cadillac Tax";

Repealing the Independent Payment Advisory Board, so our seniors can keep access to their care.

Since 2010, however, the Congressional Democrats and now President Biden have done everything they can to artificially prop up the Obamacare exchanges. The Congressional Budget Office's initial estimate for enrollment was off by one-third. Yet Democrats continued down this road and called it a success.

The only time enrollment has come close to the original projections was after Democrats spent billions of dollars to make coverage essentially free for anyone making up to $90,000 a year.

In the spring 2021, the American Rescue Plan included generous subsidies to convince people to sign up for Obamacare plans. While

the number of enrollees increased, those subsidies caused health care spending and inflation to go further in terms of inflation.

They doubled down last year with the Inflation Reduction Act which has instead continued fueling our current level of inflation by extending these federal subsidies through 2025.

If Obamacare coverage is what people wanted, why do they feel they needed Biden to get them involved?

Instead of just throwing more Federal dollars at the problem, we need to come up with real reforms to our national health care system, both delivery and coverage of care, and put patients and doctors back in charge of the decision-making, not the Federal bureaucrats.

Rather than government telling patients what they need, we must continue our work to help constituents get the right coverage for their families.

For example, Republicans have promoted the use of Association Health Plans for small businesses so they can buy at a better rate and provide coverage to their employees.

We have also returned the definition of short-term limited-duration insurance plans to what it was before President Obama changed it at the end of his administration.

While there is no simple answer to bringing down the ballooning cost of health care in America, increasing competition, reducing government meddling, and putting patients and doctors back in charge is a good place to start.

I worked with my Republican colleagues on Speaker McCarthy's Healthy Task Force in terms of health care to come up with a patient-centered vision of how to reduce government involvement in medical decisions.

The hearing is the first step to implementing many of those changes.

The Task Force spent over 18 months meeting with numerous stakeholders, providers, patient groups and others in the health care sector to gather recommendations of how to address the high cost of health care.

I know in my district, in the last eight years, it has gone up 75 percent in Florida.

Congressional Democrats negotiated Obamacare behind closed doors, and I introduced a resolution to require those negotiations take place under the watchful eye of the American public, when then Nancy Pelosi pushed through the $1.2 trillion bill and cut along secret deals, so to speak.

House Republicans, on the other hand, have worked to address the shortcomings of our Nation's health care system through open discussions with various people and economists so they can weigh in, as well as our constituents.

We are on an unsustainable path of health care spending, with over $4.3 trillion spent in 2021, accounting for nearly 20 percent of our GDP. It is at long last we need to work together and find a way to rein in the spending and make sure we deliver for our constituents.

Chairman BUCHANAN. With that, I am pleased to recognize the gentleman from Texas, Mr. Doggett, for his opening statement.

Mr. DOGGETT. Thank you, as always, Mr. Chair.

Through health care crises like the COVID–19 pandemic right up to the economic challenges caused by Putin's brutal aggression and the war crimes in Ukraine, the Affordable Care Act has been the safety net that has kept so many Americans covered and healthy.

Increased enrollment in both Medicaid and the marketplaces actually reduced uninsured rates modestly during the pandemic, despite the fact that many were losing coverage with initial job losses and economic turmoil, a situation that was, of course, made much worse by Trump's denial, delay, and dithering regarding the pandemic.

Affordable Care Act coverage has also ensured providers receive stable payments. That has been essential for rural hospitals and other health care providers so that they can stay open and assure patient access.

Whether it is an unexpected medical emergency or a diagnosis of some dreaded disease or just day-to-day wellness checks, the Affordable Care Act is there for patients and for providers.

In my home State of Texas, a true mark of the success of the Affordable Care Act is the fact that last year we had a 42 percent one year increase in the number of those who enrolled in the plan.

Now, over 2.4 million Texans are insured through the marketplace. Their families do not just have insurance, they have quality health care protection that covers their essential needs and they do not have to worry about being disqualified because of a preexisting condition.

Though the Affordable Care Act does not permit discrimination, too many, primarily from communities of color and low-income families, are still not receiving any benefit from it.

I am pleased that today, North Carolina finally joined the majority of States doing right by expanding Medicaid coverage. Those who are denied the benefits of the Affordable Care Act result from the kind of obstruction that we have in Texas where Republicans continue to deny access to a family physician for almost as many Texans as the number who benefit from marketplace coverage.

As if 50 or 60 previous votes in this committee and this Congress to repeal the Affordable Health Care Act and losing three lawsuits were not enough, today we have yet another hearing to complain about the Affordable Care Act.

While there is health care inflation no doubt, it hardly began with the Affordable Care Act. Health care costs have long been soaring much more rapidly than the overall cost of living for decades.

Returning to the days of fine print limitations, junk insurance, and exclusions and denials of coverage at the very time the coverage is needed the most will not lower anyone's health care costs. That will only deny health care coverage to Americans.

Instead, we must work to tackle the longstanding distortions in our health care system.

And, of course, the poster child to that is the pharmaceutical prices. Big Pharma continues to spike prices year after year. Most recent data show an average 31.6 percent drug price increase, almost four times the rate of inflation.

Pharmaceutical companies use their government-approved monopolies to extract the highest prices in the world, despite Amer-

ican taxpayers financing and underwriting much of the research and development for new drugs.

Instead of rewarding taxpayers for their investment in drug research, manufacturers price gouge and manipulate the patent system to wrongly extend their monopolies and fend off good old American competition.

While innovators certainly deserve a profit and an incentive to innovate and reasonable patent protection, layering patents to extend monopoly power and monopoly prices for decades is an outrageous failing about which this Congress has done very little.

Charging Americans up to six times as much as patients in other countries for a drug whose development relied upon taxpayer dollars is certainly not reasonable.

Some of us have been working for years to repeal the ban on drug price negotiation and place some restraint on these aggressive monopolies. Yet it still remains illegal to negotiate on the vast majority of drugs, and for the handful that will be subject to negotiation, no price reduction will occur for more than two years, and then, unless you rely on Medicare, you get no benefit whatsoever.

I hope that in coming months our committee can work on a bipartisan basis to seek ways to have a productive response to health care price inflation instead of just relitigating worn out and unsubstantiated accusations against the Affordable Care Act.

And I yield back, Mr. Chairman.

Chairman BUCHANAN. Thank you, Mr. Doggett.

And I also look forward to working with you and see if we can come up—I knew we have got some challenges. Let's see what we can do about moving the country forward on health care, and I know you are committed to it, and so am I.

I am pleased to recognize the Chairman of Ways and Means, Chairman Smith, for his opening statement.

Chairman SMITH. Chairman Buchanan, Ranking Member Doggett, I am pleased to join you in convening this first hearing of the Health Subcommittee in the 118th Congress.

It is also a first step in a renewed effort to address the high cost of health care in America.

Thank you, Chairman Buchanan, for your leadership, your knowledge, and your expertise. Your background as a business owner will ensure the success of the subcommittee in advancing policies that can lower the cost of health care for more Americans, for small businesses, and their employees.

The high cost of health care is a painful reality for many Americans. In field hearings, we have heard how small businesses, particularly those in rural communities, are struggling to attract and retain workers and the increasing cost of providing incentives to do so.

Health insurance is one of those key benefits, but unfortunately costs have been steadily increasing. One survey showed 91 percent of small business owners rated addressing health care costs as a major priority.

While the rising cost of health care has been a challenge for many years, we also know that higher inflation today has driven up cost. Today families are paying nearly $2,000 more out of pocket than they were two years ago.

Medical supply costs have increased 15 percent, which makes it harder for independent medical providers to keep their doors open and treat patients. We need solutions that offer patients and small business owners greater choices and flexibility.

In today's hearing and in future hearings, including field hearings, we will examine the many factors driving the unaffordability of health care and what can be done to expand care to communities who today see hospitals and clinics closing because they cannot afford to keep the lights on.

But the cost of care is only so important as families actually having access to care. I look forward to this subcommittee and our full committee diving further into some of those issues.

We will listen to the American people, including those workers, families, farmers, job creators and the job creators we are meeting in our field hearings across the country.

Through that work, we will identify the problems and the solutions in which I hope will be a bipartisan effort to address rising health care cost and improve the access and quality of care available to all Americans.

I yield back, Mr. Chairman.

Chairman BUCHANAN. Thank you, Mr. Chairman.

I now will introduce the witnesses. I am very excited. We have got three or four people that have been in business and some since 1970. I am too young for that, but I am just very excited about having people because you make up the real world. You are the job creators.

And I have been in business like you in certain businesses back 40 years with a couple of employees and a couple of bucks and built something up, but all of us want to do what we can to help you, and one of the things is adjusting the cost of rising health care costs.

So you are going to be able to deliver that reality to us hopefully today.

So the witnesses, Kelly Moore is owner of NAPA Auto Parts.

Matt Niswander is the owner of his family medicine business.

Brian Blase is the President of Paragon Health Institute.

Karen Kerrigan is President and CEO of Small Business and Entrepreneurialship Council.

And Patricia Kelmar is the Senior Director of Health Care Campaigns at the U.S. Public Interest Research Group.

Ms. Moore, I will start with you.

STATEMENT OF KELLY MOORE, OWNER, NAPA AUTO PARTS

Ms. MOORE. Chairman Buchanan, Ranking Member Doggett, and members of the House Ways and Mean Subcommittee on Health, thank you for inviting me to testify today on behalf of the small business community.

As said, my name is Kelly Moore, and I am the owner of three NAPA Auto Parts stores in Eastern Ohio.

In 2004, my husband Greg and I bet on the promise that through hard work we could achieve the American dream. We opened two stores, put everything on the line to do that. We had 20 team and family members employed.

The hard work paid off and we opened two additional stores in 2006. In 2017, we combined two of our stores and closed one, so we have currently owned the same three stores.

Our employees are the lifeblood of our company. Our employees are incredibly valuable, well trained, and we rely on their dedication, their resilience, and their passion for our business to help the business thrive.

When our business thrives so we do, but so do our employees.

Their wellbeing is a top priority for my family and me. One of the most significant challenges we face is the affordability of health insurance.

Another challenge we face is maintaining our valued employees and filling the open positions with qualified candidates. We want to be sure we are offering a competitive local wage and a competitive benefits package.

Making matters worse, small business owners do not have the scale or regulatory flexibility that large corporations enjoy, making it difficult for us to compete, especially when it comes to being able to offer health insurance.

Before the Affordable Care Act mandates were imposed, we paid 80 percent of the premiums for our employees and their dependents. However, every year after the enactment of the ACA, my insurance premiums increased by double digits.

In 2010 alone, the very first year, we experienced a 30 percent increase in premiums. Not only did we as a business experience that. Our employees experienced it in their share of the premium.

By 2015, the year-over-year increase was 21 percent. By 2016, it was 18 percent. And in 2017, benefit year was scheduled to be an additional 24 percent year-over-year increase.

During the six years following the ACA, we were forced to scale back our premium contribution in order to afford our insurance premium. We scaled it back to 70 percent and eventually to 60 percent. We made other changes, as well.

Additionally, our employees could no longer afford the plan we could secure with the plan's exorbitant deductibles and out-of-pocket limits. We were forced to terminate health insurance in 2017.

It was a gut-wrenching decision. I lost sleep. I spent a lot of hours making phone calls trying to crunch numbers, trying to find a way to insure those employees.

But the search for individual plans by my employees was even more frustrating and confusing. The terminology of health insurance plans, the apples-to-oranges comparisons, the unfamiliarity with the limits associated with different plans, they left our employees both disgusted and disgruntled with the ACA.

Currently our employees have coverage due to recent legislative and regulatory actions. We reinstituted coverage in 2019 when the Tax Cuts and Jobs Act small business deduction allowed us to deduct 20 percent of our pass-through income.

In 2020, a change in the regulations by the Trump Administration allowed NAPA Auto Parts to offer an Association Health Plan. If either of these valuable government policies were to expire, we would no longer be able to afford or offer health insurance as a benefit and an attraction to new employees.

The status quo is unsustainable. We need cost containment, choices, flexibility when it comes to our health insurance so that we can provide the best possible coverage for our employees without breaking the bank.

In closing, I would like to thank the committee for allowing me to testify, for listening to the small business community's concerns, and for your efforts to empower the small business owners, especially in the arena of health care.

I will answer any questions.

[The prepared statement of Ms. Moore follows:]

The Honorable Vern Buchanan
Chairman
Committee on Ways & Means
Subcommittee on Health
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Lloyd Doggett
Ranking Member
Committee on Ways & Means
Subcommittee on Health
U.S. House of Representatives
Washington, D.C. 20515

Dear Chairman Buchanan, Ranking Member Doggett, and Members of the House Ways & Means Subcommittee on Health,

My name is Kelly Moore, and I am the owner and operator of three NAPA (National Automotive Parts Association) retail locations in Ohio.

In 2004, my husband Greg and I bet on the promise that hard work could achieve the American Dream by opening our first two stores. Greg had been considering a career change for a few years. After exploring the options, he left the corporate world, and started a business where he could apply his knowledge and skills, as well as employ our oldest son, who was diagnosed as a young child with a developmental delay. I was employed with a local hospital system in administration. It was decided that I would work both jobs – my then position with the hospital and assist with office duties for our new company – until we felt the business was "on its feet." We employed 20 team and family members. The hard work paid off, and we opened two more stores in 2006, creating even more local jobs in Zanesville, Dresden, Coshocton, and West Lafayette. One of those jobs was mine as I left the hospital system and came on board, finally receiving a paycheck from the business. In 2017, we closed our smallest store in the village of West Lafayette, timing the closure until we could afford to expand our larger store in Coshocton and retain all the employees from both stores. We are living the Dream.

Eastern Ohio is a largely rural area with resource-rich land and the benefit of I-70 and I-77 interstates. Two of our stores, including our warehouse, are in Muskingum County. According to DATA USA, the largest area employers were in the healthcare, retail, and manufacturing sectors in 2020. The highest-paying jobs were in utilities, mining, oil & gas extraction, and agriculture. The median household income is just under $50,000, lower than the cited national median income. There are over 85,000 residents in the county, according to the U.S. Census in 2020.

Our Coshocton retail location sits in the Appalachian Regional Development area of the United States, with about 36,000 residents. According to DATA USA, manufacturing, healthcare, and retail sectors are the largest industries. The median household income is about the same as Muskingum County, according to the U.S. Census in 2020.

Both counties are very affordable places to live in Ohio, in my opinion. During the past few years, inflationary prices for everyday expenses, such as food, fuel, and utilities, are challenging this affordability. Factor in rising costs for healthcare, and it becomes clear that the median income for families in these counties cannot go far enough to cover a medical event or the high deductibles, high out-of-pocket limits, and increasing costs of prescription drugs. A quick search of the current *Affordable Care Act* (*ACA*) bronze plans for these counties require an $11,000 family deductible and set the out-of-pocket limit for families at $17,400. Clearly, these are not "affordable" options on a median household income in either of these counties.

Traditionally, employees have relied upon employers to provide health insurance as a major part of the benefits package. Employers have used the health insurance benefit as an incentive to attract great candidates for skilled positions. At our company, GKM Auto Parts, our employees are the lifeblood of our company. Our employees are incredibly valuable, and we rely on their passion, resilience, and dedication to help our business thrive. When our business thrives, owners and employees benefit. Their well-being is a top priority for my family and me. However, with the shortage of workers, it has become increasingly difficult to attract and retain talent in recent years. One of the most significant challenges we face is the affordability of health insurance. In a competitive job market, quality health insurance benefits can make all the difference when recruiting the best candidates. To make matters worse, small business owners do not have scale. They have steep regulatory burdens and stricter mandates than larger corporations, making it difficult to compete, especially when it comes to offering more affordable health insurance packages. For over 30 years, National Federation of Independent Business (NFIB) members like me have cited the cost of health insurance as the number one business problem, with 50% ranking it as a critical problem.[1]

As the cost of goods and services continues to rise, I, alongside thousands of other small business owners, am forced to make unfair and difficult choices to keep my business afloat.

Before the Affordable Care Act (ACA) mandates were imposed, we offered health insurance and paid 80% of the premium, covering office visits, medical and hospital treatments, and prescription drugs. The coverage was extended to our employees, spouses, and dependents. However, every year after the enactment of the *ACA*, my insurance premiums increased by double digits. In 2010 alone, we experienced an almost 30% increase in premiums. By 2015, the year-over-year increase was 21%; in 2016, that increase was 18%, and for the 2017 benefit year, the year-over-year increase was scheduled for 24%. We reacted throughout this period with changes in the insurance plans we could offer. We had to drop coverage for spouses. Later, when premiums continued to escalate, we ended the dental, vision, and life insurance benefits so that the premiums for those programs could be used to cover the health insurance premium increases. We scaled our contribution back to 70% and, subsequently, 60% until it was no longer a benefit to the employees, and we could no longer afford to offer health insurance. Furthermore, several *ACA* mandates resulted in less personalized options and higher costs for health insurance.

Ultimately, we could no longer afford to offer health insurance benefits, which were also becoming too expensive for employees. It was a gut-wrenching decision to make. I lost sleep. I spent most of my time at my desk, not focusing on my other duties but rather trying to crunch numbers and making phone calls to find a way to offer health insurance benefits. The worst day of my professional career was making the announcement to each employee about the termination of the health insurance benefit.

For small employers like me, navigating the highly opaque and complex system is incredibly burdensome, requiring hours of research often times with no real transparency. It is equally burdensome for my employees to navigate the system when looking for coverage on their own. Only seven of the ten opted to take out a policy or find insurance through a spouse. Even with premium subsidies offered by the *ACA* plans, the costs associated with deductibles, out-of-pocket expenses, and drug plans were still unaffordable, according to the employees who chose not to insure themselves. Two have admitted that they weighed the option of leaving us for another position.

The good news is that our employees currently have access to coverage due to recent legislative and regulatory actions. The *Tax Cuts and Jobs Act's* Small Business Deduction (Section 199A) allowed us to deduct 20% from our passthrough income, providing tax savings that we used to purchase health insurance for our employees. A change in regulations by

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

the Trump Administration allowed NAPA Auto Parts to offer an association health plan to store owners and their eligible employees that was more affordable than small group market insurance. With these savings measures, we were able to not only offer, but pay 100% of the premium for dental and life insurance for eligible employees. The association health plan has been extremely beneficial to our small business, and I am certain it would be beneficial for all small businesses interested in offering competitive health insurance plans. If either of these policies, the Small Business Deduction or the ability of small groups to purchase an association health plan, were to expire or be eliminated, we would no longer be able to offer health insurance.

Still, we continue to struggle with ever-increasing premiums, deductibles, high healthcare expenses, and out-of-pocket costs that do not seem to relent. At a time when inflation and worker shortages continue to be difficult challenges facing small business owners,[2] legislative and regulatory relief must be implemented to alleviate these artificially imposed burdens and contain the expense of healthcare. We need personalized, affordable, and flexible health insurance options for ourselves and our employees.

A one-size-fits-all health insurance system that does not take into account the unique needs and challenges facing small business owners and our employees will only continue to result in disaster. A recent survey by NFIB shows that over 90% of small business owners are concerned that the cost of providing health insurance to their employees will become unsustainable in the next 5-10 years.[3]

The status quo is unsustainable. Healthcare costs need to be contained. Again, we need more choices and flexibility when it comes to health insurance so that we can provide the best possible coverage for our employees without breaking the bank.

The past three years have called for resourceful, resilient, and creative ways to keep our doors open and all employees gainfully employed. Life in our small communities is very far removed from the media headlines. We have safe streets and concentrate on keeping our schools safe to obtain a meaningful education that can lead to a successful professional life. People in our area work hard and want a good life for themselves and their families' future. Jobs lost during the pandemic are returning to our area at the level of employment pre-pandemic. Wages have risen locally. As a business, we issued several raises and bonuses to all employees over the past few years. Most small businesses realize now more than ever it is critical to operations to keep our qualified and well-trained employees within our organization. Our business has put expansion plans on hold during the current unstable economic environment. With interest rates rising, inventories shrinking due to supply shortages, and inflated fuel and utility costs, we are waiting the times out. We don't see better economic times coming any time soon; our confidence in the economy has negated a risk-worthy business expansion. We are using this time to review procedures, eliminate costly services, and in general, get "Lean and Mean". We are steadying our business for additional economic tests. That is our focus.

I will close with a famous quote from President Ronald Reagan which reflects the sentiment in my neck of the woods, "Government does not solve problems, it subsidizes them. The government's view of the economy could be summed up in a few short phrases: If it moves, tax it. If it keeps moving, regulate it. If it stops moving, subsidize it."

I would like to thank the committee for inviting me to testify, for listening to the small business community's concerns, and for your efforts to empower small business owners. Personally, I would say that living the American Dream has less to do with what the government can do for me, with costly programs and subsidies, and more with allowing me the opportunity to accept responsibility for the lives we employ.

---

[2] William C. Dunkelberg & Holly Wade, *NFIB Small Business Economic Trends*, NFIB Research Center, March 14, 2023,
[3] Holly Wade & Madeleine Oldstone, *Small Business Health Insurance Survey*, NFIB Research Center, March 2023

Chairman BUCHANAN. Thank you, Ms. Moore.
Mr. Niswander, you are recognized.

STATEMENT OF MATT NISWANDER, NP, OWNER AND NURSE PRACTITIONER, NISWANDER FAMILY MEDICINE

Mr. NISWANDER. Chairman Buchanan and Ranking Member Doggett, members of the subcommittee, my name is Matt Niswander. I am from Lawrenceburg, Tennessee. I am a first-generation cattleman, a family nurse practitioner, and the owner of Niswander Family Medicine.

I am here to highlight the difficulties and struggles that owners and ranchers, small business owners, health care workers, and middle-class families like mine encounter every day pertaining to the cost of high-quality individual health insurance.

Small businesses like mine are struggling with the cost of providing insurance to our employees. And also, I want to discuss how increasing operating costs are making it a struggle to continue to take care of our communities.

I have the honor and responsibility of supporting nine families as employees in my medical practice. Last year we celebrated as one of my nurses found out she was expecting her third child. Her and her husband decided to check on insurance through the marketplace and found that they could get a bronze policy coverage plan for their family for $150 a month, but with a $14,000 deductible.

Her husband owns a small dirt excavating business and has no option for coverage through an employer, and we did not offer employee coverage at the time.

So we decided to check on the cost of providing that benefit to all of our employees. To cover just our employees and not their families, it was going to cost our office $34,000 a year for a plan that our employees would pay around $350 a month for a deductible of $12,000.

If we decided to cover our employees and their families, my business cost skyrocketed to $140,000 for the same plan coverage.

Here I am running a medical practice, and I cannot even offer medical benefits to my employees because of the cost. How is a small business supposed to budget for these ridiculously high prices?

And even if I could afford to offer my employees benefits, why would I want to pay for something that is going to cost them $350 a month and $12,000 annually before it even helps them out?

At this point, my employee decided to sign up for the bronze high deductible plan. She then paid $250 at every OB appointment during her pregnancy and $1,800 immediately after delivery, for a total of over $4,000 and a $14,000 deductible that was never met.

You will be happy to know that Mother and Baby are doing just fine, but their budget is not.

The cost to operate small businesses like mine have increased substantially in the last few years. Not only have the costs of supplies increased threefold compared to pre-pandemic prices, but supplies have even been unavailable at times.

Before 2019, we bought gloves for $10 a box. That same box of gloves is now $30. How can we continue to afford these price increases?

We provide health care to almost all available insurance plans in our area. The problem is that we have no bargaining power concerning the payments for these insurance companies, and payments from these companies have remained the same even though our expenses have skyrocketed.

We have seen many of our uninsured and Affordable Care Act covered families struggle with the decision of making a house payment and buying groceries versus taking care of the uncontrolled diabetes and high blood pressure that require an office visit and prescription medication.

As the cost of living in stress, especially for health care workers, increased exponentially during the COVID–19 pandemic, my employees needed and deserved raises that we gave them during this time. But due to economic stresses, we had to carefully weigh the viability of our practice with increased expenses and the same amount of income.

Instead of increasing our prices, we are getting creative and trying to rent out space in our office for other medical professionals to practice and offset our expenses slightly.

But mostly we just take the loss ourselves to continue to support our employees and our community. I do not know how many medical offices have and continue to absorb this cost, but in towns all over rural America, medical practices like mine and hospitals are closing. There are no new providers coming in to fill those gaps in those communities.

The ACA may have wanted to provide high quality, affordable insurance plans for Americans, but in rural America working class families are not seeing that.

The families in rural towns are getting older and have lower incomes and budgets that cannot include health care and have less access to primary care providers and specialists than ever before.

With less than ten percent of medical providers choosing to practice in rural areas due to more complicated aging patient populations covered by Medicare and Medicaid with lower reimbursement rates, access to those providers is only going to get worse.

Maybe ACA has decreased the number of uninsured individuals in America, but how do you expect people to use insurance that is going to make them pay more than $14,000 annually before it ever helps them out?

And if they decide to use that coverage, rural Americans are having to travel farther, wait longer, and require more extensive care than ever before, straining the health care system even more.

Benefits attract the best talent, but how can businesses be expected to sign up for terrible insurance coverage that costs us as much as hiring an additional full-time employee?

And as the expenses of operating business continue to increase, the options for redefining and pivoting become fewer and fewer.

Rural America is increasingly becoming a desert for medicine and a graveyard for our friends and families because we lack the access to affordable, high-quality insurance as we are simultaneously running off the doctors and nurse practitioners and nurses,

psychiatrists, and specialists to treat the unique needs of our rural towns.

My wife and I are the sole owners of our medical practice. We decided medical care for the people is more important than a profit.

But there is nothing affordable about the care that the Federal Government is acting like the rural Americans are getting.

Thank you, and I look forward to your questions.

[The prepared statement of Mr. Niswander follows:]

Testimony of Matt Niswander
Niswander Family Medicine
Owner & Nurse Practitioner
Before the House Committee on Ways and Means
Subcommittee on Health
March 23, 2023

Chairman Buchanan, Ranking Member Doggett and members of the subcommittee. My name is Matt Niswander from Lawrenceburg, TN. I am a first-generation cattleman, a family Nurse Practitioner, and the owner of Niswander Family Medicine. I am here to highlight the difficulties and struggles that the farmers and ranchers, small business owners, healthcare workers, and middle-class families like mine encounter everyday pertaining to the cost of high quality individual health insurance, how our small businesses are struggling with the cost of providing insurance to our employees, and how increased operating costs are making it a struggle to continue to take care of our communities.

I have the honor and the responsibility of supporting 9 families as employees of my medical practice. Last year we celebrated as one of my nurses found out she was expecting her 3rd child. Her and her husband decided to check on insurance through the marketplace and found that they could get a bronze policy coverage plan for their family for $150 per month, but with a $14,000 deductible. Her husband owns a small dirt excavating business and has no option for coverage through an employer, and we did not offer employee coverage at the time, so we decided to check on the cost of providing that benefit to all our employees. To cover just our employees and not their families it was going to cost our office $34,000 a year for a plan that our employees would pay around $350 per month for with a $12,000 deductible. If we decided to cover our employees and their families my business cost skyrocketed to $140,000 for the same plan coverage. Here I am running a medical practice and I cannot even offer medical benefits to my employees because of the cost. How is a small business supposed to budget for those ridiculously high prices? And even if I could afford to offer my employees insurance benefits, why would I want to pay for something that is going to cost them $350 per month and $12,000 annually before their benefits even start. At this point my employee decided to sign up for the marketplace insurance at $150 per month and with a $14,000 deductible. She then paid $250 at every appointment with her OBGYN during her pregnancy, and then $1800 immediately after delivery. For a total of over $4000 and a $14,000 deductible that was never met. You will be happy to know the mother and baby are doing just fine, but their budget is not. The father has recently decided to become a firefighter to gain access to affordable, quality insurance through his eventual employer.

The cost to operate small businesses like mine have increased substantially in the last few years. Not only have the cost of basic supplies increase 3-fold compared to pre-pandemic prices, but supplies have even been unavailable at times. Before 2019 we bought gloves for $10 a box. That same box of gloves is now $30. How can we continue to afford those price increases? We provide healthcare to almost all available insurance plans in our area. The problem is that we have no bargaining power concerning the payments from these insurance companies, and payments from them have remained the same even as our expenses have

skyrocketed. Also, reimbursements from federal insurance plans are almost always lower than those from commercial insurance plans. We have seen many of our uninsured and Affordable Care Act covered families struggle with the decision to make a house payment and buy groceries versus taking care of the uncontrolled Diabetes and high blood pressure that require an office visit and prescription medication. As the cost of living and stress, especially for healthcare workers, increased exponentially during the COVID-19 pandemic, my employees needed and deserved raises that we gave them during this time. But due to the economic stresses we had to carefully weigh the viability of our practice with increased expenses and the same amount of income. Instead of increasing our prices we are getting creative and trying to rent out space in our office for other medical professionals to practice and offset our expenses slightly, but mostly we just take the loss ourselves to continue to support our employees and our community. I don't know how many medical offices have or can continue to absorb the increase costs like we have, but I do know hospitals and medical practices in towns all over rural America are closing and new medical providers are not filling those gaps for the families in those communities.

Every problem has a solution, even if it isn't the solution you initially wanted. The ACA may have wanted to provide high quality, affordable insurance plans for Americans, but in rural America, working class families are not seeing that. The families in rural towns are getting older, have lower incomes and budgets that can't include healthcare, and have less access to primary care providers and specialists than ever before. With less than 10% of medical providers choosing to practice in rural areas due to a more complicated, aging patient population covered by Medicare and Medicaid with lower reimbursement rates, access to those providers is only expected to get worse. Maybe the ACA has decreased the number of uninsured individuals in America, but how do you expect people to use insurance that is going to make them pay more than $14,000 annually before it ever helps them out. And if they decide to use that coverage, rural Americans are having to travel farther, wait longer, and require more extensive care than ever before, straining the healthcare system even more. Benefits attract the best talent, but how can businesses be expected to sign up for terrible insurance coverage that costs us as much as hiring an additional full time employee. And as the expenses of operating business continues to increase, the options for redefining and pivoting become fewer and fewer. Rural America is increasingly becoming a desert for medicine and a graveyard for our friends and families because we lack access to affordable, high-quality insurance as we are simultaneously running off the doctors, NP's, nurses, psychiatrists, and specialists to treat the unique needs of our rural towns. My wife and I are the sole owners of our medical practice and we have decided medical care for the people is more important than profit, but there is nothing affordable about the care that the federal government is acting like rural Americans are getting.

Chairman BUCHANAN. Thank you.

Dr. Blase, you are recognized.

STATEMENT OF BRIAN BLASE, Ph.D., PRESIDENT, PARAGON HEALTH INSTITUTE

Dr. BLASE. Thank you, Chairman Buchanan, Ranking Member Doggett, members of the committee.

It is a privilege to testify before you today, particularly since I was once a House staffer.

My name is Brian Blase. I am president of a new health policy think tank, Paragon Health Institute, and my testimony today represents my own views.

I will focus on how well intended government policy aimed at making health coverage and care more affordable often does the opposite.

For example, the Affordable Care Act causes premiums to soar. Individual market premiums more than doubled in the first four years after its implementation. Yet plans cover fewer doctors and hospitals.

By 2021, the average ACA plan premium plus deductible for a family of four exceeded $25,000. Since coverage is cost prohibitive, most enrollees need extremely large subsidies to afford these plans.

Taxpayers pay for more than 80 percent of the premium, on average, and pick almost all the cost of premium increases over time.

This gives insurers significant pricing power and, in turn, leads to higher premiums, an inflationary spiral.

At the outset it is important to acknowledge some basic truths. First, the U.S. does not have a free market for health care. Half of U.S. health care spending is by the government. Most of the rest is heavily impacted by government policy.

As government's role in health care has expanded, prices have skyrocketed. Hospital prices have increased more than any other major economic sector, rising three times faster than inflation since 2000.

By contrast, in sectors where government's role is minimal, inflation adjusted prices typically decline while quality improves. Too often high health care prices and spending do not correspond to high value and improved health.

For example, the ACA expanded coverage and significantly increased spending primary through Medicaid, but American life expectancy declined for three straight years following the ACA's coverage provisions taking effect.

In fact, American's life expectancy was lower in 2019, before the pandemic, than it was in 2013.

There is too much government bureaucracy in health care. Government rules, despite good intentions, often restrict options for coverage and care, stymie innovation, and prevent providers from being able to best meet their patient needs.

Government also mismanages programs to an epic degree. There is $100 billion in annual improper Medicaid payments, for example.

There is too much insurance bureaucracy in health care. Insurance is important, but having insurance pay for routine and shoppable services leads to over-consumption and waste. People often secure better prices by not using insurance.

One study estimated that cash prices are 40 percent cheaper than prices with insurance.

For health care services where third party is limited, such as cosmetic surgery and Lasik, real prices have declined while quality has increased.

Moving forward we should keep two principles in mind. First, policy changes always produce unintended consequences. We should evaluate the outcomes, not the intentions behind policies.

For example, many ACA proponents thought it would reduce ER visits because people would get a usual source of care. The exact opposite happened. ER use surged with the ACA, often for non-emergent care.

Second, when government subsidizes something, it becomes more expensive. Subsidies increase demand, raise prices, and increase total spending, and must be funded by taxpayers.

Both the American Rescue Plan Act and the Inflation Reduction Act expanded the ACA's already substantial subsidies. Most of the benefit went to people who already had coverage. Families with incomes well above $250,000 now qualify for large subsidies.

The expanded subsidies incentivize employers to drop or replace coverage, raising overall deficits, and all of the new spending on the expanded subsidies also increases inflation.

Congress should consider building on existing policies that expand coverage options in improving status, including Association Health Plans, which allow employers to have economies of scale in obtaining health insurance for their employees, making coverage more affordable.

Individual coverage health reimbursement arrangements enable employers to offer coverage by making tax preferred contributions if the workers can buy coverage that works best for them.

Price transparency rules empower patients and employers to know prices before purchasing services, and health savings accounts give people incentives to ensure value from their health care expenditures.

In conclusion, Congress should trust people and let Americans have the freedom to spend their own money on the health care and coverage that works best for them.

Thank you, again, for the opportunity to testify today, and I look forward to any questions.

[The prepared statement of Dr. Blase follows:]

PARAGON
HEALTH INSTITUTE

Testimony of Brian C. Blase, PhD before the
House Committee on Ways and Means Subcommittee on Health
"Why Health Care Is Unaffordable: The Fallout of Democrats' Inflation on Patients and Small Businesses."
March 23, 2023

My name is Brian Blase, and I was privileged to work for the House Committee on Oversight and Government Reform from 2011 through 2014. You have vital jobs serving the American people, and it is an honor to testify before this Committee today on this important topic.

I am the founder and president of a new health policy think tank — Paragon Health Institute. My testimony today represents my views and not those of Paragon. I am also a visiting fellow at the Foundation for Government Accountability. From 2017 through 2019, I served as a Special Assistant to the President for Economic Policy at the White House's National Economic Council.

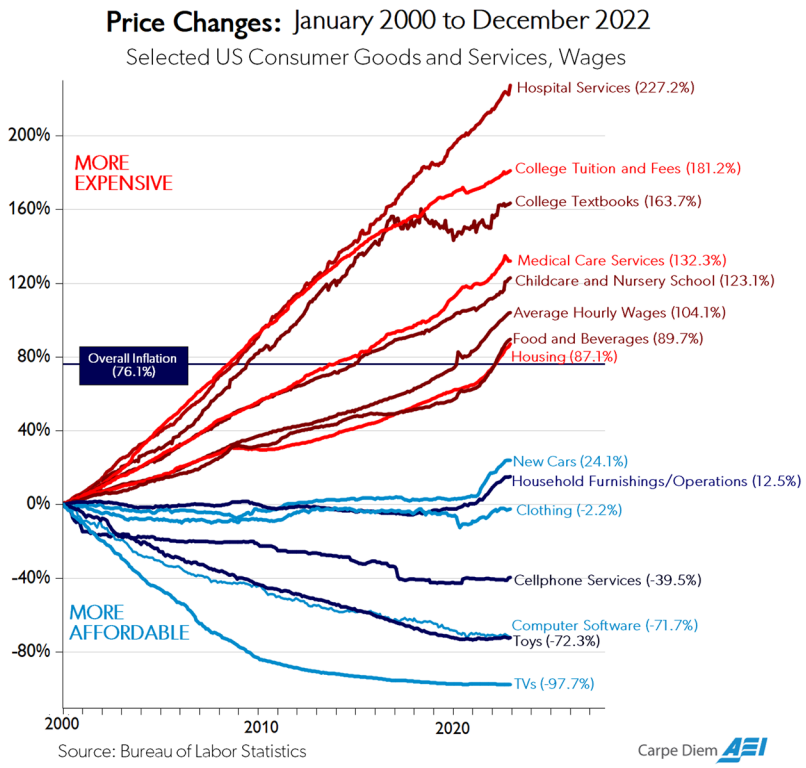
For many people, neither health care nor health coverage is affordable. Counterproductive, ill-advised government policies have significantly contributed to high and rising health care prices, costs, and spending. For example, the coverage and benefit mandates in the Affordable Care Act (ACA) significantly increased insurance premiums in the individual market and to a lesser extent, the small group market. According to an analysis by The Heritage Foundation, individual market premiums increased 129 percent on average from 2013 — the year before the ACA's provisions took effect — to 2019.[1] The ACA mandates that most significantly increased premiums were rules that expanded the services for what health insurance needed to cover as well as restrictions that prevented premiums from reflecting expected health expenses and produced adverse selection in the market. The ACA, with its complexity and emphasis on accountable care organizations, was designed to increase consolidation in health care markets,[2] and consolidation reduces competition and often raises prices, reduces access, and lowers quality of care.[3]

In many areas of the economy, products and services have become higher in quality over time while real prices, after accounting for inflation, have declined (Figure below: "Price Changes").[4] Unfortunately, this has not been the case for most health care products and services.[5] As the following figure shows, prices for hospital services — the largest component of health care expenditures — have increased three times faster than general inflation over the past two decades.[6]

As health costs have risen, insurance premiums have correspondingly soared, even as plan deductibles have risen dramatically. In 2021, health care spending was 18.3 percent of U.S. Gross Domestic Product, a 38 percent increase from the 13.3 percent of U.S. GDP expended on health care in 2000.[7] There is also significant waste in the health care sector, with some estimates

[1] Edmund F. Haislmaier and Abigail Slagle, "Obamacare Has Doubled the Cost of Individual Health Insurance," Heritage Foundation, March 21, 2021, https://www.heritage.org/sites/default/files/2021-03/IB6068.pdf.
[2] Bob Kocher, "How I Was Wrong About ObamaCare," The Wall Street Journal, July 31, 2016, https://www.wsj.com/articles/i-was-wrong-about-obamacare-1469997311.
[3] Martin Gaynor, "'Examining the Impact of Health Care Consolidation' Statement before the Committee on Energy and Commerce, Oversight and Investigations Subcommittee, U.S. House of Representatives," December 13, 2018, https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3287848.
[4] Mark Perry, "Chart of the day.... or century?" Carpe Diem, American Enterprise Institute, https://twitter.com/Mark_J_Perry/status/1616903822118649858
[5] Id.
[6] Id.
[7] "National Health Expenditures 2021 Highlights," Centers for Medicare and Medicaid Services (CMS), https://www.cms.gov/files/document/highlights.pdf.

suggesting that up to a quarter of health care spending provides people with little, if any, health benefit.[8]



Importantly, over the past few decades, there have been some noticeable advances in health care, such as a decline in cardiac mortality, improvement in cancer survival rates, a cure for Hepatitis C, and new AIDS treatments. Yet, health outcomes have stagnated despite the Affordable Care Act's (ACA) new spending and the significant expansion of Medicaid. American life expectancy was lower

[8] William H Shrank, Teresa L Rogstad, and Natasha Parekh, "Waste in the US Health Care System: Estimated Costs and Potential for Savings," JAMA (U.S. National Library of Medicine, October 15, 2019), https://pubmed.ncbi.nlm.nih.gov/31589283/.

in 2019 (a pre-pandemic measure) than it was in 2013, before the ACA's coverage and spending provisions took effect.[9]

Government Subsidies Contribute to Rising Health Care Prices and Costs

There are many policies — at both the federal and state levels — that raise health care prices and costs. Generally, in most areas of the economy, high prices convey high value. But because of government's heavy involvement, excessive third-party payment, and generally consolidated markets — high prices in health care are often not a reflection of high value. A major consideration for policymakers in addressing high prices for medical care should be examining how existing government policies contribute to the problem and then focusing on reform.

The federal government — through tax and spending programs — inflates health care spending and is responsible for substantial expenditures that provide little, if any, benefit to Americans. As mentioned above, estimates indicate that up to 25 percent of spending on health care provides no health benefit, with some of it actually harmful, to our health. Reforms are clearly needed, particularly to our health care entitlement programs.

A primary way that government inflates health care prices and costs is through tax and spending policies. In 2021, government health care spending — including both state and local government spending — was 49 percent of total U.S. health care expenditures.[10] Federal policy also has a major influence over private sector health care spending, particularly through the tax exclusion for employer-sponsored health insurance. The White House estimated that this tax exclusion will reduce federal revenue — both income and payroll tax collections — by $387 billion in 2023.[11]

The key economic reality is that when government subsidizes something, that thing becomes more expensive. Subsidies increase demand, raise prices, and thus increase total spending in that area. Substantial and open-ended federal subsidies for health insurance mean that most Americans have comprehensive health insurance. This in turn puts upward pressure on health care prices and diminishes the amount of shopping for health coverage and care.

For complete economic analysis, the taxpayer share of the total cost must be considered. For households to receive subsidies, other households must finance those subsidies. This financing can occur through higher taxes or through greater debt. More debt represents higher taxes in the future, either through direct taxes or higher inflation.

Although the magnitude of government subsidies for health care increases prices and spending, the design of the subsidies is also problematic. Historically, government programs and tax policy have encouraged third-party payment of health services. Thus, for the vast majority of health care transactions, individuals do not directly spend their own money but instead rely on a government program or their insurance plan. Insurance should play a significant role in financing catastrophic and expensive care but having insurance pay for routine and shoppable services rather than relying on markets for these services distorts decision-making and leads to overconsumption and waste.

---

[9] "U.S. Life Expectancy 1950-2022," MacroTrends, https://www.macrotrends.net/countries/USA/united-states/life- expectancy, retrieved February 13, 2022.
[10] Centers for Medicare & Medicaid Services *National Health Expenditures 2021*,
[11] Office of Management and Budget, "Analytical Perspectives Budget of the U.S Government Fiscal Year 2024" (Office of Management and Budget, March 9, 2023), https://www.govinfo.gov/content/pkg/BUDGET-2024-PER/pdf/BUDGET-2024-PER.pdf.

While inflation in health care services has been substantial, health care services where third-party payment is limited — such as cosmetic surgery and Lasik-eye surgery — have had real price declines as quality has significantly improved.[12] Also, a number of physician practices and medical centers, such as the Oklahoma Surgery Center, do not accept insurance and have much lower average prices.[13]

Disappointing ACA Exchanges

The ACA made individual market health insurance less affordable and introduced a generally inefficient set of subsidies. The ACA expanded coverage in two ways — with a large Medicaid expansion funded almost entirely by federal dollars and with new premium subsidies to help people afford individual market insurance that was made much more expensive because of the ACA's extensive new federal regulations.

Nearly the entire net coverage gains from the ACA occurred through Medicaid expansion, although many people who gained coverage through Medicaid were, in fact, not eligible for the program.[14] Enrollment in the individual market exchanges has largely been disappointing, falling far below original projections. From 2015-2020, exchange enrollment averaged about 10-11 million people[15] — about 60 percent below what the Congressional Budget Office projected in May 2013 in its last analysis before the ACA's provisions took effect.[16]

Low exchange enrollment may be explained by the individual market premiums increasing 105 percent from 2013 to 2017.[17] The vast majority of enrollees receive large subsidies as the premium increases have largely priced unsubsidized individuals out of the market.

For the unsubsidized, the average exchange plan annual premium plus deductible for a family of four exceeded $25,000 in 2021 and continues to climb.[18] In addition to the high cost, ACA plans tend to have narrow networks, excluding the best hospitals and doctors in local regions. For example, in Texas, not a single ACA plan covers Houston's world-renowned MD Anderson Cancer Center.[19]

Misguided ACA Subsidy Expansion

Rather than addressing underlying problems with the ACA that caused high premiums and deductibles and narrow plan networks, the American Rescue Plan Act (ARPA) further increased

---

[12] Mark Perry, "What economic lessons about health care costs can we learn from the competitive market for cosmetic procedures?" American Enterprise Institute, April 25, 2019, https://www.aei.org/carpe-diem/what- economic-lessons-about-health-care-costs-can-we-learn-from-the-competitive-market-for-cosmetic-procedures-2/.
[13] For a discussion of the Oklahoma Surgery Center: Russ Roberts and Keith Smith, "Keith Smith on Free Market Health Care," Econtalk, November 18, 2019, https://www.econtalk.org/keith-smith-on-free-market-health-care/.
[14] Brian Blase and Aaron Yelowitz, "The ACA's Medicaid Expansion: A Review of Ineligible Enrollees and Improper Payments," Mercatus Center, November 25, 2019, https://www.mercatus.org/system/files/blase-medicaid- expansion-mercatus-research-v1.pdf.
[15] The average number of enrollees over the course of the year accounts for the fact that some people who choose coverage during open enrollment fail to pay any premium and net attrition in enrollment over the course of the year.
[16] "CBO's May 2013 Estimate of the Effects of the Affordable Care Act on Health Insurance Coverage," Congressional Budget Office, May 2013, https://www.cbo.gov/sites/default/files/recurringdata/51298-2013-05- aca.pdf.
[17] ASPE Data Point, "Individual Market Premium Changes: 2013-2017," Assistant Secretary for Planning and Evaluation, May 23, 2017
[18] BY Davalon, "How Much Does Health Insurance Cost Without a Subsidy?" eHealth, January 21, 2022, https://www.ehealthinsurance.com/resources/affordable-care-act/much-health-insurance-cost-without-subsidy.
[19] https://www.mdanderson.org/patients-family/becoming-our-patient/planning-for-care/insurance-billing-financial-support/insurance-plans.html (Accessed on March 20, 2023).

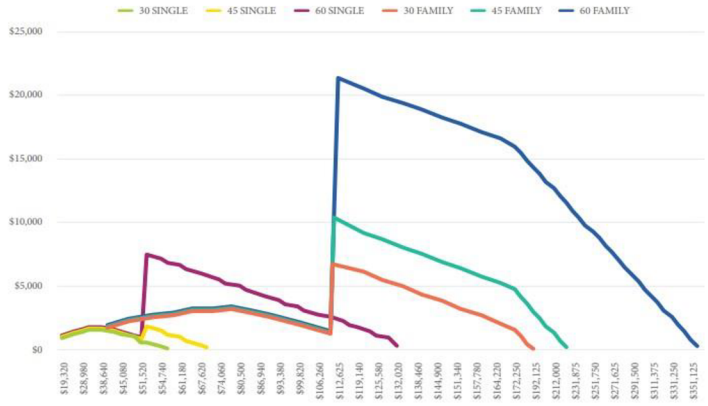
subsidies for this coverage from 2021-2022. ARPA increased the amount of taxpayer assistance that people receive to purchase exchange plans in two ways. First, it reduced what people with income between 100 and 400 percent of the federal poverty level (FPL) need to pay for a benchmark plan. Second, it lifted the cap on subsidy eligibility at 400 percent of the FPL. The Inflation Reduction Act (IRA) continued the expanded subsidies through 2025.

According to CBO, the enhanced subsidies were the most inflationary part of the IRA and reduce work and economic output.[20] The typical exchange enrollee now pays only about 15 percent of premiums, with taxpayers picking up the other 85 percent. Here are half a dozen additional problems.

First, as the figure below (taken from a report I authored for the Galen Institute in 2021)[21] demonstrates, the relatively wealthy receive far more benefit from the subsidy expansion than lower-income families. The figure shows the benefit in expanded PTCs for six different households at various income levels.

FIGURE 1

Increase in Premium Tax Credit Amount for Households at Various Income Levels (2021)



SOURCE: Author's calculations based on the subsidy formula and using national averages for premiums.

NOTE: The figure scale changes at an income of $172,250 so the information can fit on the figure.

In areas of the country where exchange premiums are high, the expansion of the ACA subsidies leads to extremely high taxpayer subsidies for affluent households. For example, the benchmark premium for an exchange plan in Prescott, Arizona, for a family of five with a 60-year-old household head is

[20] Congressional Budget Office, "Economic Analysis of Budget Reconciliation Legislation" Congressional Budget Office, August 4, 2022, https://www.cbo.gov/publication/58357.
[21] Brian Blase, "Expanded ACA Subsidies: Exacerbating Health Inflation and Income Inequality," Galen Institute, June 11, 2021, https://galen.org/assets/Expanded-ACA-Subsidies-Exacerbating-Health-Inflation-and-Income-Inequality.pdf.

$50,923 in 2023.[22] A benchmark plan covers 70 percent of a household's expected health care expenses on average. Of note, the fact that the exchange plan for a family of five can be more than $50,000 a year suggests serious underlying problems with the program.

- If that family made $150,000, they would qualify for a subsidy of $38,173.
- If that family made $350,000, they would qualify for a subsidy of $21,173.
- If that family made $500,000, they would qualify for a subsidy of $8,423.
- This family does not lose subsidy eligibility until they make more than $ 599,000.

Second, the subsidies go directly to health insurance companies, subsidizing their profits even though enrollees may place low value on the coverage and would prefer different health care and health coverage products.

Third, if the subsidies are extended, millions of people will likely lose workplace coverage. This will be especially true of employees at smaller firms since these firms are not subject to tax penalties from the ACA's employer mandate. In fact, CBO projects that about 3.1 million people will replace private unsubsidized individual market insurance or employer-provided insurance with subsidized exchange coverage.

Fourth, the subsidies are inflationary in their design and will drive up health care prices and health spending, as well as prices throughout the economy.

Fifth, the expansion of these subsidies will likely result in an annual federal spending increase of about $30 billion or more, depending on the extent of employer drop as the subsidies are generally larger than the tax revenue loss associated with the tax exclusion for employer coverage. From a federal budget perspective, employer-sponsored health insurance is the least expensive option on average—only about one-third of the budgetary cost of the other main types of coverage for the non-elderly. According to the Congressional Budget Office, the average federal subsidy per enrollee under 65 is $2,000 for employer coverage, compared to a roughly $5,800 cost for Medicaid and CHIP enrollees and individual market exchange enrollees.[23]

CBO estimates that making the expansion of subsidies permanent would increase premium tax credits (PTCs) by $305.5 billion from 2023-2032, with a deficit increase of $247.9 billion. (The deficit increase is less than the PTC cost because of higher federal revenues resulting from a shift in compensation from untaxed health insurance to taxable wages.)

Sixth, the projected PTC cost per newly insured is nearly $14,000 a year over the next decade—a high amount that shows that most of the new spending is simply replacing private spending with government spending.

---

[22] The numbers that appear in this testimony are from the Kaiser Family Foundation's health insurance subsidy calculator. The zip code was 86301 and the information is for two 60-year old adults and children with the ages of 20, 18, and 16.
[23] Congressional Budget Office, "Federal Subsidies for Health Insurance Coverage for People under 65: 2022 to 2032" Congressional Budget Office, March 23, 2022, https://www.cbo.gov/publication/58263.

Unlawful and Unwise "Fix" to the So-Called Family Glitch

Another inefficient enhancement of the ACA subsidies is the unlawful expansion of subsidies promulgated through a Biden administration regulatory action to fix the so-called family glitch. I have previously written at length about the unlawful nature of this action as well as the policy problems.[24] In sum:

The White House press release for the proposed rule stated that about 200,000 additional people would gain insurance coverage on net if this rule were to be finalized. These two estimates together show that the cost to provide health insurance coverage would be a staggering $225,000 over ten years for just one additional person. This huge cost would result from the rule's primary economic effect: replacing employer-financed coverage with public subsidies. And of course, the economic burden from taxation, or deadweight loss, would be significant if this rule is finalized — on the magnitude of several billions of dollars of economic loss each year.[25]

Reforming Federal Health Insurance Subsidies

Policymakers should look for ways to reorient existing expenditures to minimize harmful distortions in the health care market and to expand families' ability to access affordable health insurance coverage and affordable health care services. A guiding principle for reforming government health financing would be to allow Americans to control more of their own money for health care and coverage rather than to continue to have the government control how most of their money is spent. A guiding principle for reforming government health care subsidies should be to permit individuals and families' greater control over the resources instead of having the government pay so much directly to insurers for restricted choices of plans.

Grandfathering Existing Enrollees to Expanded Subsidies

A permanent expansion of the enhanced ACA subsidies would increase inefficient health care spending and, in doing so, would exacerbate inflationary pressures in the economy. For the variety of reasons that I discuss above, Congress should not extend the enhanced subsidies. At the very least, a better option than permanently extending the enhanced subsidies would be to permit existing enrollees to keep the enhanced subsidy but prevent new enrollees from receiving it. A grandfathering policy would mean that no one who currently receives an extra subsidy would lose that subsidy, and it would severely limit the harm from a permanent extension — both minimizing employers dropping coverage and reducing the inflationary and deficit-increasing aspects. Nearly half of exchange enrollees have coverage for less than a year, largely because they get jobs and leave the program for employer-provide coverage. Thus, the number of people with enhanced subsidies will rapidly decline over time, restoring the original subsidy design of the ACA.

HSA Option

Last year, Paragon released a policy proposal that would represent a major reform of the ACA

[24] Brian Blase, "The Case against a 'Fix' for the ACA Family Glitch" Paragon Institute, June 6, 2022, https://paragoninstitute.org/aca-family-glitch-letter/.
[25] Id.

subsidy structure.[26] Our proposal would permit lower-income exchange enrollees to take a portion of the government subsidy that now goes to health insurers as a health savings account (HSA) deposit instead. Currently, exchange enrollees with income below 250 percent of the federal poverty level quality for a cost-sharing reduction (CSR) subsidy that reduces plan deductibles, cost-sharing amounts, and out-of-pocket limits.

This proposal would significantly expand consumer control over their health care, permitting them maximum flexibility for how to use the government subsidy. Giving lower-income exchange enrollees an additional way to use their CSR subsidy expands Americans' welfare since some enrollees would prefer an HSA deposit over the reduction of their plans' cost-sharing components. The HSA funds could be used for a broader set of health services than what a health plan typically covers, help ease family cash flow, accumulate year after year, and better prepare the HSA owner to pay for health care expenses in retirement.

Nearly seven-in-ten enrollees with income below 200 percent of the FPL would benefit from selecting the HSA option, with an average financial benefit of around $1,500 over the year. More than three-quarters of enrollees with income between 200 and 250 percent of the FPL benefit from selecting the HSA option, with a smaller average yearly benefit between $500 and $600.

1332 Waivers

A far more efficient approach than expanding ACA subsidies would be for policymakers to redirect a portion of existing government spending on health care to financing high risk pools or state reinsurance programs. Such an approach, as demonstrated by the 17 states that have used Section 1332 waivers to establish reinsurance programs, would better target federal funds to individuals who have expensive medical conditions or who experience significant spending during a period of time.[27]

Helping Employers and Workers Obtain Affordable Coverage

Roughly half of Americans receive health insurance through their employer or the employer of someone in their family. Typically, employers offer workers comprehensive health insurance that covers a large number of hospitals and doctors. Workers at large firms often receive several different plans from which to choose, while most workers at smaller firms only receive one plan option.

Employers provide coverage for a variety of reasons, including that it is a tax-free employee benefit. Economists universally agree that employees pay for their health insurance — both the employer and employee shares of the coverage — in the form of reduced wages. This reality means that the rising premiums and overall costs for employer coverage have significantly eaten away at wage increases over this period.

According to the Kaiser Family Foundation's survey of employers, the average premium for single coverage was $7,911 and the average premium for family coverage was $22,463 in 2022. In 2000, the respective premiums were $2,471 and $6,438. The premium includes both the employee share as well as the employer share; although referred to as the employer share, this amount is paid for by workers in the form of lower wages.

---

[26] Brian C. Blase, Dean Clancy, Andrew Lautz, and Roy Ramthun, The HSA Option: Allowing Low-Income Americans to Use a Portion of Their ACA Subsidy as a Health Savings Account Contribution, Paragon Health Institute, November 2022, https://paragoninstitute.org/wp-content/uploads/2022/11/202211_Blase_TheHSAOption_DRAFT_11-16-22-V4.pdf.
[27] Doug Badger, "How Health Care Premiums Are Declining in States That Seek Relief from Obamacare's Mandates," Issue Brief No. 4990, The Heritage Foundation, August 13, 2019, https://www.heritage.org/sites/default/files/2019-08/IB4990.pdf.

Over this period, premiums for individual coverage increased 220 percent, and premiums for family coverage increased 249 percent — much greater than the 70 percent increase in overall prices during this period.[28] Although premiums for workplace coverage have increased, the increase in premiums for individual market coverage — which was much more affected by the ACA — rose far more rapidly since 2013.

Premiums for employer coverage increased by about 14 percent between 2013 and 2017, compared to the 105 percent increase in individual market premiums.[29] Using 2013 to 2017 is the best period to measure the effect of the ACA on premiums because the ACA's key provisions took effect in 2014. Additionally, 2017 was the first year without the ACA's transitional reinsurance and risk corridor programs, which were intended to reduce premiums in the ACA's transition period.

Since 2010, when the ACA was enacted, there has been a 30 percent decline in the number of workers covered by employer health benefits at firms with between 3 and 24 workers, a 28 percent decline at firms with between 25 and 49 workers, and a 17 percent decline in the number of workers covered by employer health benefits at firms with between 50 and 200 workers.[30] While there has been a sizeable drop in employees with employer coverage at small firms, coverage at large firms has only had a slight decline.[31]

According to the Kaiser Family Foundation's survey, the number one reason that small employers do not offer coverage is the high cost.[32] Among small firms that do not offer health insurance, 79 percent believe employees prefer higher wages to health insurance benefits, compared to only 12 percent who believe employees prefer health insurance.[33]

Clearly, as premiums have increased, particularly in the individual and small group markets most affected by the ACA, enrollment in private coverage has declined. According to The Heritage Foundation's analysis of insurance data from the National Association of Insurance Commissioners and Mark Farrah Associates as well as Medicaid data from CMS, the number of people with employer coverage declined by nearly six million from 2013 through 2021.[34] Medicaid and CHIP enrollment soared by more than 25 million people during this period.

There are ways to increase affordable health coverage without new federal spending. Many policies implemented by the previous administration expanded affordable coverage options for employers and families without new federal spending.

These policies included:

- expanded coverage options through Association Health Plans (AHPs)

[28] Federal Reserve Bank of Minneapolis, "Consumer Price Index, 1913," Federal Reserve Bank of Minneapolis, accessed March 20, 2023, https://www.minneapolisfed.org/about-us/monetary-policy/inflation-calculator/consumer-price-index-1913-.
[29] According to the Kaiser Family Foundation employer insurance survey, self-only premiums were $5,884 in 2013 and $6,690 in 2017. For family coverage, the respective premiums were: $16,351 and $18,764.
[30] Id, Figure 3.11. In 2022, 31 percent of employees at firms with between 3 and 24 employees were covered by the firm's health benefits. This percentage was 42 percent of employees at firms with between 25 and 49 employees and 50 percent of employees at firms with between 50 and 199 employees.
[31] Id.
[32] Id, Figure 2.14.
[33] Id, Figure 2.16.
[34] Edmund F. Haislmaier, "Health Insurance Enrollment in 2021 and Its Implications for 2023," Heritage Foundation, February 13, 2023, https://www.heritage.org/sites/default/files/2023-02/IB5303.pdf.

- new flexible financing methods through individual coverage health reimbursement arrangements (HRAs) which built off qualified small employer health reimbursement arrangements (QSEHRAs), and
- price transparency policies intended to improve the functioning and efficiency of health care markets.

Association Health Plans (AHPs)

All employers — especially small employers — need additional options to provide coverage to their workers. One such option is to permit employers to band together to offer coverage through Association Health Plans. While AHPs have existed for decades, employers needed to have a close nexus in order to join together and offer coverage. For example, dental practices could form an AHP, but a dental practice and an auto mechanic shop in the same town could not.

In June 2018, the Department of Labor finalized a rule creating a new pathway for any employer, including sole proprietors, within a state and or common metropolitan area to join together and offer coverage through an AHP. This rule provided smaller employers a way to gain the regulatory advantages and economies of scale that large employers receive when offering health insurance.

As discussed in a *Washington Post* piece from early 2019, the AHP expansion had a promising start with most new AHPs launched by regional chambers of commerce.[35] According to the *Washington Post*, "there are initial signs the plans are offering generous benefits and premiums lower than can be found in the Obamacare marketplaces."[36] The *Post* wrote that an analysis of the new plans showed they offered benefits comparable to most workplace plans and did not discriminate against people with preexisting conditions.[37] A study by the Foundation for Government Accountability found that new AHPs produced savings of 29 percent on average.[38] One local chamber of commerce that enrolled hundreds of employers was projected to save policyholders more than $2,000 on average.[39] The Congressional Budget Office projected that these new AHPs would cover as many as 4 million people by 2023, half a million of whom would have been uninsured.[40] Unfortunately, a March 2019 decision by a federal judge invalidated this new pathway.[41] Although the Department of Justice appealed this decision and the appellate court heard arguments in November 2019, the court granted the Biden administration's motion to pause the appeal while the DOL considers further agency action.

---

[35] Paulina Firorzi, "The Health 202: Association health plans expanded under Trump look promising so far," Washington Post, January 30, 2019, https://www.washingtonpost.com/news/powerpost/paloma/the-health- 202/2019/01/30/the-health-202-association-health-plans-expanded-under-trump-look-promising-so- far/5c50ba751b326b29c3778d05/.
[36] Id.
[37] Id.
[38] Hayden Dublois, "Association Health Plans Work: How the Trump administration expanded access to affordable & quality health care," October 27, 2020, Foundation for Government Accountability, https://thefga.org/wp-content/uploads/2020/10/AHPsWork-Trump-admin-expanded-access-to-affordable-quality-health-care.pdf.
[39] Eugene Scalia, "How the Labor Department is defending your access to association health plans," *Washington Examiner*, November 12, 2019, https://www.washingtonexaminer.com/opinion/op-eds/how-the-labor-department-is- defending-your-access-to-association-health-plans.
[40] "How CBO and JCT Analyzed Coverage Effects of New Rules for Association Health Plans and Short-Term Plans," CBO, January 2019, https://www.cbo.gov/system/files/2019-01/54915-New_Rules_for_AHPs_STPs.pdf.
[41] In July 2018, a coalition of 12 Democratic attorneys general filed a lawsuit challenging the final AHP rule for violating the Administrative Procedure Act. The attorneys general argued that the DOL's interpretation of "employer" was inconsistent with ERISA and the rule was intended to undermine the ACA. On March 28, 2019, Judge John D. Bates of the U.S. District Court for the District of Columbia found that the AHP rule was "clearly an end-run around the ACA" and struck down most of the rule. Judge Bates found that allowing any employers within a state or common metro area to join together did not meaningfully limit the types of associations that could qualify to sponsor an ERISA plan and that the working owner provision is inconsistent with ERISA, which is to regulate benefit plans that derive from employment relationships.

Given the litigation challenges and the Biden administration's apparent opposition to AHPs, congressional action is likely necessary for businesses to benefit from the new AHP pathway. As projected by CBO, these new AHPs would help hundreds of thousands of businesses and millions of employees obtain more affordable health coverage and would reduce the number of uninsured. This increase in health coverage would involve no new federal spending.

ICHRAs and QSEHRAs

In June 2019, the Departments of Health and Human Services, Labor, and the Treasury issued a rule creating individual coverage Health Reimbursement Arrangements (ICHRAs). Like AHPs, ICHRAs should be bipartisan. They work within the ACA's basic framework and should significantly increase individual market enrollment.

As of January 1, 2020, employers have been able to provide tax-preferred contributions through an ICHRA, which their employees can use to purchase the individual market plan that work best for them. Most employers that offer health insurance only provide workers with a single option, so the HRA rule has the potential to significantly increase worker choice and control over their health insurance. Employees are currently limited to purchasing ACA- compliant plans in the individual market, although Congress could permit employees to use their HRAs to purchase a broader set of plans.

ICHRAs will help employers attract and retain employees, gain greater predictability over their health costs, and reduce administrative expenses, allowing them to better concentrate on their core business purpose. The rule should help reverse the decline in small employers that offer coverage to their workers. Moreover, the rule contains significant flexibilities for larger employers to offer coverage to part-time workers or hourly workers.

According to estimates provided in the June 2019 rule, 800,000 employers will offer ICHRAs, and more than 11 million people will receive individual market coverage using this type of HRA by the middle of this decade.[42] This rule is expected to reduce the number of people without health insurance by about one million.[43] According to the Departments' analysis, "Most of these newly insured individuals are expected to be low- and moderate-income workers in firms that currently do not offer a traditional group health plan."[44] Similar to AHPs, the increase in insured people through ICHRAs involves no new federal spending.

ICHRAs have similarities to Qualified Small Employer Health Reimbursement Arrangements (QSEHRAs), which Congress enacted in a bipartisan basis in 2016. QSEHRAs permit employers with no more than 50 full-time employees to reimburse individual market premiums. QSEHRAs have some limitations that do not apply to ICHRAs, such as setting an overall limit on the amount the employer can reimburse as well as a prohibition of creating classes of employees to vary benefit offerings. However, QSEHRAs represent a valuable coverage option for many small businesses and their employees.

Congress could codify the 2019 HRA rule to enhance employers' certainty about the future of defined contribution health insurance. Policies that improve the individual market would boost the opportunity

[42] Department of the Treasury, Internal Revenue Service, 84 Fed. Reg. 28959 (June 20, 2019) https://www.govinfo.gov/content/pkg/FR-2019-06-20/pdf/2019-12571.pdf.
[43] Id, at 28965
[44] Id.

for employers and employees to benefit from ICHRAs. One such policy would be to permit states greater flexibilities over benefit requirements and pricing, such as widening the three-to-one age rating restriction in the ACA. There is not yet good data on the uptake of ICHRAs, and there is a lot of education needed to ensure that employers and brokers understand them. Moreover, migration to ICHRAs has been affected by employers' understandable focus on weathering the pandemic as well as a general risk aversion to changing employee benefits in such a tight labor market.

Price Transparency

In 2019, HHS finalized a rule requiring hospitals to post complete price information starting in 2021. In 2020, HHS with the Departments of Labor and Treasury finalized a separate rule that requires health insurers and health plans to post complete price information starting this year.

Price information can enable both individual consumers as well as employers to be better shoppers of health care. Price information is particularly important in health care because it is a large part of the typical families' budget and because there is significant variation in prices — with prices for the same service often varying by magnitudes, even within the same geographic area.

I analyzed these requirements and their potential impact in a 2019 report.[45] Expanded price transparency should result in five benefits.

- First, price transparency will encourage more consumers to shop and obtain lower prices.
- Second, price transparency will help employers establish better payment structures. These payment structures include reference pricing models, in which the plan sets a payment rate regardless of which provider delivers the service and which have been shown to generate significant savings.
- Third, price transparency will better enable employers to monitor the effectiveness of their insurers by comparing different rates received by providers across payers and across regions.
- Fourth, transparent prices should help employers eliminate counterproductive middlemen and contract with other entities that will incentivize employees to utilize lower-cost providers, including ones outside of their local region.
- Fifth, just as sunlight is often the best disinfectant, price transparency will better enable consumers and the broader public to hold providers accountable when prices reach outrageous levels.

Disappointing Health Benefits from Government Coverage Expansion

While access to affordable health coverage and care are important, it is vital for policymakers to recognize two key facts. First, a large amount of medical spending is wasteful — with some of it even harmful to patients. Second, health insurance expansions, particularly through government programs such as Medicaid, tend to have disappointing results in terms of health improvements.

[45] Brian Blase, "Transparent Prices Will Help Consumers and Employers Reduce Health Spending," Galen Institute, September 27, 2019, https://galen.org/assets/Blase_Transparency_Paper_092719.pdf.

A significant concern with our high medical spending is that a large share of it — estimated by some researchers to be 25 percent of spending as mentioned above — does not provide Americans with any benefit.[46] In fact, some of that spending may instead harm our overall health. A 2016 study found that medical errors are the third leading cause of death in the United States and as many as 250,000 people die each year from errors in hospitals and other health care facilities.[47] Medical tests and treatments all carry some risk. Those that are unnecessary will result, on balance, in harm to patients.[48]

The impact of health insurance on health is not as clear or as positive as commonly believed. At a macro level, despite the significant increase in health coverage beginning in 2014 as a result of the ACA, American life expectancy declined for three straight years from 2014 through 2017.[49] The 2018 Economic Report of the President by the White House's Council of Economic Advisers (CEA) put it this way:

[T]he evidence shows that health insurance provided through government expansions and the medical care it finances affect health less than is commonly believed. Determinants of health other than insurance and medical care — such as drug abuse, diet and physical activity leading to obesity, and smoking — have a tremendous impact and have exacerbated recent declines in life expectancy, despite the ACA's increased coverage.[50]

The CEA report evaluated numerous studies, including the two well-known health insurance experiments — the RAND health insurance experiment and Oregon's Medicaid experiment — in its conclusion that expansions of government coverage produce limited health benefits. They suggest at least four reasons why health insurance, through government coverage expansions, have a minimal effect on health.

According to the report, "The first three of these reasons — that the uninsured were often able to obtain care before coverage, access problems for patients who gain Medicaid coverage, and mandated insurance benefits that have a minimal impact on health — are particularly salient when examining the results of the ACA coverage expansion."[51]

The fourth reason raised by CEA is that "public coverage may have limited or possibly negative effects on health because of its long-run impact on innovation. Many governments, particularly in Europe, have paired large coverage expansions with the imposition of price and spending controls. These centralized controls may have an adverse impact on medical innovation and make healthcare less effective and more costly to obtain in the future."[52]

The lack of clear health benefits from the expansion of Medicaid, which I detailed in a report released

---

[46] William H. Shrank, Teresa L. Rogstad, and Natasha Parekh. "Waste in the US Health Care System: Estimated Costs and Potential for Savings." JAMA. 2019 Oct 15;322(15):1501-1509. doi:10.1001/jama.2019.13978. https://pubmed.ncbi.nlm.nih.gov/31589283/.
[47] Martin A. Makary and Michael Daniel. "Medical error — the third leading cause of death in the US." *BMJ* 2016;353:i2139, https://www.bmj.com/content/353/bmj.i2139 (published May 3, 2016). [18] Atul Gawande
[48] Atul Gawande. "OVERKILL." *The New Yorker*, May 11, 2015, https://www.newyorker.com/magazine/2015/05/11/overkill-atul-gawande.
[49] Owen Dyer, "US life expectancy falls for third year in a row," *BMJ* 2018;363:k5118, https://doi.org/10.1136/bmj.k5118 (published December 4, 2018).
[50] *Economic Report of the President with The Annual Report of the Council of Economic Advisors*, February 2018, https://www.govinfo.gov/content/pkg/ERP-2018/pdf/ERP-2018.pdf.
[51] Id.
[52] Id.

in the spring of 2020, should raise policymakers' concern about additional subsidies that simply expand government spending on the current structure.[53] I concluded that large coverage expansions disappoint for several reasons: the uninsured receive nearly 80 percent as much care as similar insured people, the crowd-out of potentially superior private coverage, and the indirect effects on others such as longer wait times for care.

Furthermore, the ACA's model of subsidization results in direct payments from the government to health insurance companies. A 2018 report from the Council of Economic Advisers found that health insurer profitability had soared—more than doubling the growth of the S&P 500 in the first four years of the ACA's enactment.[54] Both the design of the ACA's premium subsidies as well as the ACA's Medicaid expansion were inflationary and resulted in high payments to health insurance companies. There have been a variety of news stories documenting how these programs that are intended to benefit lower-income Americans have produced windfall profits for health insurance companies.[55]

Adverse Consequences of New Government Price Controls for Pharmaceuticals

One of the few constraining factors on increasing health costs in recent years has been innovation.[56] For example, the inflation measure for prescription drugs shows that drug prices have been relatively flat while overall prices have soared.[57] Yet it was in this environment that lawmakers enacted sweeping new powers for the Secretary of Health and Human Services to set pharmaceutical prices and impose penalties on manufacturers that raise prices faster than inflation. These provisions will increase launch prices, make it harder for generics to come to market, and reduce the incentive for innovators to bring new drugs to market.[58] According to University of Chicago economist Tomas Philipson, who was the chairman of the White House Council of Economic Advisors from 2019-2020, the pricing provisions in the Inflation Reduction Act (IRA) will significantly reduce the number of new drugs, lowering both the quality and longevity of Americans' lives.[59]

Conclusion

Renowned health economist and Harvard Business School professor Regina Herzlinger has written that "choice supports competition, competition fuels innovation, and innovation is the only way to make things better and cheaper."[60] Unfortunately, government policies—despite good intentions—

[53] Brian Blase and David Balat, "Is Medicaid Expansion Worth It?" Texas Public Policy Foundation, April 21, 2020, https://www.texaspolicy.com/wp-content/uploads/2020/04/Blase-Balat-Medicaid-Expansion.pdf.
[54] The Council of Economic Advisors, "The Profitability of Health Insurance Companies," The Council of Economic Advisors, March 2018, https://trumpwhitehouse.archives.gov/wp-content/uploads/2018/03/The-Profitability-of-Health-Insurance-Companies.pdf#:~:text=Despite%20significant%20initial%20financial%20losses%20in%20the%20individual,taxpayers%20fund%20almost%20all%20of%20the%20higher%20premiums.
[55] Chad Terhune and Anna Gorman, "Insurers Make Billions off Medicaid in California during Obamacare Expansion" Los Angeles Times, November 5, 2017, https://www.latimes.com/business/la-fi-medicaid-insurance-profits-20171101-story.html.
[56] Joel Zinberg, "Drug Prices Haven't Been Going Up," The Wall Street Journal, December 26, 2021, https://www.wsj.com/articles/drug-prices-havent-been-going-up-generics-inflation-caps-biden-costs-innovation-11640533671.
[57] Id., The inflation measure, cpi-Rx, measures price changes of drugs purchased with a prescription at a retail, mail order, or internet pharmacy. Prices reported represent transaction prices between the pharmacy, patient, and third party payer, if applicable.
[58] Phillip L. Swagel, "Cbo.gov," *Cbo.gov*, August 4, 2022, https://www.cbo.gov/system/files/2022-08/58355-Prescription-Drug.pdf.
[59] Tomas J. Philipson, "'Inflation Reduction Act' Main Impact Is To Cut Health, Not Inflation," Newsweek, August 2, 2022, https://www.newsweek.com/inflation-reduction-act-main-impact-cut-health-not-inflation-opinion-1729324.
[60] Regina Herzlinger, *Who Killed Health Care?: America's $2 Trillion Medical Problem - and the Consumer-Driven Cure*, McGraw-Hill, 2007.

often stifle choice, competition, and innovation in health care. Furthermore, these programs and policies produce incentives that lead to waste rather than value in our health care expenditures.

- Government mandates have pushed up the price of insurance. The high price of insurance necessitates large subsidies, so people can afford the coverage.
- Government restricts people from buying coverage that works best for them and prevents small employers from joining together to gain the same advantages that large employers obtain in their coverage.
- Government contributes to higher health care prices and overall inflation with poorly designed subsidies.

Although increasing subsidies may be tempting, expanding inefficient health care subsidies makes health care less affordable. Government spending replaces private spending that would have otherwise occurred. Government subsidies often permit insurers to raise premiums with taxpayers on the hook for the higher premium cost. The subsidy cost of nearly $14,000 per newly insured from the expansion of exchange premium subsidies by the American Rescue Plan Act and Inflation Reduction Act is testament to this inefficiency. Two main subsidy reforms I presented above would be permitting the enhanced PTCs to expire after 2025 and permitting exchange enrollees to receive their cost-sharing reduction subsidy as an HSA deposit.

Fortunately, by reforming existing government programs and pursuing policies that promote choice and competition in health care, policymakers can expand access to affordable health coverage without new government spending.

The following policies, if fully implemented, would help millions of families, and reduce the number of uninsured by a projected two million people—all without any new federal spending:

- Association Health Plans, which offered significant savings to small employers for high-quality coverage.
- Individual coverage health reimbursement arrangements, which permit employers a way to provide health coverage in ways that employees may prefer.
- In addition to the expansion of coverage opportunities, new price transparency rules that are properly implemented can improve the functioning of health care markets and expand opportunities for consumers and employers to maximize value from their expenditures.

Lastly, policymakers should avoid centralized regulatory or price controls that would diminish health care innovation. Rather policymakers should pursue policies that create a climate conducive to innovation in which entrepreneurs are best serving patient needs.

Thank you for the opportunity to testify before the Committee today, and I look forward to your questions.

Chairman BUCHANAN. Thank you.

Ms. Kerrigan, you are now recognized.

STATEMENT OF KAREN KERRIGAN, PRESIDENT AND CEO, SMALL BUSINESS AND ENTREPRENEURSHIP COUNCIL

Ms. KERRIGAN. Good afternoon, Chairman Buchanan and Ranking Member Doggett and members of the committee.

Again, my name is Karen Kerrigan. I am the service president and CEO of the Small Business and Entrepreneurship Council, SBE Council.

It is an honor to be with you this afternoon to explore how high costs are impacting small businesses and possible ways we can strengthen and improve affordable health coverage and increase flexible choices for entrepreneurs and their employees.

Access to health care has remained a core issue for our network of small business owners since our founding nearly 29 years ago. Both in good economic times and in bad, the cost of health care has remained one of their top issues of concern.

Obviously, the sting of higher cost is felt more acutely during challenging periods or times of high inflation and economic uncertainty, as we are currently experiencing.

And, indeed, inflation and higher costs are hitting small businesses hard. These increases stretch across inputs including health coverage cost.

Inflationary pressures have been a painful drag over the past year or more, and recent surveys show that inflation continues to rank as the top concern. An Upswell Small Business Owners survey reports that 47 percent of respondents cite inflation as their top concern, 17 points higher than a year ago.

A February 2023 Goldman Sachs 10,000 Small Businesses Survey reported that inflationary pressures worsened over the past three months for 72 percent of the business owners polled.

Higher health coverage costs are adding to the pressure. An October 2022 survey by Small Businesses for America reported that 41 percent of small business owners said that the rising cost of health insurance caused them to increase prices of goods and services.

These cost pressures come on top of the challenges small business owners are facing when it comes to finding and retaining workers and upward pressure on labor costs, in general.

Indeed, next to inflation being ranked as a top challenge, filling job openings ranks as a close second or on par with inflation. That is why business owners view benefit offerings, such as health coverage, as a competitive necessity in their efforts to attract and retain employees.

Health coverage costs have been increasing every year. 2023 is no different. Many of our small business members have reported increases in their range of five percent to 20 percent. This is unsustainable, especially in the current environment.

As my written testimony points out, small business owners place high importance on access to health coverage. When asked to identify the biggest benefit of offering health coverage, business owners say it is to promote the health and wellbeing of their employees. That is, providing health coverage is the right thing to do.

But only 17 percent of small business owners believe that the health care solutions available to them have kept up with changing times. They want policies that provide them with choices, relief, and incentives.

In our survey, 72 percent believe that employers and employees, not the government, should decide which health plan to offer workers.

Congress can support small businesses by reforming existing programs, options, and policies, and make targeted improvements that we need to increase small business coverage.

In my written testimony, I note areas for possible reform, enhancing the small business health care tax credit, making targeted fixes to QSERHRAs, enhancing health savings accounts, and tax changes that would produce equity for the self-employed regarding their ability to exclude health insurance premiums from the self-employment tax.

SBE Council looks forward to exploring these solutions and others, including how telehealth, emergent technologies, and Web3 can play a growing role in delivering quality care in cost effective and innovative ways.

Obviously, the health and wellbeing of all of our citizens are critical to the competitiveness of our Nation. Certainly this is a vital issue that drives the liability of so many of our Main Street businesses and firms.

I look forward to our discussion today and follow-up conversations in the future that will lead to meaningful reforms for small businesses and their employees.

Thank you.

[The prepared statement of Ms. Kerrigan follows:]

Testimony of Karen Kerrigan before the U.S. House Ways and Means Committee
"Why Healthcare is Unaffordable: The Fallout of Democrats' Inflation on Patients and Small Businesses"
March 23, 2023

My name is Karen Kerrigan and it is an honor to be a part of this important Committee hearing today to discuss the ways we can strengthen and improve affordable health coverage and options for entrepreneurs, small businesses and their employees. Similar to the importance that small business owners and entrepreneurs place on access to health care, our organization is passionate about access to quality health care and wellness for all Americans. Indeed, when asked to identify the biggest benefit of offering health insurance coverage, small business owners say it is to promote the health and well-being of their employees.[1] That is, providing access to health care and health coverage is the right thing to do.

I serve as president & CEO of the Small Business & Entrepreneurship Council (SBE Council), a nonprofit advocacy, research and education organization dedicated to promoting entrepreneurship and protecting small business. SBE Council's network of small business owners and entrepreneurs stretches across all sectors of the economy and all areas of the country – from urban to exurban, suburban to rural. As you are well aware, small businesses are the backbone of the U.S. economy, employing 61.7 million Americans totaling 46.4% of private sector employees.[2] Their resiliency over the past three years or more in the face of unprecedented challenges has been extraordinary, and it is critical that policies and programs meet their evolving needs to ensure local economies – and our national economy – remain vibrant, competitive and resilient. Helping small businesses with their human capital needs is critical to that end, which is why SBE Council is highly engaged with our business allies on many fronts, including the Critical Labor Coalition, Small Business Roundtable and Council for Affordable Health Coverage, among other collaborative efforts.

Since our founding more than 28 years ago, SBE Council has worked to strengthen and improve the ecosystem for healthy startup activity and small business growth. Access to - and the cost of - health care and health coverage have remained core issues for our network of small business owners since our founding. In good economic times and in bad, the cost of health care has remained a top issue of concern for America's small business and self-employed sector. Obviously, the sting of higher costs is felt more acutely during challenging periods, or times of high inflation and economic uncertainty, as we are currently experiencing.

Inflation and higher costs are hitting small businesses hard, and these increases stretch across inputs, including health coverage costs. Inflationary pressures have been a drag on small businesses over the past year or more and recent surveys of small businesses show that "inflation" continues to rank as top concern. For example:

---

[1] SBE Council/Morning Consult Survey, "Small Business Health Care Benefits," June 30, 2021, PowerPoint Presentation (sbecouncil.org)

[2] U.S. SBA Office of Advocacy, "Frequently Asked Questions About Small Business 2023," March 7, 2023, Frequently Asked Questions About Small Business 2023 – SBA's Office of Advocacy

● In a recent Upswell Small Business Owners Sentiment Survey, over 47% of small business owners cite inflation as their top concern (17 points higher than a year ago) – "73% of small businesses experienced increased costs in 2022 and 68% of those businesses passed some or all of those increases on to their customers."[3]

● A February 2023 Goldman Sachs 10,000 Small Businesses survey reported that inflationary pressures worsened for small businesses over the past three months for 72% of business owners polled.[4]

Higher health coverage costs are adding to the pressures of small business owners.

These cost pressures come on top of the challenges small business owners are facing when it comes to finding and retaining workers, and upward pressure on labor costs in general. Indeed, next to inflation being ranked as a top challenge for small businesses, filling job openings ranks as a close second or on par with inflation for most small businesses. That is why small business owners view benefit offerings, such as health coverage, as a competitive necessity in their efforts to attract and retain employees. In SBE Council's Morning Consult survey with the U.S. Hispanic Chamber of Commerce, we found that next to promoting the health and well-being of their employees, small business owners say that offering health coverage is critical to retaining current employers and reducing turnover and helping them attract employees in the competitive job market.[5] But again, coverage costs are steep and prices continue to rise.

According to the Kaiser Family Foundation in its 2022 Employer Health Benefits Survey released in October of 2023, "The average annual premium for single coverage for covered workers in small firms ($8,012) is similar to the average premium for covered workers in large firms ($7,873). The average annual premium for family coverage for covered workers in small firms ($22,186) is similar to the average premium for covered workers in large firms ($22,564)."[6]

For 2023, prices have gone higher.[7] Many of our small business members have reported increases in the range of 5%-15%. This is unsustainable, especially in the current environment.

Steep costs and rising premiums are why many small businesses simply cannot afford health insurance benefits for their employees. According to SBE Council's survey on health coverage, more than half (55%) of small business owners cited high costs as a barrier to offering health

---

[3] Upswell Small Business Sentiment Survey, February 2023, 2023SMDSentimentSurvey.pdf (hubspotusercontent-na1.net)

[4] Goldman Sachs/10,000 Small Businesses Survey, "Small Business Owners Give the Federal Government Low Grades for Effectiveness of Programs, Services and Tax Credits Available to Small Businesses," Feb. 6, 2023, Goldman Sachs | 10,000 Small Businesses Voices: Survey: Small Business Owners Give the Federal Government Low Grades for Effectiveness of Programs, Services, and Tax Credits Available to Small Businesses

[5] Ibid, page 1.

[6] Kaiser Family Foundation, "2022 Employer Health Benefits Survey," October 27, 2022, Section 1: Cost of Health Insurance – 10020 | KFF

[7] Jacqueline Neuber, "As Health Insurance Costs Rise, Employers Weigh the Risks of Offering Too Little," Crains New York, October 28, 2022, As health insurance costs rise, employers weigh the risks of offering too little | Crain's New York Business (crainsnewyork.com)

insurance benefits. Therefore, and not surprisingly, it is estimated that 97% of businesses with more than 50 employees provide coverage for their workers while the offer rate is only 31% for businesses with less than 50 employees.

Small business owners want elected officials and government policies to get this right.

The small business community has been promised lower costs and more choices in the past. For most small business owners, the opposite has occurred. Only one-in-five (17%) of small business owners in our Morning Consult survey strongly agree that the health care solutions available to them have kept up with changing times.[8] They want policies that provide them with choices, relief and incentives, not more government mandates that restrict choices or drive prices higher. In our survey, 72% of small business leaders agree that employers and employees, not government, should decide which health plan to offer workers.[9]

With 89% of small business owners reporting that their full-time employees are very/somewhat satisfied with the health insurance options offered by their place of employment, and 87% reporting that their employer-provided health insurance has a positive impact on reducing employee health care costs, it is SBE Council's view that policies should support and be targeted toward helping more small businesses access private coverage.[10] This is the "sweet spot" for reform. We believe this approach will be more cost-effective for the taxpayer and provide small business employees with better access to health care.

In terms of affordable options for small businesses, Congress can look to existing programs, options and policies and make targeted improvements that would lead to increased small business coverage. For example:

Health Care Tax Credits: Restrictive rules governing the Affordable Care Act's tax credit for small businesses have produced poor uptake and utilization. Loosening wage restrictions, making the credit permanent and less complex, and allowing the tax credit to be used outside of the Small Business Health Option Program (SHOP) – for private coverage – is the type of reform that would produce meaningful results for small businesses and their employees, and is one supported by small business owners in SBE Council's surveys.

The Self-Employment Tax: Self-employed individuals should be fully allowed to deduct the cost of their health insurance premiums. Currently they cannot, which results in an additional 15.3% tax that no other business owner or worker pays.

Health Savings Accounts (HSAs) and Flexible Savings Accounts (FSAs): The arbitrary limits on Health Savings Accounts and Flexible Spending Accounts need to be reformed and expanded. We support allowing HSA funds to be used to pay premiums and direct primary care expenses. SBE Council supports reforms that would allow individuals to open and contribute to an HSA without the requirement that the individual be covered under a high deductible health plan (HDHP).

---

[8] Ibid, page 1.
[9] Ibid.
[10] Ibid.

Qualified Small Employer HRAs (QSEHRAs), Individual Coverage (ICHRAs): The key drawback in these plans is that neither resulted in a tax-free way to provide additional funds to purchase insurance. The value of the premium tax credit (for those who qualified) deceases via the amount received by the employer. This can be fixed by making QSEHRA and ICHRA funds that small businesses provide additive to the premium tax credits that employees receive in the individual marketplace. The result is more affordable insurance for employees and more incentive for small businesses to offer HRA funds. Business owners should be allowed to participate in these HRA plans.

SBE Council believes there are reform approaches that can be embraced on a bipartisan basis. Our organization looks forward to exploring all of these ideas and more – including how telehealth, immersive technologies and Web3 – can play a role in delivering quality care in cost-effective and innovative ways.

Obviously, the health and well-being of all of our citizens is critical to the competitiveness of our nation. Certainly, this is a vital issue that drives the viability of so many of our Main Street businesses and firms. I look forward to our discussion today, and follow up conversations in the future that will lead to meaningful reforms for small businesses.

Chairman BUCHANAN. Thank you.

Ms. Kelmar, you are recognized.

STATEMENT OF PATRICIA KELMAR, SENIOR DIRECTOR OF HEALTH CARE CAMPAIGNS, U.S. PUBLIC INTEREST RESEARCH GROUP

Ms. KELMAR. Thank you very much, Chairman Buchanan, Ranking Member Doggett, and members of the subcommittee.

I am Patricia Kelmar, the Senior Director for Health Care Campaigns for U.S. PIRG, the Public Interest Research Group.

We are nonprofit consumer advocates who have been working for 50 years to protect consumers.

We are aligned this afternoon in a common mission to identify the best solutions to high prices that we pay so health care can be affordable for everyone.

Every week I interact with patients who contact us for help in solving difficult medical problems. For example, David, an engineer, and Christy, an IT analyst who shared their experience with the birth of their first child last fall.

Baby Theo arrived early and was having breathing difficulties. The doctors at their local hospital recommended specialist care at the nearby children's hospital.

Theo was transferred by ambulance 16 miles to get to the children's hospital, and he was able to receive the care that allowed him to go home with his folks just two weeks later.

The grateful parents had paid their deductible and their out-of-pocket maximum when the hard bill came in. What put them over was the $7,000 bill from the ambulance company. Insurance had paid $1,000, but the couple was shocked to learn that they had to pay the remaining $6,000 because that 16-mile ambulance ride was provided by an out-of-network provider.

They tried negotiating with the health plan and the ambulance company, unsuccessfully. They had to set up a 30-month payment plan with the ambulance company, which means that Baby Theo will be almost three years old by the time they end up paying off that medical debt.

Circumstances like this can set families back for years, struggling to pay for expensive medical bills that they cannot control or negotiate.

In the U.S., we rely on several different types of insurance. It comes in public programs, like Medicare, Medicaid, and through private insurance, through our employers or unions or through the ACA marketplace.

Insurance works when everyone has it because we spread the cost of all that care amongst a broader population, and the ACA has enabled us to get most people insured, filling in those gaps.

But when the prices of care are so high, health insurance, no matter how we design it, will not change the amount that we have to spend. Three-quarters of the money that is spent in employer insurance goes to prescription drugs and the services provided at in and out of out-patient hospital facilities.

Prescription drug prices have increased 60 percent in the last ten years. Even with insurance, one in four families find it difficult to fit prescription drugs and medications into their family budget.

They either do not fill their scripts or they skip doses, all resulting in worsening health.

And the high prices charged by hospital-owned facilities make up more than half of our insurance health care expenditures. Tremendous consolidation is driving up prices. With recent vertical integration, those high prices from hospitals are coming into our own family-owned and smaller health care physician practices that are being bought up by the larger conglomerates.

And those prices are set by that larger health care system, not by our local providers.

The patient is the last in that conversation. They are the ones who are paying the prices.

Private equity investment is also growing in the health care sector, and of course, they have to maximize profits for their ROI.

These higher prices have not improved the quality of care. So the most effective way to achieve affordability is to address high prices of prescription drugs, in particular, and hospital-based services. Those are the cost drivers.

And the best way to do that is by improving competition and constraining overcharges in both of those sectors.

You have already made very important headway with the important bipartisan law, the No Surprises Act, which prevents over a million surprise medical bills every month, and with the ability for Medicare to negotiate prescription drug prices in the coming years.

But we can do better. When generic drugs come to market, we know that competition can drive prices down by as much as 80 percent. We need to put an end to the tactics like patent thickets, product topping, and other mechanisms that keep generics and biosimilars from making it to our pharmacy shelves.

We need a menu of tools to address the impact that consolidation has brought on prices and causing them to go up. We need greater enforcement against anticompetitive practices and ensuring that nonprofit hospitals promote and distribute their financial assistance money to people that need them.

States are even experimenting with good ideas like cost containment boards, and California is, frankly, actually making its own medications to address high drug prices.

It is time for bold, innovative price containment ideas to help the millions of insured Americans like Christy and David so they are not staying up at night wondering if that next cancer diagnosis or car accident will end up putting them into bankruptcy.

So thank you very much. I look forward to taking your questions, and thank you for listening to perspective of the consumer today.

[The prepared statement of Ms. Kelmar follows:]

(202) 546-9707
PIRG.org
Info@PIRG.org

Testimony of U.S. PIRG at a House Ways and Means Committee, Subcommittee on Health hearing on Why Health Care Is Unaffordable

Patricia Kelmar, U.S. PIRG Senior Director, Health Care Campaigns
March 23, 2023

Thank you Chairman Buchanan, Ranking member Doggett and members of the subcommittee for this opportunity to discuss the high prices of health care

I am Patricia Kelmar, senior director for health care campaigns for U.S. PIRG, the Public Interest Research Group. With our state PIRG affiliates, I work to promote policies that advance high value health care. Our health care dollars should be spent effectively to achieve high quality outcomes. We are aligned in a common mission today to identify the best solutions to the high prices that we are paying in today's health markets. We know we can do better to bring costs down while achieving better individual care and improving population health.

Every week I interact with members of the public who contact us, usually in their attempt to solve a difficult medical billing problem. For example, David, an engineer, and Christy, an IT analyst, reached out to share their experience with the birth of their first child last fall. Little Theo arrived early and was having difficulty breathing. The doctors at their local hospital recommended specialist care at a nearby children's hospital to properly diagnose and treat their baby. Theo was transferred by ambulance to that hospital 16 miles away. There he was diagnosed with multiple heart and lung diseases and in his two week stay he received the care that allowed him to go home with his family.

Weeks later, David and Christy received a 7,000 bill from the ambulance company. Their insurance company covered $1,000 of it. The couple was shocked to learn it was their responsibility to pay the remaining $6,000. They didn't understand why they still owed this amount, when they had already paid their deductible and their out of pocket maximum. The problem arose because it was an out-of-network ambulance that transported Theo to the specialists. Dave and Christy had received the "balance bill" for the amount not covered by the health plan. Over the following weeks, they tried negotiating with the health plan and the

ambulance company to lower their amount due. Unsuccessful, they decided to set up a 30 month payment plan to pay off the $6,000. Theo will be nearly three by the time that debt is paid off.

Circumstances just like this can set families back for years, struggling to pay for expensive medical bills that they can't control or negotiate.

Insurance allows more people to access health care.

The U.S. relies on insurance programs to help people access health care prevention services and treatment. Insurance works to spread across a broader population the costs of caring for sicker patients, making it less financially devastating for individuals who need the most care. But insurance also is intended to encourage everyone to use health care services to stay healthier and prevent illnesses. In the U.S. we provide insurance through a mix of programs - Medicare, Medicaid, the plans offered on the Marketplace through the Affordable Care Act, and employer-sponsored and union coverage. To spread costs evenly, everyone should be insured. Since its passage 13 years ago, the Affordable Care Act (ACA) has helped cut the uninsured rate nearly in half[1] and thanks to our different programs, only about 8% remain uninsured today.[2]

Health care prices are driving our national health care spending.

Per capita spending on health care is double the average of other wealthy countries.[3] And the major reason is because of U.S. prices for health care. Our prices have been rising every year for decades. The two highest drivers of our national health care expenditure are the prices of prescription drugs, and the prices of inpatient and outpatient hospital services as seen clearly in this example of 2020 data. Hospital services and prescription drugs make up almsot three-

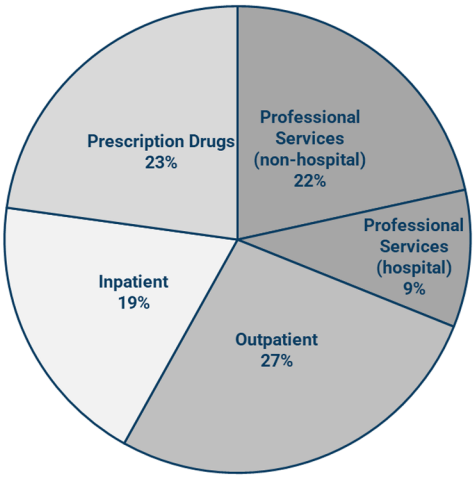
---

[1] Aiden Lee et al., *National Uninsured Rate Reaches All-Time Low in Early 2022* (Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, Aug. 2022) https://aspe.hhs.gov/sites/default/files/documents/15c1f9899b3f203887deba90e3005f5a/Uninsured-Q1-2022-Data-Point-HP-2022-23-08.pdf

[2] See note 1.

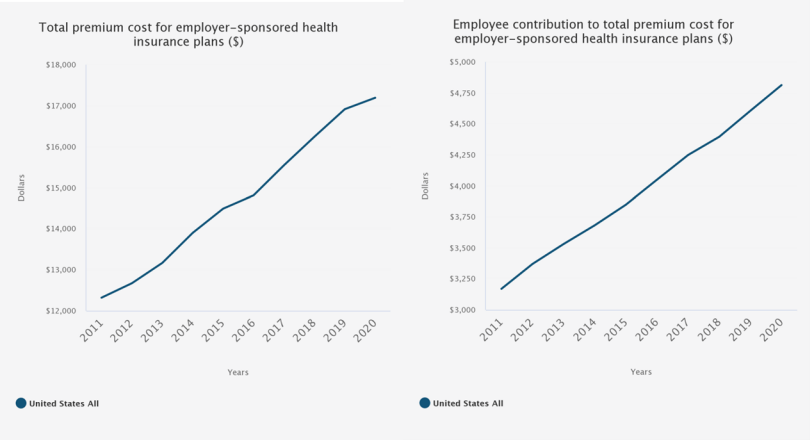
[3] Peter G. Peterson Foundation, Key Drivers of the National Debt, https://www.pgpf.org/the-fiscal-and-economic-challenge/drivers

quarters of the per-person health care spend for employer sponsored insurance. (See chart below).



Source: Health Care Cost Institute, 2020, Per person spend is $5,607. https://healthcostinstitute.org/hcci-research/hccur-data-point-use-and-spending-on-clinician-services-in-hospital-and-non-hospital-settings

Employers and businesses find it difficult to pay for ever increasing costs of employee health care coverage and feel the pressure to offer or design plans that push more of the costs onto their workers, in an effort to keep down premium costs. That results in employees paying more in deductibles, co-payments and co-insurance. The price burden is real and has been growing every year since at least 2011. See chart below.



Source: The Commonwealth Fund: https://www.commonwealthfund.org/datacenter/total-premium-cost-employer-sponsored-health-insurance-plans?performance_area=9356 and https://www.commonwealthfund.org/datacenter/employee-contribution-total-premium-cost-employer-sponsored-health-insurance-plans?performance_area=9356

So even with a good insurance plan by a well-meaning employer, many families still struggle to pay their out-of-pocket share for their health care. And for those with high deductible, minimal coverage plans, the out-of-pocket burden is even higher, and with no ability of the consumer to negotiate a lower price.

But why are prices for medications and hospital services so high? Lack of competition.

The lack of competition in prescription drugs.

U.S. prescription drug spending increased 60% over the last decade[4] and prices continue to rise, sometimes multiple times in a year. Two-thirds of U.S. adults rely on prescription drugs.[5] And yet 1 in 4 people struggle to pay for them.[6] When people can't fit the cost of their medications

[4] I-MAK, "Overpatented, Overpriced Curbing patent abuse: Tackling the root of the drug pricing crisis", September, 2022. https://www.i-mak.org/wp-content/uploads/2018/08/I-MAK-Overpatented-Overpriced-Report.pdf

[5] Emily Ihara, "Prescription Drugs", Georgetown University Health Policy Institute, accessed at https://hpi.georgetown.edu/rxdrugs/#:~:text=More%20than%20131%20million%20people,United%20States%20%E2%80%94%20use%20prescription%20drugs

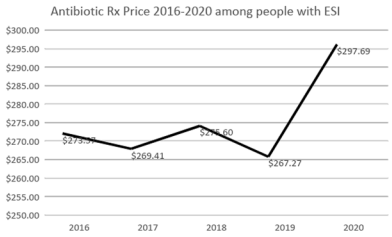
[6] Ashley Kirzinger et al., "Poll: Nearly 1 in 4 Americans Taking Prescription Drugs Say it's Difficult To Afford Their Medicines, Including Larger Shares Among Those With Health Issues, With Low Incomes and Nearing Medicare Ages", KFF, March 1, 2019, https://www.kff.org/health-costs/press-release/poll-nearly-1-in-4-americans-taking-prescription-drugs-say-its-difficult-to-afford-medicines-including-larger-shares-with-low-incomes/

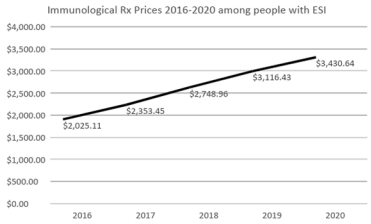
into their monthly budgets, they make decisions that negatively impact their health such as not filling prescriptions or skipping doses.[7] High drug prices impact all insured people, not just those taking medications. Because drug expenses make up 20% of our insurance costs, when drug prices go up[8], employers find it more difficult to keep insurance premiums affordable. High prescription drug prices are also a huge burden on our important taxpayer-funded health programs like Medicare and Medicaid.

What should be done to address prescription drug prices?

What's missing in the drug marketplace is competition. The FDA demonstrated that with the introduction of even one generic competitor, the price for that medication drops by almost 40%, and if we get four competitors, generic prices are almost 80% less than the brand name drug before competition was introduced.[9] Savings from new generic drug approvals are dramatic - $10-20 billion annually.[10] That's the power of a competitive marketplace.

Below you can see rising prices of just some of our most important classes of medications. However, note that in the cardiovascular area, where there are more competitors, prices are trending downwards.



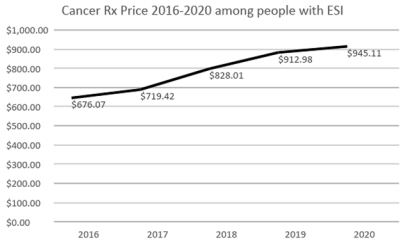


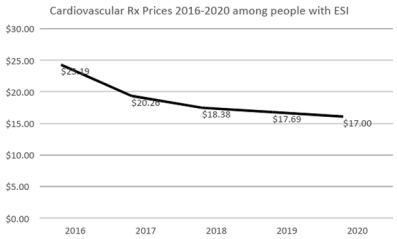
[7] See note 6.

[8] AHIP, "Your Health Care Dollar: Vast Majority of Premium Pays for Prescription Drugs and Medical Care", Americas Health Insurance Plans, September 6, 2022, https://www.ahip.org/news/press-releases/your-health-care-dollar-vast-majority-of-premium-pays-for-prescription-drugs-and-medical-care

[9] FDA, "New Evidence Linking Greater Generic Competition and Lower Generic Drug Prices", 2019 https://www.fda.gov/media/133509/download

[10] Ryan Conrad PhD et al., "Estimating Cost Savings from New Generic Drug Approvals in 2018, 2019, and 2020", US Food and Drug Administration, August 2022, https://www.fda.gov/media/161540/download





Note: Price is price per 30 days supplied

Source: Health Care Cost Institute, Health Care Cost and Utilization Report 2020 Downloadable Data, https://healthcostinstitute.org/health-care-cost-and-utilization-report/annual-reports

Americans love the cost savings of generics. Congress, the Patent and Trademark Office and the FDA should break down the barriers that prevent generics and biosimilars from coming to the market to compete. Pharmaceutical companies are abusing patent law through tactics like product hopping, patent thickets and pay-for-delay.

While brand-name drugs make up only 8% of prescriptions, they account for 84% of all U.S. drug spending.[11] Imagine the kind of savings we could achieve if we made drugs compete in an active market. Without competition from generic drugs, brand-name companies can keep their prices high for decades. It's not just a huge financial hit impacting our insurance premiums and public health programs, but it's a budget buster for our out-of-pocket costs as well.

It's important to focus on all drugs, not just prescription drugs that folks take at home. Data shows even higher price increases for drugs administered in doctor's offices and hospitals, prices increased over 40% for those drugs between 2016-202.[12] Greater oversight of billing practices for these drugs should be conducted. Is this a competition issue, a site-payment issue, or is something else happening with these drugs?

High in- and outpatient hospital prices are rising in the wake of extensive market consolidation.

[11] IQVIA Institute for Human Data Science, *The Use of Medicines in the U.S. 2022*, April, 2022, 39. https://www.iqvia.com/insights/the-iqvia-institute/reports/the-use-of-medicines-in-the-us-2022

[12] HCCUR Data Point: Trends in Total (Administered and Prescription) Drug Spending in ESI, https://healthcostinstitute.org/hcci-research/hccur-data-point-trends-in-total-administered-and-prescription-drug-spending-in-esi

Prices for hospital services are also driving our national health care expenditures. And there is one significant reason: consolidation. Health markets are becoming increasingly concentrated with recent unchecked merger activity, including both horizontal and vertical consolidation among hospitals and physicians.[13] Between 1998 and 2021, there were more than 1800 hospital mergers reducing the number of hospitals in the country from 8,000 to 6,000.[14] In many metropolitan areas, just one health system has the majority of market power.[15] Insurers with only one hospital system in a region have no leverage to negotiate lower market-based prices.

One study found that prices at monopoly hospitals are about 12 percent higher than at hospitals that have 4 or more competitors.[16] Another study found that hospitals that are part of a health system charge 31 percent more for services than hospitals that are not part of a larger system.[17] To be clear, these higher prices do not even result in an improvement in quality outcomes.[18]

Although horizontal consolidation does not impact Medicare prices for physicians or hospitals that are generally paid based on the prospective payment systems, vertical mergers can result in higher Medicare charges. That's because physician offices purchased by a hospital can bill higher Medicare rates by coding the service as a hospital outpatient department, even though it is actually provided in that same physician's office location.[19]

But we know that prices don't have to be high for hospitals to keep their doors open. For example, in 2018 the average price for a knee or hip replacement at an in-network facility in the Baltimore area ($23,000) was half the average price in the New York City Metro area ($58,000).[20] These price differentials are seen across the country and with new transparency laws, we'll soon have a clearer understanding of which hospitals are better at controlling prices, which will make it even more obvious that the competitive market for hospital care is broken.

---

[13] Michael Furukawa et al., "Consolidation of Providers into Health Systems Increased Substantially, 2011-2016" https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2020.00017

[14] Hoag Levins, "Hospital Consolidation Continues to Boost Costs, Narrow Access, and Impact Care Quality, Jan. 19, 2023 https://ldi.upenn.edu/our-work/research-updates/hospital-consolidation-continues-to-boost-costs-narrow-access-and-impact-care-quality/

[15] Health Care Cost Institute, HMI Interactive Report, https://healthcostinstitute.org/hcci-originals/hmi-interactive#HMI-Concentration-Index

[16] Zack Cooper et al. "The Price Ain't Right?" Sept. 2018, https://pubmed.ncbi.nlm.nih.gov/32981974/

[17] Nancy Beaulieu et al. "Organization and Performance of U.S. Health Systems," JAMA, January 2023, https://jamanetwork.com/journals/jama/article-abstract/2800656

[18] Lovisa Gustafsson et al., "The Pandemic Will Fuel Consolidation in Health Care" Harvard Business Review, March 9, 2021, https://hbr.org/2021/03/the-pandemic-will-fuel-consolidation-in-u-s-health-care

[19] Karyn Schwartz, KFF, "What we know about provider consolidation", Sept 2020, https://www.kff.org/health-costs/issue-brief/what-we-know-about-provider-consolidation

[20] Nisha Kurani et al., "Price Transparency and Variation in U.S. Health Services", Jan 2021 https://www.healthsystemtracker.org/brief/price-transparency-and-variation-in-u-s-health-services/

With no cost constraints and almost no competition, employer and private insurers are paying 247 percent of what Medicare would have paid for the same in- and outpatient services services.[21]

Private equity investments in health care are pushing the business of health care toward maximum profits.

Private equity investment is further challenging our health markets, driving prices higher in even more sectors. The impact of a change in ownership to private equity is dramatic and swift. Private equity-controlled practices in the areas of dermatology, gastroenterology, and ophthalmology charged an average of 20 percent more per claim and increased the amount per claim allowed by payers by 11 percent shortly after the acquisition.[22]

There is no doubt that private equity invests in the health care services in which they can charge whatever they want. But when we step in to address their anticompetitive practices, things are better for consumers. When the No Surprises Act banned balance billing by out-of-network air ambulances, private-equity backed air ambulance providers, notorious for staying out-of-network and charging higher prices, quickly started closing helicopter sites, allowing community-based air ambulance providers to serve the area with lower prices. Those same private-equity backed companies however do continue to run their ground ambulances, a service where the surprise billing prohibition does not apply and they can profit off of balance billing.

What can be done to address high prices in hospital-owned settings?

For geographic areas where markets haven't already undergone dramatic consolidation, greater oversight should be given to pending mergers. Regulators should carefully consider past behaviors of health systems and evaluate the potential impact of even "small" mergers on health markets. It is only a temporary fix when regulators approve mergers after gaining promises from the consolidating parties to hold costs down or keep service lines open. Three or five years pass and the promises expire. Regulators should also actively audit and monitor hospital and insurance contracts to ferret out anti-competitive agreements, such as all-or-nothing clauses that force health plans to include higher priced health systems in networks, driving up prices for everyone.

---

[21] Christopher Whaley, Rand Corp., "Nationwide Evaluation of Health Care Prices Paid by Private Health Plans", 2021, https://www.rand.org/pubs/research_reports/RR4394.html

[22] Yashaswini Singh et al. JAMA,"Association of Private Equity Acquisition of Physician Practices With Changes in Health Care Spending and Utilization" Sept 2022, https://jamanetwork.com/journals/jama-health-forum/fullarticle/2795946

States are innovating their own solutions - creating cost containment structures for both prescription drugs (Prescription Drug Affordability Boards) and for overall health care costs, such as the Massachusetts Health Policy Commission and Rhode Island's use of an Affordability Standard. These forays into cost containment can offer some new solutions which Congress should build upon and improve.

Congress should put an end to add-on charges simply because the service is offered in hospital-owned buildings. Consumers can't possibly be expected to figure out whether their physician's office is now owned by a hospital. Prohibit facility fees and establish site-neutral payments to start paying for the actual service, rather than the location of the service.

Additional Congress and regulators could better support employers by translating the new hospital price and health plan transparency data points into a format that can help plans create high value networks with reasonable prices and outstanding quality.

High-priced health care burdens families with medical debt.

In conclusion, it's important to remember that these high prices result in higher medical bills that hurt families in the near term and can have lasting negative financial consequences. One study shows almost 20% of individuals have medical debt with a mean amount of $429.[23] But the patients I'm talking to have bills that are so much higher - and they are desperately trying to figure out how to pay them, knowing they are just one more illness away from losing their car or worse, their home.

Medical debt can carry a long tail. According to the Consumer Financial Protection Bureau, as of mid-2021, 58% of bills in collections and on credit reports were medical bills.[24] Bad credit scores follow people for years, impacting their ability to rent or buy a home. These lasting financial impacts shouldn't be the result when someone finally gets through chemo or survives a car crash.

While we work to get health care prices under control, we need to provide immediate relief to patients who need care.

- Every day I celebrate the millions of surprise out-of-network bills already prevented by the No Surprises Act. But of the 3 million insured patients who ride in an ambulance in the next year, half will be exposed to a potential out-of-network surprise bill. It's time to close that gap, and impose a ban on ground ambulance surprise billing.

---

[23] Raymond Kluender et al, JAMA, "Medical Debt in the U.S. 2009-2020" https://jamanetwork.com/journals/jama/fullarticle/2782187

[24] CFPB Estimates $88 Billion in Medical Bills on Credit Reports, CFPB news release, March 1, 2022, https://www.consumerfinance.gov/about-us/newsroom/cfpb-estimates-88-billion-in-medical-bills-on-credit-reports/

- Congress should require reviews of nonprofit hospitals' financial statements and penalize hospitals which fail to fulfill their mandated nonprofit obligation to offer financial support for vulnerable patients. And hospitals must do a better job notifying patients about their financial assistance policies and help them use it.
- Patients deserve to know what their costs will be before they receive care. Regulations requiring Advanced Explanation of Benefits from insurers should not be delayed (No Surprises Act).
- And because medical debt is unlike other consumer debt, we need new rules against abusive medical debt collection actions. Patients need more time to heal and more time to fight inaccurate bills, up-coding, claim denials, or illegal balance billing. We should prohibit suing patients, garnishing wages or placing liens on homes for debts for medically necessary care.

I look forward to working with members of the subcommittee to work on these and other recommendations to achieve a high value health system that gives us the quality care we desire, without the high price tags we have today. Thank you for your commitment to solving this issue.

Chairman BUCHANAN. Well, thank you.

And I want to thank all of you for your testimonies. Now we will proceed to the question-and-answer part. I will go first.

Ms. Moore, you know, it looked like you had started business back in the 1970s or so, and that is when we first started, but I know for 20 years that I was in business, the first 20, we only had five, ten, 15. We paid for everything, 100 percent. There were no deductibles.

And it seems like in the last ten, 15 years, it has gotten pushed and it is only impacting in a negative way small businesses like yourself, but it has gotten pushed to the families.

Where we used to pay everything, now we pay half or we pay 60 percent. They are picking up 40, and then you wonder why is it that so many people seem to be working paycheck to paycheck.

One of the biggest reasons, in my opinion, is just because of the growth of the cost of health care and having to pick it up. It impacts small business, but that family of four is typically, and every area it is different, but let's say 1,600. But they are paying 700 a month out of pocket.

So what is your experience with that as you look back? Is it the same thing where everything has been accelerated?

I am not looking to place blame, but I am just looking at what the reality is for someone like yourself.

Ms. MOORE. We inherited the health plan when we opened our first doors from the previous owner until that premium period ran out. Back then employees had a $500 deductible.

Like I said, we not only covered employees and dependents. We offered spousal coverage at that time.

With the ACA came the challenges of meeting payroll and also health insurance. Payroll, it was a time in business that, quite frankly, the 2008–2009 recovery time was not coming fast enough for businesses like mine.

So what happened was we dropped that coverage for spouses; and then, we had to decrease the premium contribution, as I said, from 80 to 70, then 60. We ended vision, life, and dental insurance coverage for our employees.

But I am glad to tell you that because of those changes made after 2019 or I guess they were enacted in 2017–2018, we were able to reinstitute not only health insurance but pay 100 percent of a life insurance policy for our employees and all of their dental and vision.

Chairman BUCHANAN. What is your cost for a family of four?

Ms. MOORE. For health insurance?

Chairman BUCHANAN. Yes. You have got an employee, married and two kids. What are you paying per month or per year?

And I am saying not you. Just overall what is the bill? And how do you split it today?

Ms. MOORE. Currently the bill for nine eligible employees who are taking advantage of ours is $7,800, and they are paying a portion of that.

Chairman BUCHANAN. And do you mind me asking? What are they paying, their portion? Are they paying half?

Ms. MOORE. Sixty percent of that. So you are looking at——

Chairman BUCHANAN. Four or 5,000 a year then they are paying.

Ms. MOORE. Yes.

Chairman BUCHANAN. That is my point.

Ms. MOORE. And the median income in our area is about $50,000 per household income, median income.

Chairman BUCHANAN. So that is a lot of money, 4,000.

Ms. MOORE. That is a whole lot of money.

Chairman BUCHANAN. And I want to touch because it is not about tax, but you did say 199(a) because you are a pass-through entity, and you took advantage of that, that 20 percent reduction, because a lot of people do not understand it passes through you, yourself, and if you are married, your husband.

But explain that a little bit more, how that made the difference for you, that 199(a). It is just obviously less taxes and you are able to cover more for the employees. Is that what happened?

Ms. MOORE. That is exactly what happened.

And in addition to that, we were able to take some of that income and boost our inventory. Our inventories had been dwindling because the cost of inventory was escalating. So that 20 percent not only helped us cover health insurance. It helped us meet some other significant expenses for our business.

Chairman BUCHANAN. Let me just switch gears here a little bit.

Mr. Niswander, let me ask you. In your business you have what, nine employees did you say?

Mr. NISWANDER. Yes, we have 11 including me and my wife.

Chairman BUCHANAN. Okay. Let me ask you about your patients. You are in a rural community. What are they doing for insurance? Are most of them on Medicare or Medicaid?

But what are the small business people or people who are trying to buy insurance that do not have that coverage? Someone mentioned that 50 percent of people have some insurance through the government or whatever, but there is another 50 percent or more, whatever that number is, that does.

So you have got your experience, but what are you finding about just the rural community in general in terms of who pays what and how much?

Mr. NISWANDER. In our practice, about 40 percent of our patient load is Medicare or Medicaid insured patients.

Chairman BUCHANAN. Okay. And then in terms of the people that do not have the coverage, what are they doing for insurance?

They come into your office. Do they have insurance, small business people like yourself?

Mr. NISWANDER. The ones that we see in our community that are covered under Medicaid and ACA coverage, oftentimes do not come to our office because of the looming figure of that $14,000 deductible that blue collar working families like myself just do not have in the bank.

Chairman BUCHANAN. Yes. I saw a poll today, and I am glad to get it out to everybody, but they were saying, which was shocking to me, 40 percent of people do not go to the doctor for something because they cannot afford to pay for it and 25 percent of that or let's say 25 percent of the total basically have real issues

and they are serious issues and they know they need a doctor, but they do not do it because they cannot afford to pay the bill.

Thank you, and now I will recognize the gentleman from Texas for any questions he might have.

Mr. DOGGETT. Thank you, Mr. Chairman.

And to all of our witnesses, you know, it really is remarkable that today we are celebrating the 13th anniversary of the Affordable Care Act. It has been amazingly resilient. It survived literally dozens of attempts in this committee and other places within the Congress to substitute Nothing Care for Obamacare. It has been all the way to the Supreme Court three times with one lawsuit after another, and it has been upheld.

And we have had four years of sabotage by President Trump. I think that against that background the fact that so many Texans decided last year to vote themselves by enrolling in the Affordable Care Act is an indication of the value that it offers.

Let me ask you, Ms. Kelmar, before the Affordable Care Act, we are all concerned about rising prices today, but before we had an Affordable Care Act, were health care prices or goods and services soaring and high above the ordinary cost-of-living index?

Ms. KELMAR. Health care prices have been rising for decades. It has been higher than inflation, and it has continued to rise. So yes.

Mr. DOGGETT. What about those individuals who have no coverage at all. Providing people Nothing Care so that they are without insurance, what will that do in terms of decreasing health care costs?

Ms. KELMAR. The average amount of money in a person's savings account in the U.S. is about $400, and when we can see just one simple ambulance bill being, you know, $6,000, we just know that folks do not have that kind of money to pay off a bill in an emergency situation, let alone be able to go to the doctor for their regular preventative checkups.

That is why insurance is so important, because it allows us to spread the costs among wider populations, helping everyone to be able to access that care that they need, whether they are healthy or very sick.

Mr. DOGGETT. How about these junk insurance policies that President Trump was so fond of that excluded essential services? Some of them had preexisting condition limitations.

What do those do to reduce the cost of health care?

Ms. KELMAR. So the best insurance is the one that is promoting the primary care and the preventive services and covers those kinds of treatments, and then makes sure that we are trying to look at the broader population health.

So when we have gaps in coverage and the important treatments are not provided, then people ignore the care or cannot get the care and/or alternatively, they are going into debt to get the care, which makes them a less active member of society and the economy.

So it is really important that our insurance programs are reliable, trustworthy, that we can depend on them to provide the care that we need, but that is the reason why we really need to get at the price issue, because prices of insurance are going up because

of the payouts to the drug companies and to the hospitals for that care.

So we need to get a handle on those prices, and we need to probably come up with a menu of solutions in order to address them.

Mr. DOGGETT. And I believe you had a statistic about drug price inflation. Of all the forms of health care inflation, are not drug prices right at the top?

Ms. KELMAR. Certainly, and a lot of that has to do with the fact that we have not been seeing the kind of generic competition that we need in the marketplace to make sure that we can bring down drug prices.

With just the introduction of a couple of drugs into the market to compete, that enables people to shop around or the insurance companies in this case to shop around and get a better price and bring down the drug prices in the marketplace.

So it is really important that we encourage great generic and biosimilar competition, and we break down those barriers that are keeping them off the shelves.

Mr. DOGGETT. Well, I think every significant new drug approved in the last decade has had significant taxpayer funding in the research, and yet taxpayers do not get any break. They have to pay more than people in other countries, and we face continual resistance in this Congress to doing anything about that.

Similarly, you reference other problems that could help bring down prices, such as dealing with the role of private equity, which has been involved in the consolidation and increase in prices in many parts of the health care industry.

Similarly, the important work of the Biden Administration through the Federal Trade Commission is often overlooked, but when you have a monopoly, whether it is in prescription drugs or in some other health care sector, you get monopoly prices, and things are driven up.

So there are many areas we need to work together on and overcome lobby resistance to try to bring health care cost down.

Thanks to all of you.

Ms. KELMAR. Thank you.

Chairman BUCHANAN. I now recognize the gentleman from Nebraska, Mr. Smith.

Mr. SMITH of Nebraska. Thank you, Mr. Chairman.

Thank you to all of our witnesses for sharing your perspective and your insights.

Where do I begin?

The cost of health care pre-inflation that we have seen in the last couple of years was bad enough, and now it is even worse. I grow frustrated when there are comparisons made from the dais perhaps here that are not really reflecting reality.

I am concerned that the overall cost of health care has driven up health insurance plans for workers, public sector, and private sector. I marvel at the fact that before Obamacare—I cannot quite call it the Affordable Care Act because I do not think that is accurate—but before there was this outsized intervention by the Federal Government, we had, you know, high risk pools that existed that, yes, those premium levels were offensive. They were painful.

But now, it seems that everyone in the individual market, now that they pay a similar amount, it is not as offensive. I worry about things like that.

And I worry about the fact that a recent Gallup poll found 38 percent of Americans delay medical treatment in the last year because of cost concerns.

I worry that the cost of medical equipment and supplies has increased 15 percent just since the beginning of the Biden Administration.

Hospitals have seen nearly a 25 percent increase in labor cost per discharged patient since the beginning of the pandemic.

I could go on here with further notes, but suffice it to say that we have got a worker shortage. We had a worker shortage even before the vaccine mandate. Found out perhaps the vaccine mandate was not as productive as some would have argued. We have finally gotten rid of that, but there has been a lot of pain along the way.

So I hope that we as a combined body of policy makers and certainly experts with some great insight, that we can have the conversations that we need to have to deliver better results for the American people.

I believe my colleagues who supported Obamacare meant well. The results, I think, have been disastrous. I think that my colleagues who supported the spending two years ago out into the economy against the warnings of economists, very reasonable economists, against their warnings that it would trigger inflation, I worry that those results have also been disastrous.

So as we sort out all of this and hopefully get our country on a better path certainly as it relates to small businesses and actually workers in whatever size business, I hope, can experience better results moving forward.

But, Mr. Niswander, I have to say I am impressed with your diverse professional background, and I am guessing that you provide some great services to your community and help feed the world. I appreciate that.

Can you perhaps tell us how the rising labor cost has specifically impacted your business across the industries in which you work and what you would do if the cost of paying your employees increased by another 25 percent over the next three years that we are all fearful of?

Mr. NISWANDER. So like I mentioned in my opening statement, prices have increased threefold, and we are talking about basic supplies to run a medical office, Band-Aids, syringes, needles, things that are fixed that I cannot pass on to the patient and that I cannot control there.

We are talking about pennies sometimes, but the price of syringes, for instance, has increased by about 15 cents apiece, which does not sound like much, but when you use hundreds a week that adds up to your bottom dollar.

That has impacted us that we cannot offer this cost that we would have maybe paid for health insurance. We cannot offer that to our employees. We cannot retain the talent that we need. We cannot invest in new and better technologies, better serve our rural communities that do not have access to those new and advancing technologies.

But for me personally, it created a lot of sacrifice. I am a first-generation cattleman, and since I was 16 years old working on a dairy farm, I dreamed about having a farm. I bought that farm in 2014, and last year I had to sell it in order to keep our medical practice alive and our patients taken care of and my employees' families fed.

I do not have another farm to sell.

Mr. SMITH of Nebraska. Thank you.

And do not have a lot of time left, but I hope that we can get to the point where we truly address cost rather than just shifting around who pays for what and saying everything is all better.

Thank you. I yield back.

Chairman BUCHANAN. I now recognize the gentleman from California, Mr. Thompson.

Mr. THOMPSON. Thank you, Mr. Chairman.

And thank you to all of the witnesses that are here today.

I really truly appreciate my Republican colleagues giving us an opportunity to point out and talk about the health care cost issues that we face collectively. I believe strongly that every American should have access to quality, affordable health care and want to work to make sure that that becomes a reality.

I do wish, however, that my friends on the other side would help us figure out how to address these issues rather than just spend all of their time criticizing why the many things that we have done to date have not completely solved this issue.

The issue of access to quality, affordable health care has long been something that plagued us before the Affordable Care Act and after the Affordable Care Act. But I think it is important to point out that last year it was Democrats that passed legislation allowing Medicare to negotiate the price of prescription drugs. That provision alone is going to save Americans and the Medicare program billions of dollars on their prescriptions.

We also passed legislation capping the price of insulin for Medicare beneficiaries at $35 a month, and now that is being followed by private sector providers as well.

And of course, 13 years ago, as has been pointed out, we passed the Affordable Care Act, historic legislation on which tens of millions of Americans rely for health insurance and which for the first time required insurers to cover a range of mental health challenges that all Americans face.

Unfortunately, my colleagues who are quick to criticize also voted against all of those provisions. So no to lower drug prices, no to affordable insulin, no to mental health coverage. Over 70 times they voted to do away with the Affordable Care Act.

But all of their efforts failed because the law actually does work. I am willing to work with anyone to lower the cost of health care, but let's be honest. Virtually every step Congress has taken to lower health care cost has been opposed by my friends on the other side.

I would like to enter into the record a statement from Keep Us Covered, which outlines why the Republican proposals, some of which are being discussed today like the individual coverage HRAs, will undercut the gains made in the ACA and allow for discrimination against workers.

Mr. Chairman.
Chairman BUCHANAN. Without objection.
[The information follows:]

Statement from Keep US Covered to the U.S. House Ways and Means Committee Hearing "Why Healthcare is Unaffordable: The Fallout of Democrats' Inflation on Patients and Small Businesses"
March 23, 2023
Written Statement for the Hearing Record

I am Sonja Nesbit, Senior Advisor to Keep US Covered, and I am submitting this testimony on behalf of our campaign, which is committed to protecting and expanding quality health coverage and improving care for working Americans. Keep US Covered's campaign partners include AIDS United, American Nurses Association, American Psychiatric Association, Business Forward, Community Catalyst, Little Lobbyists, and Small Business Majority. Our mission is to promote public policy changes that ensure health coverage delivers for people when they need it, beginning with the reversal of harmful and potentially discriminatory policies put in place during the previous administration, including Individual Coverage Health Reimbursement Arrangements (ICHRAs) and the dramatic expansion of short-term limited duration insurance (STLDI), better known as junk insurance. We also seek to broaden our national health care conversation to better account for the many factors that lead to health disparities.

The Subcommittee has invited witnesses who have been advocates for the ICHRA system, and we believe it is important to provide a different perspective and underscore how the scheme represents a threat to both quality coverage for working people and the Affordable Care Act (ACA).

ICHRAs Are a Threat to Quality Coverage, the ACA, and Health Equity

ICHRAs undermine the quality and reliability of health coverage, open the door to discrimination in the workplace, and undermine the affordability of the ACA marketplaces. This new system for health coverage originated from an executive order signed by former President Donald Trump in 2017. Different types of Health Reimbursement Arrangements (HRAs) have long existed as a way for employers to help employees pay for certain health care related expenses. In 2017, however, Mr. Trump signed an executive order that sought to significantly expand the use of HRAs. The result was a new regulation finalized in 2019 that created what are now known as ICHRAs as a replacement for traditional employer-sponsored insurance.

For employers participating in this ICHRA system, employees no longer receive coverage provided by their employer. Instead, workers in ICHRAs receive a stipend and are left to find coverage on their own. If the stipend does not cover the cost of coverage for the employee and their family, the worker must pay the difference out of pocket. Still more concerning, this regulation allows workers to be divided by "class" so that some "classes" continue to receive their regular health coverage from employers while others are given an ICHRA and are forced to find their own coverage. This regulation went into place in 2020.

For struggling families, vulnerable populations, and those with pre-existing conditions, ICHRAs represent a harmful precedent and could result in a higher number of underinsured people, weaken coverage, and systematically shift people who are more expensive to cover off of private insurance and into government risk pools.

Biden Administration Reviewing the Trump-Era Policy

President Biden has recognized the threat posed by ICHRAs. In one of his first acts as president, on January 28th, 2021, he signed Executive Order 14009, which directs relevant federal agencies to review this Trump-era regulation, along with rules boosting junk insurance, and directing those agencies to consider "suspending, revising, or rescinding" the rules. To date, that process remains ongoing, and Keep US Covered continues to urge the Biden Administration to quickly follow through on this effort and do away with ICHRA and junk insurance rules put in place by the last administration.

ICHRAs Invite Health Discrimination

The Affordable Care Act enshrined – in federal law – new protections for Americans. The law "prohibits discrimination on the basis of race, color, national origin, sex, age, or disability." ICHRAs undermine this promise. One of the most troubling features of the ICHRA system is the way it invites discrimination and threatens health equity by allowing employers to divide their workforce into "classes."

This rule means that some workers or "classes" of workers – such as hourly wage workers, or those in a particular location – get different insurance than other people in the same company. Allowing workers with the same employer to be divided into different "classes" all but guarantees some receive inferior forms of coverage.

For example, workers in a factory in one state could be dumped into an ICHRA, while executives at headquarters in another state keep their employer-provided health plan. This may benefit the company or those who get to keep their current coverage, but it's unfair to the workers placed in an ICHRA.

This is a clear invitation for discrimination. Health experts have warned that higher risk groups of employees (i.e., the most expensive ones to insure) could be cleaved off a company's health plan and forced into an ICHRA, hurting the most vulnerable in a workforce while protecting those who are better-off.

ICHRAs Threaten the ACA, Damage Risk Pools

The ability to move high-risk – and more costly to insure – workers into an ICHRA not only leaves them at risk of getting weaker coverage, it also threatens the stability and affordability of the Affordable Care Act marketplaces. The cost of coverage on the ACA exchange is set in part by the combined cost of people buying coverage there. Shifting high-cost workers off of job-

based insurance and onto the ACA marketplaces will drive up prices for everyone who relies on it and could ultimately threaten the stability of the entire program. The ACA marketplaces were designed to strengthen individual health coverage options, not serve as a place to send high-risk workers

A study from Avelere Health examined the consequences of shifting workers onto ICHRA plans, and noted the potential risk it poses. Avalere wrote, "Enrollment shifts to ICHRAs, premiums, and OOP costs may vary for different workers based on factors such as part-time status, income level, geographic location, age, or health status. For example, employers targeting a class of employees that may be 'higher risk' for ICHRA offers could adversely impact the individual market risk pool."

Indeed, Avalere cites an analysis from Kaiser Family Foundation that examined how employers would use the ICHRA system and found that among larger employers currently offering ICHRAs or planning to offer them, 60% intend to utilize them for low-wage workers.

ICHRAs Undermine Health Equity

Now more than ever it's critical that health care policy work to advance health equity. Instead ICHRAs move us backward, increasing costs for those who can least afford it and allowing employees to be divided into haves and have-nots in the workplace. The ACA marketplaces were meant to provide choice and options. But if ICHRAs become commonplace, more affordable options might leave the marketplaces entirely, reducing choice for everyone. ICHRAs jeopardize the health coverage that workers have earned and so many families depend on.

Administration Can Act to End ICHRAs and Rein in Junk Insurance

We have been heartened that most employers have recognized the flaws in the ICHRA system, including the potential for discrimination. Adoption of the policy is currently low, but there remain many in public policy arenas promoting it. Fortunately, this threat to a quality health system can be removed before it expands any further. Rolling back ICHRAs and junk insurance are two actions that the Biden Administration can take now to overturn harmful policies from the previous one, which will help more Americans get – and keep – the quality health care they need. Doing so would also strengthen the Affordable Care Act by protecting risk pools from the potential influx of high-cost consumers dumped onto the open market.

As a nation, we have made significant progress to expand access to quality, affordable coverage and advance health equity, but serious hurdles remain. Repealing the rules for ICHRAs would keep us moving forward, and we are eager to work with Congress and the Administration to advance health policy that promotes fairness and protect quality coverage for working Americans.

Mr. THOMPSON. Thank you.

And I want to also point out that the average premium for ACA plans in my district was $697 without subsidies, but $241 for those eligible for the ACA tax credit.

And also, I want to point out that California's uninsured population dropped from 17 to seven percent after the ACA was put into place.

And then as I mentioned before, the ACA provided mental health coverage to an estimated 48 million people who otherwise would have gone without that help.

I have a couple of questions. Ms. Kerrigan, you talked about the importance of telemedicine. That is something that ironically has good bipartisan support. Legislation of mine was put into the COVID legislation that expanded telemedicine for Medicare folks. It has created a very safe environment for people to get health care.

And we actually extended that. I believe that we should really expand telehealth and provide that access to folks who are in Medicare and others as well.

Could you talk just briefly on how much that will help with access and how much it will help with affordability?

Ms. KERRIGAN. Oh, I think it would be extraordinary and significant, and it was also great to see at the end of last year, you know, the CARES Act piece where employers could reduce covered telehealth services by allowing employers to provide pre-deductible coverage for such services. That has been expanded, and I think that needs to be made permanent.

But absolutely, technology can play a big role in reducing health care and giving people more access to health care. I think particularly in rural areas, too, where you do have, you know, the challenges cited by the other witnesses in terms of, you know, hospitals being closed or are closing and not having access to providers.

So people who lack mobility, I just think all in all it would do a lot to help drive down the cost of health coverage, give people more access, and just help the system be more productive and efficient.

Mr. THOMPSON. Thank you very much.

Mr. Chairman, Mr. Schweikert and I have telehealth in a bill and we would appreciate any help you could provide to get that marked up on the floor.

Chairman BUCHANAN. I look forward to working with you.

Mr. THOMPSON. Thank you.

I would like to recognize the gentleman from Pennsylvania, Mr. Kelly, who is obviously like myself and some of us up here that have been in business a long time and dealt with this issue head on.

Mr. Kelly.

Mr. KELLY. Thank you, Chairman.

And thank you all for taking a day out of your life to come down here.

We have been attempting since this session started to go out into the country. So we were in Oklahoma one time, and we were in West Virginia another time in very small, small communities.

And, Ms. Moore, I am also in the automobile business. So I am really interested. You know, when I looked at your input to this and I hear your testimony, I cannot help but be impressed by your story. What you and your husband have been able to accomplish is the American dream.

I do not know that you had a lot of government help doing that. I think once you became profitable, the government came knocking, and we find many ways to shake pennies out of people's pockets because we are going to do it the right way.

And we are only $33 trillion in debt. So I would challenge anybody. If you want to watch a model, please do not bring anybody here in to tell you how to run your business.

So but looking at what you do, and I know this because I am the same way, the same as Mr. Niswander. Really, how many sleepless nights do you have trying to figure out how you are going to make payroll?

And how many times do you have to pay everybody but yourselves in order to keep that out there?

Now, you did talk a little bit about inflation because there are many times that we talk about things and it kind of takes your mind off of what is really happening in your store, in your neighborhood, in your county and your State and in your country.

So can you talk a little bit on what inflation and supply chain disruptions have impacted, how it has impacted your business and how you have had to adjust to the benefits that you provide to your employees?

Ms. MOORE. Well, with the supply shortages are critical. We have shared this with a number of people, but in Keith Lines, we are getting shipped 40 to 60 percent of what we order. Those orders come with a discount, which we then are able to pass on to our customer.

When we cannot secure those with a discount, we are having to get rapid items much more expensively. So it is driving up not only our costs, but also the cost of our customers, putting a hurt on the small business customers we have.

Not everyone is a giant corporation in our area. Most own a garage or diesel mechanic shop and help out with the stone haulers or the cement workers. The fleet garages are our big customer.

So supply shortages continue to challenge us. We are thinking of creative ways. We are looking for outside suppliers, but then you have a product that you may not be familiar with, you may not have experience with. So warranty items become an issue.

Mr. KELLY. Yes, and we are in the same position. I think any of us that are in businesses know how tough it has been to attract talent and give the benefits package to them that they need to have.

Because you are in competition with everybody else that is looking for talent.

Ms. MOORE. Yes.

Mr. KELLY. So the benefits package is a big deal.

Mr. Niswander, just between the two of you all, I said it and I am sure Vern has gone through the thing. There are many, many nights when I sleep. Mrs. Miller and I agree on everything because she is also an automobile dealer.

But if you all can talk about it because it comes down to this. We are talking about health care and how it is soaring, the cost of keeping people healthy. What is it that we could do?

And you want to keep these benefits there to attract the best people to address the people that you serve.

So, Mr. Niswander, I do not know how you have done it, but having health care in a rural area, being able to take care of those folks and knowing that your model, your model for a profit is very small and leaves little room for any types of mistakes.

And that is why I think we keep talking about we are going to get good health care for people. I really appreciate that. I cannot afford anything we are doing right now.

You know we started off at 80–20. Then we went to 70–30. Then we went to 60–40, and right now we are contemplating going to 50–50 because we cannot afford to be in a competitive area with another person who has also the same products that we do, and it is all based on total cost of operation.

So, Mr. Niswander, just share a little bit. I mean, for you to do what you had to do and keeping the medical part going on right now, the rural part, and calling on people and trying to keep them healthy.

Mr. NISWANDER. There is a word that my colleagues here and some of you had mentioned, and it is the word "affordable," and you talked about out-of-network payments, right?

You tell uninsured Americans what good is that insurance if they get the card with their name on it but they cannot use it?

Access to health care is a problem. Mr. Doggett mentioned maintaining keeping rural hospitals open. Texas leads the Nation in closed hospitals in the last ten years. In my State in Tennessee, 16 hospitals have closed in the last ten years. Thirteen of those have been in rural areas.

My hospital in my county is on the verge of closing. The county next to me just closed last year. Access to health care is a problem, people. It is not affordable.

Families are having to drive from my practice over two hours to get to a specialist, as simple as an ear, nose and throat doctor. It is not that there is not one closer. Medicaid pays on average about 60 cents on the dollar compared to commercial payers. What physician office wants to accept that?

They drive past ten, maybe 20 specialists to get to the one that will accept their insurance.

People in my community do not make a lot of money. Thirty-six thousand dollars is the average income. They are asking them to pay a $14,000 deductible, drive two hours to get to a specialist, take a day off work that they cannot afford that is going to take food out of the kids' mouths?

Affordable Care Act is anything but that.

Mr. KELLY. Thank you.

Chairman BUCHANAN. I now recognize the gentleman from New York, Mr. Higgins.

Mr. HIGGINS. Thank you, Mr. Chairman.

You know, it is obvious that we are still discussing health care. You know, there are still many challenges in front of us. I believe that health insurance companies jack up premiums, and then when

you go to use the health care that you have already paid too much for, there is very little underlying insurance.

And that was a problem before the Affordable Care Act because people convinced markets junk policies. It really did not mean anything to anybody other than the temporary satisfaction that you had health care.

Since the Affordable Care Act, I voted for it, not perfect by any means, but 35 million more people have health insurance that is more affordable because of the Affordable Care Act.

Prior to the Affordable Care Act, if you had a kid that was stuck with cancer, insurance companies could deny you coverage because of a preexisting condition. You cannot do that anymore. It is against the law.

Policies have to cover preexisting conditions. What are they? Diabetes, cancer, epilepsy, lupus, asthma, pregnancy, and that is just part of the list.

So the insurance company always had the upper hand. The idea here was to pool the American people so that there was leverage to negotiate a better deal for consumers that they did not have on their own.

And if the Affordable Care Act is so bad, why did our colleagues' efforts 51 times to repeal it fail? Because maybe it is not perfect, maybe we can do better, but the Affordable Care Act is better than what we had. And the whole objective was to bend the cost curve and to increase the number of people who would have health insurance coverage. Both objectives have been met.

You talk about the high cost of premiums. You are right. Before it was about 15 percent annually. Bending the cost curve is not taking away the annual growth in health care premiums. It is lowering them.

Are they as low as we want them to be? Absolutely not. But if this Congress worked in a bipartisan way like we did with an infrastructure bill which was bipartisan, we could create a better program than the Affordable Care Act.

Why are we not allowing people to buy into Medicare at 50 years old? They would save 40 percent on their premiums. You would not have to create a new program. You just allow them to enroll in the program at their own cost.

So I guess my point here is that, you know, we are not defending the perfect here. Everybody, even the most vociferous proponents of the Affordable Care Act will acknowledge that it is not perfect, and we still have a long way to go.

But every story that you tell, the problem with rural areas, that we do not have doctors and nurses and health care providers, they do not want to go there. Why? Because that is not the population where they can make as much money as they would otherwise be able to do in a more densely urban or suburban area.

So we all have an obligation on both sides of the aisle to do a lot better for you.

The Inflation Reduction Act, again, was just a start. I have been here for a lot of years, and everybody has been talking about "Why is Medicare not authorized to negotiate drug prices?" The VA does it and they realize a significant reduction.

Why? Because life and insurance are all about leverage. So why would we not use the leverage of Medicare beneficiaries to lower the cost and drive up the quality of health care on behalf of all of you who have a personal story that I believe, that I believe.

So the Inflation Reduction Act begins to do that, but unfortunately, progress in Congress is typically very incremental. We should be making major progress to hold down the cost of insulin, which this bill does, to hold down the cost of individuals on a yearly basis to $2,000.

But they are never a finish. They are a start, and all of us should demand much better from Congress, particularly hearing your stories and particularly when it comes to the high cost of health care.

With that I yield back.

Chairman BUCHANAN. Thank you.

I now recognize the gentleman from Ohio, Dr. Wenstrup.

Mr. WENSTRUP. Thank you, Mr. Chairman.

Thank you all for being here today.

Of course, we all know that the inflation that we are dealing with today is not helping the situation whatsoever, and you know, people talk about insurance as though that equals care, and I think most of you on the panel know that does not equal care just because you have a policy.

And we talk about negotiating drug costs. There is a difference between the negotiation and a dictation, and if there is a dictation and it is "take it or leave it," and then you are left out, then that drug is no longer available and it stymies the possibility for more research and development, and we have to be considerate of that.

And I am bothered when I hear my colleagues say things like they want to accomplish something on this committee, but then they say Republicans are for Nothing Care.

Well, I am sorry. That reminds me of a line from The Princess Bride. "We are all men of action. Lies do not become us."

So let's have serious conversation. We are about a healthy America, is what Republicans are for. We are about prevention. We are about diagnosis and treatment and making America a healthier place.

But what we do not want is the government in between the doctor and the patient, and I can tell you that first hand, and I know Dr. Murphy can as well, and I know Mr. Niswander can as well.

That is part of the problem. So when you are trying to create savings, you have created the problem. It is interfering with the doctor and patient.

Look. I love our safety nets. I am proud to live in a country that has programs like Medicaid and Medicare, and especially with Medicaid though. I want fewer people to need it, not more people on it.

And that is a difference between Republicans and Democrats. Democrats call success putting more people on the government program when we say success is fewer people needing it.

When I started in practice, I had two employees, and if someone was sick my mom came in. You can probably relate to that, right?

And the patient came in. If it was just for an office visit, I gave them their bill. They paid it, and they submit it to insurance.

Now we get the government involved, and now everything has got to change, and I have got to hire more employees, and I have got to, you know, file all of the claims, and I have got to have every word perfect in the chart.

You know, there was one time I had a patient and he said, "Doc, how much is this going to cost?"

And I said, "Well, I can numb you up here in the office and it's about $300."

And he said, "Honestly, I don't have any money." And then he said, "You know what? I raise chicken. Do you like chicken?"

I said, "You have got a deal."

You can probably relate to that, too.

And I did not expect anything of him, but he delivered with that, by the way, and I took care of him. But now you cannot because now you are giving someone a special favor because of all the rules coming in from the government.

Oh, no, you are giving favoritism to one person over another. How about you are helping somebody in need? And why can that not be okay?

But that is where we are today. So I went from my practice and grew my own administration. Then I joined a large orthopedic group, and you know, recently because of things like decreased reimbursement to physicians, the change in the Surprises Act that HHS put in that we did not put in the law, the bipartisan bill that we passed, they changed the rules to favor the insurance companies and drive down what you pay doctors. That is when they quit. And that is when they quit taking calls.

But that is what our government is doing.

I do have a rural community in my area, and a lot of rural communities, and one of the doctors, he said, "I just do not take insurance at all because mostly what I do are office visits, and if I have to refer to a specialist, that is when their insurance kicks in, but they just pay me a small amount, and it is half of what it would be if I was taking Medicare and everything else."

And it works. It works in that environment. So we have got to get the government out.

And to the point, too, the other large orthopedic group in our town, they went private equity, and they quit taking Medicaid. When I first started, if I saw one or two Medicaid patients a month or something, I did not care. That was about all I saw.

But as the numbers grow, you cannot keep your doors open. It is a business, right? And it is very hard.

So my question for you, Mr. Niswander, and I think this can kind of hit home with everything because I talked about the need to practice with very little assistance in the office. You said you have 11 employees. How many of those actually touch patients and provide medical care?

Mr. NISWANDER. Every one of them.

Mr. WENSTRUP. So out of 11, you have them all. So there is no one who is just administrative. There is no one who is just—that is what I am trying to differentiate.

Mr. NISWANDER. So we have a billing company and a company that processes our claims for us. That is two separate companies

there. We pay them a percentage out of our income as well, every claim that is processed.

Mr. WENSTRUP. For many people that is in their office and those are the employees.

Mr. NISWANDER. That is correct.

Mr. WENSTRUP. So you have people producing, but you do have to pay for all of the administrative burdens that have been put on us over the years.

Well, I think this is what we have to focus on, and let's focus on the health of America and our patients and be sure that when we are doing something from the government level, we are actually helping, not hurting.

And I yield back.

Chairman BUCHANAN. Thank you.

I now recognize the gentleman from Pennsylvania, Congressman Evans.

Mr. EVANS. Mr. Chairman, I wanted to thank you for calling us together to mark the 13th years since President Obama signed the Affordable Care Act into law.

First, Mr. Chairman, I would like to ask to submit the testimony of Walter Rowen, co-chair of the Small Business for America's Future and President of Susquehanna Glass in Columbia, Pennsylvania, for the record.

Rep. Evans

SMALL BUSINESS
FOR AMERICA'S FUTURE

WRITTEN TESTIMONY FOR THE UNITED STATES
HOUSE OF REPRESENTATIVES
COMMITTEE ON WAYS AND MEANS
SUBCOMMITTEE ON HEALTH

BY WALT ROWEN
CO-CHAIR OF SMALL BUSINESS FOR AMERICA'S FUTURE
PRESIDENT OF SUSQUEHANNA GLASS IN COLUMBIA, PA
MARCH 23, 2023

My name is Walt Rowen, president of Susquehanna Glass in Columbia, PA and Co-Chair of Small Business for America's Future (SBAF)—a national coalition of small business owners and leaders working to provide small businesses a voice at every level of government. We're committed to ensuring policymakers prioritize Main Street by advancing a just and equitable economic framework that works for small business owners, their employees, and their communities.

As a representative of small business owners across the nation, I want to express small businesses' unwavering support for the Affordable Care Act (ACA) and to stress the importance of maintaining and strengthening this landmark legislation. Small businesses, which employ nearly half of all Americans and drive economic activity in every community across the country, are the backbone of the national economy. It is imperative our interests be protected.

Susquehanna Glass is a family-owned glass decorating business that has been in operation for 113 years, and I can tell you the high cost of healthcare has long been a significant concern for small business owners for a long time. We offer healthcare coverage to all our full-time employees, so I know firsthand how rising healthcare prices not only strain budgets and eat into the bottom line, they also impose undue hardship on the dedicated employees who make small businesses thrive.

As employers, we want to take care of our workforce, and in an increasingly competitive labor market, offering a solution for comprehensive health insurance benefits can be a way to attract and retain top talent. Before the implementation of the Affordable Care Act, securing affordable healthcare for small businesses and their employees was more often a losing battle. In most markets, it was too expensive for both the companies and their employees. However, the ACA has revolutionized the landscape by providing affordable options to small businesses through initiatives such as the small business tax credits, the Small Business Health Options Program (SHOP) Marketplace, and the individual Health Insurance Marketplaces.

The enactment of the ACA has expanded healthcare coverage to tens of millions of Americans, including small business owners, their employees, and their families, through subsidies available on the Health Insurance Marketplaces. This expansion of coverage is unprecedented in scale and has had a transformative impact on the lives of countless individuals. Currently, 35 million people have health coverage thanks to the ACA.

Small business owners and self-employed individuals constitute a substantial portion of Marketplace enrollment among working-age adults, accounting for 25 percent of enrollees. Moreover, the implementation of the ACA has led to a remarkable decrease in the uninsured rate among self-employed adults aged 21-64. In 2019, the uninsured rate for this demographic was nearly 10 percentage points lower than pre-ACA rates, a testament to the significant impact of the legislation.

It's also helped spark a wave of new small businesses by incentivizing people to take the leap into entrepreneurship. They're able to leave a job with employer-based insurance and take this bold step knowing they will still have a healthcare option. New small business applications are higher than pre-pandemic levels for the second year in a row. In 2022, 5 million small businesses were created down just slightly from 5.2 million in 2021.

Despite the progress made under the ACA, we recognize that the legislation is not without its flaws. Recent improvements, such as the enhanced tax credits on the Marketplace and the fix for the "family glitch," have substantially benefited small business owners, their employees, and their families by making healthcare coverage more affordable. However, there is plenty more work to do.

Susquehanna Glass offers a range of coverage options to its full-time employees. Our most popular policy is an HSA plan with a $3,500 deductible and a monthly cost per single employee of around $600. That same plan for a family costs upwards of $1,000 per month with a $7,000 total family deductible. The company pays approximately 50% of these costs. To cover the 13 employees who take the coverage, the company pays more than $46,000 annually. Our current payroll runs between 40-50 people, so we're only getting about 25% participation and the main reason is the expense of the coverage.

We firmly believe in the continued pursuit of policy solutions that lower out-of-pocket costs for purchasing health insurance and acknowledge that further action must be taken to address the underlying issue of escalating healthcare prices. Lowering healthcare costs is critical not only for small businesses but also for all consumers. And there are plenty of targets for meaningful action.

Small business owners know that high healthcare costs are driven by prescription drug costs—95% of small business owners say pharmaceutical companies are responsible for rising prices in a recent SBAF survey—and the increasing rate of hospital consolidation—94% point to hospitals in the same survey. The high cost of coverage and care creates very real economic challenges and inflationary pressures. SBAF research shows nearly half of small business owners have increased the prices of their goods or services to offset healthcare costs, 38 percent have delayed growth opportunities, and 28 percent have held off on hiring new employees.

Small Business For America's Future research underscores the desire among small business owners for policymakers to take decisive action to address the rising costs of healthcare. Small business owners are eager to see policies that ensure they and their employees have access to affordable, high-quality healthcare coverage.

In conclusion, we implore you, the esteemed members of this committee, to recognize the crucial role that the Affordable Care Act plays in supporting small businesses and their employees. Repealing or weakening the ACA would be a significant blow to these vital economic contributors, causing undue harm and potentially stifling growth and innovation.

Instead, we urge you to focus on enhancing and refining the legislation, further reducing the financial burden on small businesses and their employees, and ultimately improving access to affordable, quality healthcare for all Americans. By taking these actions, you will not only ensure the continued success and prosperity of small businesses but also contribute to the overall health and wellbeing of our nation.

Thank you for your time and consideration.

Walter Rowen
President
Susquehanna Glass, Co.
Columbia, PA

In his testimony, Mr. Rowen states, "Before the implementation of the Affordable Care Act securing affordable health care for small businesses and their employees, there was a much more hostile battle. However, the Act has revolutionized the landscape for providing affordable options to small businesses through initiatives such as the small business tax credit, the Small Business Health Care Option Program Marketplace, and the Individual Health Insurance Marketplace."

He goes on to say, "It also helps start a wave of new small businesses by incentivized people to take the leap into entrepreneurship."

And towards the end, he states, "Repeatedly weakening health care will be a blow to the vital small economic contributions." This is important.

Mr. Rowen makes clear, however, the Affordable Care Act has helped small businesses across America, and I thank him for sharing his testimony with us.

The Affordable Care Act was a life changing model that improved countless lives. I will list just a few examples.

The ACA provided coverage to millions of Americans and initiated over 21 million through Medicare expansion and over 16 million were enrolled in marketplace plans.

The ACA people were successful in preventing—and it is important, as he then said this. When it approached time, it gave people a sense of hope. No, it is not perfect, but it gave people a sense of hope.

I want to take a moment to talk about the medical dent the Affordable Care Act made and what it has attempted to do. More than 100 million Americans are dealing with this issue of medical debt. Let me repeat that: over 100 million Americans.

In the past five years more than half of U.S. adults fought against debt. I want to thank those not here and the members who took the lead on this issue. It was working together that made a difference.

We cannot afford to go back. American families cannot afford having more costs thrown on their budgets, and it is important that it will only work when we work together.

President Biden has moved in the right direction when he called the Affordable Care Act a big deal. I will say it is a little stronger than that.

I look forward to working with my colleagues in trying to provide and make sure that health care is a reality. No, it is not a question that is perfection, but it is an issue that we all must work together.

So I sit here today saying to my colleagues on both sides of the aisle that, yes, we can. We can help and be beneficial. We must keep that in mind in terms of who we are working for, and it is important to recognize that the people are really watching all of us in terms of our ability to make a difference.

Not a question of repeal, but a question of how can we do better. I would say to you, Mr. Chairman, that this hearing is a beginning. We must keep working together.

Thank you. I yield the time back, Mr. Chairman.

Chairman BUCHANAN. I like that mindset. This is the beginning. So that is my goal.

Pursuant to committee practice, we will now move two-to-one questioning order.

I recognize the Congressman, Dr. Murphy from North Carolina.

Mr. MURPHY. Thank you, Mr. Chairman.

And I want to thank all of the witnesses for coming today.

This is a difficult problem. It is a strangling problem. Medical debt is the number one cause of bankruptcy.

But let's look at the facts. I love my Democratic colleagues, and we are throwing all of these platitudes forth, but you are guys that are in business and actually seeing real life things compared to [audio disruption].

I think they are. Look. I am amphibious. I can move to a different one.

So all right. It is back. Now I am in stereo.

So I have lived in the real world. I have practiced for over 30 years. I have run a practice. I know where every paperclip was as far as our overhead, and then I worried, worried, worried. There were several quarters where I never got paid because we had to pay for our employees.

And we debated because when I first started practicing, we paid for every penny of our employees, but let us look at what has happened with government health care. So let us look honestly, objectively at what has happened since Obamacare.

I am going to give you a few parameters that show us what it has done. It has been abysmal to medicine.

Since Obamacare, one-quarter of physicians more have had their practices fail in one way or another and then what happens? They do one of three things.

They either quit because they cannot take it.

Number two, they get assimilated by a hospital where the cost of care by employee physicians is close to twice what it is for a private physician.

Or, three, they just take cash, and we are seeing more and more and more of this because if you look at what has happened to premiums, let us look at real cost of health care. It has skyrocketed since Obamacare. Why? Consolidation.

That is the number one reason where you have monopolies not only with hospitals and large systems—and God has given me a voice now—not only with large systems, but look at insurance companies. Look at PBMs that have actually destroyed pharmaceutical medicine, the cost of pharmaceutical medicines.

So let me ask you this, Mr. Niswander. If it continues on the present trajectory, given the cost of living, the equipment cost of inflation over the last two years, the fact that you cannot charge any more for Medicare patients because you can charge them—I love this—I can charge them a million dollars for a surgery, but I will still get a buck 50. It does not matter what I charge, but what Medicare pays, Medicare pays.

Where do you see your practice in five years?

Mr. NISWANDER. So currently we have been able to continue practicing medicine. Our nurse practitioners make less and get reimbursed less. My employees do not get their benefits that large systems do.

We tried to rent out space to other medical professionals to practice to kind of offset our costs there.

And as I mentioned, I sold my farm in order to keep our office going.

And you are correct. Right now we have got a problem where rural hospitals are closing and they are the backbone for these rural communities for these families to get health care instead of having to drive several hours away to find that same hospital for emergency care.

I do not have another farm to sell. I mean, you look at this happening again. What am I supposed to do?

Practices like mine, I have had two close in the last year, primary care offices, and those offices are not being filled. They are for sale. Nobody wants to buy them.

Mr. MURPHY. Rural areas—I do not want to interrupt just because we have a limited amount of time. But the way this trajectory hits and continues is the cost of care, cost of care, cost of care goes up until nobody can afford it anymore.

We spend now, and everybody talks about Medicare for all. They have absolutely no understanding of what that means, absolutely none. It makes them feel good inside. It makes them feel great inside, but they have no clue as to what that means.

The cost of care, we had to fight tooth and nail against the other side so that physicians and providers would only be cut two percent last year rather than eight percent.

So you cut, you cut, you cut to feed an absolutely monstrous government bureaucracy which has grown and grown and grown in the last 13 years, until you cannot cut anymore and people say to hell with it. I am done.

We are going to have a cataclysm occur in the next three to five years with surgeons in this country because nurse practitioners, PAs cannot do surgery. They can help with primary care. They cannot do surgery.

So, no, there were some good things with the Affordable Care Act. There were. There were some good things, but what it has done to medicine as a whole has crippled this country.

I thank you for what you do, but it is important that people who are in the field give testimony to what they are doing, not only people that own small businesses, but people who own practices because you are in double jeopardy there because you are getting your rates cut at the same time you cannot expense it more, at the time that inflation is killing you.

Thank you, Mr. Chairman. I will yield back.

Chairman BUCHANAN. Thank you.

I am excited to always have two doctors on this committee because you have worked in the real world, not just in medicine, but running a practice, running your business. So we appreciate your knowledge and capability.

I now want to recognize the Congressman from Oklahoma, Mr. Hern.

Mr. HERN. Thank you, Mr. Chairman.

You have five business people in a row here. I spent 35 years in business running all kinds of businesses, owning, operating, you

know, from aerospace to agriculture, to banking and 34 years of McDonald's franchises.

You know, I have never seen something so convoluted as the health care industry in this country, and it has not gotten simpler. Having seen hundreds of thousands of dollars taken off the bottom line and wasted when you could supply health insurance to your employees, in any other industry you would know the cost of service of the product you are buying, and as a consumer you can shop for the best price, but in health care, people have no idea of the true cost of the health care service or the treatment.

It is the only thing you buy if you think about it for a minute. It is the only thing you pay for that you do not know what the cost is before you get it.

The exorbitant cost of the health care, a mass of subsidies, tax credits, employer and insurance contributions. Not a single person in this room can tell me the true cost of their last health care appointment, and that is a problem.

Unfortunately, the hidden cost of health care is exacerbated by the Democrat policies. Just last year my colleagues on the other side of the aisle voted to completely hide the cost of health insurance under the disguise of free, zero premium health care for many Americans.

The expansion of the Obamacare subsidies cost the American taxpayers $64 billion, but the greatest cost of all is to the society. We need a safety net for people that are falling on hard times, falling through the cracks, but not families that are making upwards of $600,000 as we are currently stating.

Do we need a safety net that empowers people, high ended cost of health care through government subsidies? Why impose families that are already struggling to pay their bills under Biden inflation?

We should not be surprised that Democrats keep pushing for these policies. My colleagues today were pointing to reports with increasing enrollment in the Obamacare markets and Medicare roles.

It is not a victory to have a health insurance card in your pocket but no cash in your wallet. I think you said that earlier, especially if the services that come with the health insurance care are too expensive.

Democrats are misleading Americans telling them that they have care when all they have is a plastic card. The actual care costs are even more.

Coverage mandates began with the passage of Obamacare over a decade ago. Since then Democrats have continued to almost exclusively focus on those policies and the individual market, have done nothing to help the 48 percent of Americans who obtain their coverage from their employer.

It should come as no surprise when there has been no work for Democrats to salvage their failed small business exchanges and small business health tax credits. I would encourage my colleagues to go to HealthCare.gov/smallbusiness, and see for yourself that small businesses have no options, no options for coverage in the shop exchange in many States, including my own home State of Oklahoma.

No shop insurance means no access to the small business taxpayer, which explains why only 6,000 people used the small business tax credit in 2016. Let me say that again. There are 33 million small businesses in America, and only 6,000 were using the tax credit.

It is really sad that Democrats could expand Obamacare tax credits for a family making nearly $600,000, but do nothing to fix Obamacare's broken small business provisions.

But this is a new day in the House of Representatives. The American workers spoke loud and clear last November. America's workers are tired of being left behind and punished for pursuing the American dream.

I am proud for the health care policy platform we put together and the commitment to America with the Healthy Future Task Force over the last year, as chairman of the Task Force Affordability and Subcommittee Chairman.

I want to quickly highlight some reforms from this list that our committee should consider.

The first one is make health care coverage portable.

Make health care savings accounts accessible to more people.

Reduce the Obamacare paperwork burden on small businesses.

And allow businesses to join together through association health plans.

Mr. Blase, we have spoken many times. You did a lot of great work on that year of work. We have seen the highly mobile labor market, and now more than ever workers need health care that is portable.

Can you speak to how health and reimbursement accounts provide American workers and employers more flexibility?

Dr. BLASE. Yes. Thank you, Congressman.

It is the new individual coverage health reimbursement arrangement. They took effect in 2020, and it allows employers to offer a contribution that workers take and then buy the individual plan that works best for them.

So it is really the small business owners, they care about the workers. They want to offer them health coverage. It is about trusting people to make the best decisions for them and giving them as many options as possible for their coverage.

Mr. HERN. What has been the effect of the expanded subsidies on the employer market?

CBO and JCT estimated that 2.3 million employers would drop coverage, and do you agree with that estimate?

Dr. BLASE. Yes. I actually think it could be more than that if the expanded subsidies are made permanent. The expanded subsidies are really large. So it provides employers with an incentive to drop coverage.

They could increase wages when they drop coverage and have their workers qualify for expensive tax credits in the exchanges that just add to deficits and just worsen the overall inflation problem.

Mr. HERN. Thank you, and I yield back.

Chairman BUCHANAN. Thank you.

I now recognize Congressman Davis, the gentleman from Illinois.

Mr. DAVIS. Thank you, Mr. Chairman.

And let me thank you for calling a very informative and important hearing.

And I also want to thank all of our witnesses, and I appreciate greatly the voices that we are hearing today from small businesses.

But I would also like to note that not all small businesses are expressing the same sentiments, and I ask unanimous consent to submit for the record a statement from Small Business Majority, whose opinions are quite different.

SMALL BUSINESS MAJORITY

WRITTEN STATEMENT FOR THE RECORD BEFORE THE U.S. HOUSE COMMITTEE ON WAYS & MEANS

Health Subcommittee Hearing on Why Health Care is Unaffordable

March 23, 2023

JOHN ARENSMEYER

FOUNDER & CEO, SMALL BUSINESS MAJORITY

Dear Chairman Smith and members of the Subcommittee on Health:

My name is John Arensmeyer, and I am the founder and CEO of Small Business Majority, a national small business organization that empowers America's diverse entrepreneurs to build a thriving and equitable economy.[1] We engage our network of more than 85,000 small businesses and 1,500 business and community organizations to advocate for public policy solutions and deliver resources to entrepreneurs that promote equitable small business growth. As a leading representative of America's 32 million small businesses, Small Business Majority is pleased to submit written testimony on the importance of building upon the Affordable Care Act (ACA) to combat high healthcare costs for small businesses.

Small Business Majority has been a long-standing advocate for small businesses that have historically struggled to access quality health coverage due to costs and whose employees have represented a disproportionate share of uninsured workers. We are uniquely positioned to offer several policy solutions to overcome current challenges and submit suggestions to ensure that small business owners can access affordable healthcare in the long term.

This week marks the 13th anniversary of the enactment of the ACA. It's important to note the strong impact this law has had on narrowing healthcare disparities and expanding affordable healthcare coverage. The ACA has been nothing short of a game changer for small business owners, their employees and solo entrepreneurs. More than half of small business employees are enrolled in the ACA marketplaces nationwide, and more than half of all ACA marketplace enrollees are small business owners, self-employed or small business employees.[2]

Before the ACA passed, small business owners paid, on average, 18% more than their big business counterparts. Since 2010, the increase in small business healthcare costs has been at the lowest level in years, following regular double-digit increases prior to the law's enactment. The ACA has also eliminated "job lock," allowing workers who once felt tied to their job by their benefits package to seek out their own entrepreneurial path or join thriving small businesses. Entrepreneurs with pre-existing conditions are now more comfortable pursuing their American dream because the ACA has increased healthcare options for small business owners and created opportunities that were not previously available. This access to coverage is particularly important in light of the record number of new businesses created in 2022.

The ACA has been further strengthened by the American Rescue Plan, which included provisions to significantly increase the size of healthcare premium tax credits and expanded eligibility to those making more than 400% of FPL. The Inflation Reduction Act (IRA) law further solidified this boost to small business owners by extending these important tax credits set to expire in 2022 through 2025. Without the IRA, healthcare premiums would have soared, leaving small business owners plagued with worry on how to pay for quality healthcare amid rising premiums and prescription drug costs.

---

[1] https://smallbusinessmajority.org

[2] https://smallbusinessmajority.org/our-research/healthcare/small-businesses-see-significant-gains-aca

Unfortunately, despite the tremendous achievements of the ACA, small businesses and their employees continue to struggle to afford health insurance and obtain quality healthcare. We are currently dealing with challenges related to ongoing rises in inflation, supply chain disruptions, and workforce shortages. These issues have created barriers for smaller firms that cannot keep up with increased healthcare costs and are being priced out of health insurance. Making healthcare more affordable is critical to small businesses and it is an issue that remains top of mind for small business owners.[3]

Addressing costs

While the ACA has made great strides in expanding affordable coverage to more small business owners and their workers, more needs to be done to address costs. Premiums are still too high, and more than half of small businesses are unable to offer health coverage for their employees. The smallest businesses have the toughest time affording coverage. In fact, only 39% of firms with 3-9 workers offered coverage in 2022, according to Kaiser Family Foundation.[4] Contrast this with firms with 200 or more workers; 99% of them provided coverage in 2022.

However, efforts to chip away at the ACA will only serve to disrupt the marketplace and, in turn, harm small business owners, their employees and self-employed individuals. For instance, using association health plans (AHPs) to lower healthcare costs for small businesses is structurally flawed. AHPs raise rates in the small group market by splitting the small business owners into two different pools: one pool for businesses with young, healthy workers that want bare-bones plans and one for firms that need more comprehensive coverage. This leads to significant spikes in premiums–particularly for those small businesses with older or sicker workers.

Additionally, AHPs are also not subject to all of the ACA's benefits and offer fewer consumer safeguards. AHPs are permitted to use age, gender, industry, occupation or other demographic factors to set premiums for member employers nor do they require coverage for basic services like maternity care, emergency services or hospitalization. If a plan subscriber needs costly care, the entire plan could be canceled. We cannot support small businesses saving money by shifting their costs to other small businesses. We must have a system that lowers prices across the board.

Policy solutions

While we believe more should be done to lower healthcare costs, undermining the ACA would eradicate hard-won benefits for America's entrepreneurs, causing a rapid rise in healthcare costs and creating economic instability. Instead, we encourage Congress to advance legislation that would stabilize healthcare marketplaces and protect the robustness of coverage options for small business owners and their employees. Some of those solutions include the following:

- Make the expanded tax credits provided by the IRA permanent. Ensure that the millions of sole proprietors, small business owners and their employees who count on these essential savings can continue to access low premiums and affordable healthcare coverage when needed.
- Pass policies that stop hospitals from engaging in anti-competitive practices, large mergers, and abusive hospital pricing, which are driving up healthcare costs dramatically.
    - Block anti-competitive hospital business practices.
        - Stop abusive hospital pricing by banning predatory billing practices that are not disclosed and justified.
        - Create a cost commission to set reasonable hospital reimbursement rates based on quality and outcomes.

---

[3] https://smallbusinessmajority.org/our-research/small-business-and-state-union

[4] https://files.kff.org/attachment/Report-Employer-Health-Benefits-2022-Annual-Survey.pdf

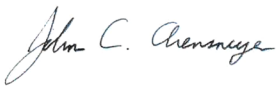
        - There is bipartisan support for cracking down on egregious practices, like hospitals requiring insurers to contract with affiliated hospitals rather than letting the insurers contract with lower-cost, higher-quality hospitals.[5]
    - **Block hospital mergers and acquisitions that are likely to increase patient costs while not improving medical quality or outcomes.** Ensure vertical integration between hospitals and physicians is done to improve patient outcomes, not to bolster profits and market power.
        - Hospital consolidation has played an outsized role in making healthcare less affordable for consumers and employers. Evidence suggests that consolidation leads to higher hospital and provider prices and higher total expenditures—all while having little to no impact on improving the quality of care for patients, reducing utilization, or improving efficiency.[6]

- Create a "public option" or a standardized plan to help drive down the cost of hospital and physician services.
    - A public option will be open to small business owners and their employees. This would infuse the healthcare marketplace with new plan options and would force insurance companies to be more competitive.
- Calculate marketplace premium tax credits based on the cost of a gold-level plan (80% actuarial level) instead of a silver-plan (70% actuarial level).
- Extend Medicare pharmaceutical drug inflation rebates under the IRA to the private market, which penalizes drug manufacturers for raising prices faster than inflation. This will also discourage manufacturers from increasing prices in the commercial market to offset lower prescription drug prices negotiated by Medicare.
- Immediately expand Medicaid in states that have refused to do so. For states that continue to refuse to expand Medicaid for ideological reasons, pass the "Medicaid Saves Lives Act" to allow consumers in those states to buy coverage in the individual marketplace.

Conclusion

Small businesses are slowly rebuilding from the pandemic and remain optimistic about their business operations. However, the lack of access to affordable and quality healthcare, especially for those small businesses in under-resourced and rural communities, can create barriers to entrepreneurial success. We urge policymakers to address high healthcare costs, but we must do so in a responsible way. There are policies in place that can be expanded and shored up to create sustainable and equitable solutions to healthcare affordability challenges. Repealing or ignoring those policies will be a disservice to our nation's job creators. I appreciate the opportunity to comment on these critical issues.

Sincerely,



John Arensmeyer
Founder & CEO
Small Business Majority

---

[5] https://www.fiercehealthcare.com/hospitals/new-bill-aims-to-clamp-down-hospital-anti-competition-tactics-like-all-or-nothing

[6] https://www.kff.org/health-costs/issue-brief/what-we-know-about-provider-consolidation/

As a matter of fact, their opinions suggest that efforts to chip away at the ACA will only serve to disrupt the marketplace and, in turn, harm small business owners, their employees, and self-employed individuals.

If the Republicans are successful in repealing the Affordable Care Act and substantially reducing Medicaid, Illinois families will have higher health care costs. Without the ACA, 68,000 Illinoisans will have higher premiums, up to an average of at least $6,500.

At least two million people in Illinois with preexisting conditions will be subject to the denial of health care insurance coverage and charged more by market health insurance enterprises.

We would be looking at 4.5 million Illinoisans at risk of lifetime benefit caps.

Ms. Kelmar, if I could ask you, if the ACA is repealed, what would be the impact on mental health?

Ms. KELMAR. It is already very difficult for people to get mental health services and to pay for it out of pocket. So having a good insurance plan that covers that and offers that is a really great way to not only make sure that folks have the coverage for the kinds of care that they need, but we all know that good mental health plays into your physical health as well.

Mr. DAVIS. And just thinking of average basic health care that several million people now have been able to acquire coverage who otherwise would not and did not have it prior to the ACA, what would be the impact on the economy and the economics of the environment where they are?

Ms. KELMAR. Well, people need insurance because there is no way they can pay for all of their care out of their own pocket, and wages will never cover those kinds of costs, especially for the sickest.

So the reason that the United States has moved towards an insurance system is because it spreads out the risk and it spreads out the cost of the sickest people onto everyone so everyone can have access to care.

Having a good insurance policy also enables us to be able to get that preventative care that we need to make sure that we are not getting sicker, and we have to address that we have a very different health care system now than we have had in the past.

With the consolidated health markets, we are seeing prices just skyrocket, and there is no ability for insurance plans to be able to shop around and find another alternative when that can mean it only has one consolidated health system demanding the same prices throughout.

So we really have to get to the cost issue to make sure that the health insurance programs that we are running in the U.S. are paying reasonable prices and not inflated prices.

Mr. DAVIS. Let me thank you very much.

I come from a school of thought that says let the good outweigh the perfect, and I think this is one of those instances why that is the case.

Thank you very much, and I yield back, Mr. Chairman.

Ms. KELMAR. Thank you.

Chairman BUCHANAN. Thank you.

I now recognize the Congresswoman from West Virginia, Mrs. Miller.

Mrs. MILLER. Thank you, Chairman, and thank you, Ranking Member.

And thank you all for being here today because it helps to have people testify on the real impacts from the policies that come out of Washington, D.C.

About a month ago, this committee met in my home State of West Virginia, and we heard about the tangible impacts of the failed Democrat policies, many of which have contributed to record high inflation and what effect it is having on folks outside of the Beltway.

One of the most compelling testimonies that I heard was from a lady named Ashley Bachman who owns a restaurant in Petersburg, West Virginia. And she testified that she was unable to offer health care to her employees because of how expensive it was.

As a matter of fact, her whole family is uninsured because she cannot afford the monthly health care bill on top of all the costs associated with her business.

And I was really kind of sorry to hear that story.

Ms. Moore, first of all, I want to thank you for showing the respect that you have for your employees and how important they are to your business. So many times people in this bubble seem to think employers are the bad guys.

And you are not, and you do really appreciate your employees.

You shared the difficulties of being a small business owner in the Appalachian region. Ohio is part of the Appalachian region. You talked about your experience having to cut health insurance benefits for your employees.

Can you just talk a bit about making that decision and how hard it was as a business owner?

Ms. MOORE. I will share and I will try not to tear up because these are individuals. We know their children. We know their extended families not because I grew up in those communities that I have business in; only because we have a relationship as an employer-employee relationship that extends far beyond a paycheck.

When I had to look an adult man in the face and tell him, "I cannot help you anymore. Find insurance for your family, for your two growing sons, and I know that your wife is not eligible at her employer for insurance. So I am going to leave the whole family of four out to defend for themselves. I cannot do a single thing for you."

I could not even because of the mandates supplement and give him extra money to help find. I mean my hands were totally tied.

Mrs. MILLER. I hate to stop you because we only have so much time, and I am really happy that you are now able to reinstate their health coverage.

You know, your employees thankfully have health coverage, but most people in rural America still do not, and I need to ask Mr. Niswander a couple questions.

Your being a health care provider for such a rural community certainly gives you a unique insight into the struggles of rural America and what we face when trying to receive health care.

Have you seen patients who are unwilling to get treatment for their medical services because they are worried about the high cost?

Mr. NISWANDER. I have actually. Just last week I had a patient that came in that I have not seen for a long time who is a very brittle diabetic who needs several bottles of his $30 insulin every month that she cannot afford, and she delayed care for many months, even from calling me, to a point that her foot developed a necrotic wound that put her in the hospital with a high deductible plan on the ACA coverage.

She came to my office with a wound bag attached to her foot and talked of amputating that foot now. It was the fear of the high deductible plan that kept her from getting care.

Mrs. MILLER. It is just so difficult for patients to physically travel where they need to, let alone receive the care, and it is a shame that the cost of care is just another barrier.

It seems another issue I feel is an obstacle to quality health care in rural America is the difficulty retaining a robust rural health workforce, and I think you all agree to that.

Can you talk just a bit about finding health care providers to come and join your practice?

Mr. NISWANDER. It is difficult in rural America. The insurance reimbursement rates, like Dr. Wenstrup and Murphy are aware, are fixed. We have no bargaining power whatsoever. Expenses are going up.

The pandemic is over but the price increases are not. That translates into many medical practices closing down because of the strain that puts on the ones that are left.

We talked about mental health resources. Over 70 percent of psychiatrists do not accept insurance because the reimbursement rates are so terrible.

Our patients are suffering because rural America's hospitals are shutting down left and right.

Mrs. MILLER. You are exactly right.

Mr. Chairman, I yield back my time.

Chairman BUCHANAN. I now recognize the gentleman, the Congressman from Pennsylvania, Mr. Fitzpatrick.

Mr. FITZPATRICK. Thank you, Mr. Chairman.

Thank you to the panel for being here today.

Many employees are seeing their insurance premiums rise. At the same time hospital finances are worse than they have been in recent memory.

In my district in Bucks County, Pennsylvania, many hospitals that I hear from are experiencing what they refer to as unsustainable losses.

Mr. Niswander, how have you dealt with facing narrow or even negative margins for the care that you provide in your institution?

Mr. NISWANDER. We have fixed costs in medicine that we cannot pass along to the patients. They just are what they are, and we have to have those things to operate. We have nurse practitioners that earn less. My employees do not get the benefits that they deserve and need, and we and my wife often eat the cost.

Patients come in with high deductibles, and we give our care away completely for free.

I do not know how many hospitals or how many primary care physicians can do that or continue to do that, but I know that they are closing down left and right in rural America.

Mr. FITZPATRICK. The reality is there are hospitals losing money. In Southeastern Pennsylvania, the region I represent, and also across the entire country, but at the same time costs of providing health insurance for employees have gone up significantly.

If premium increases are not translating into greater financial stability for these struggling health care providers, my concern is those increased premium costs are being lost to inflation and other statutes in the health care market, threatening to leave hospitals and health care providers like Mr. Niswander with difficult choices that generally mean either reduced access to care or further increased prices for patients.

Mr. Blase, what do you think has been the primary factor driving these insurance costs up?

And do you think patients and small businesses can see even further price hikes in response to some health care providers continuing to struggle?

Dr. BLASE. Yes, I think there are two reasons, Congressman. One the other witness talked about, the growing consolidation in the health care sector. That really accelerated with the ACA with hospitals merging and with hospitals acquiring physician practices.

The ACA had one provision that reduces hospital competition. So they prevent Medicare payments from going to new physician-owned hospitals, which is anticompetitive. And, you know, whenever you have anticompetitive policies, that is going to increase overall costs.

I do think, too, just the design of the health insurance, that we talk about health insurance as expensive because health care prices are high, and that is true. But you also have the issue that when government mandates the health insurance be very expansive and then heavily subsidizes the health insurance, those things increase health care prices as well.

So the government regulation over what health insurance has to cover, the very expansive subsidies that have been added to in the Inflation Reduction Act also push up health care prices.

Mr. FITZPATRICK. Ms. Kelmar, how do you think hospitals struggling with increasing cost is ultimately going to impact patients?

Ms. KELMAR. The problem is that we cannot see a lot of the quality measures that we really need to see and that we are still paying very high prices for.

So we are in a system that we spend most of our health care dollars, especially in the commercial market, as a fee-for-service payment system, and so that means the more things that you do to a patient, the more money you can make, and that drives up prices as well.

So between the consolidation, which is pushing our prices up because there is less competition in those local markets, and the way that we pay on the fee-for-service system, those are the kinds of things that keep driving up those dollars that are coming out of our insurance, which is causing pressure on both the businesses and employers who are trying to offer us our health insurance, but then

they are having to shift off that extra cost onto us in our out-of-pocket premiums.

Mr. FITZPATRICK. Thank you.

Mr. Chairman, I yield back.

Chairman BUCHANAN. Thank you.

I now recognize the gentleman, Congressman from Virginia, Mr. Beyer.

Mr. BEYER. Mr. Chairman, thank you very much.

And I thank all of you for this. It has been a very fascinating hearing, and I have really appreciated hearing from all of us, including Dr. Murphy and Dr. Wenstrup.

I want to point out, Mr. Blase, that you pointed out the 18.3 percent GDP last year. Well, it was 17 percent in 2010 before the ACA kicked in.

I have also been in business for years, and all the things we talked about narrowly and how much we can pay for our employees, we did all that through the 1990s and the 2000s, and by 2010, we could barely pay for any of it before ACA kicked in.

So I am thrilled that we are here to think about the ideas dealing with consolidation, which we have seen again and again is a terrible thing. PBMs.

I am thrilled that we are not turning away people now because of preexisting conditions, which I did more than once with my own employees very, very sadly.

So let me just lay three ideas out there for you.

Number one, claims data. Many of you already do this probably, but all payer claims' databases collect health care claims. They are personally I say great because Virginia has one, and it has State policy makers, private payers, and academics' critical data that inform decisions about health care costs and quality.

And I strongly believe that increasing claims transparency has the potential to increase the quality and delivery of health care, in addition to making it more affordable.

States are already leading the way in implementing this well-conceived innovation. Colorado uses APCD data to assess differences in pricing for common procedures and how the utilization of health care services changes over time.

We have certainly seen the examples of some places where there are lots and lots of C sections and other places where there are personally none with the same population.

Oregon uses the data to help guide its health system transformation, resulting in $139 million in savings from 2013 to 2014. Minnesota uses it.

Colorado and Utah took different approaches to Medicaid expansion, and they were able to evaluate expansion through a more rigorous approach by using neighboring control State data.

These myriad differences in State administration create many opportunities to compare States and evaluate differences.

The second thing I want to talk about is improving diagnosis in medicine. Everyone knows the story of someone that took six years to get a diagnosis when it could have taken two.

According to the National Academy of Sciences, Engineering, and Medicine, diagnostic errors impact more than 12 million Americans every year.

So we also found out that most people experienced at least one diagnostic error in their lifetime, and postmortem research has shown that diagnostic errors contribute to approximately ten percent of patient deaths.

The estimates were that waste associated with diagnostic errors cost our health care system about $100 billion annually. Just imagine what those savings could do to the cost of health care.

By the way, I forget what doctor it was who talked about the obnoxious part of government interfering in the relationship between the doctor and patient. Let me promise you way before there was ACA, you had insurance companies doing the exact same thing, to our great frustration.

And lastly, I want to talk about ACA since it is, as my friend Dwight Evans said, the anniversary today. A key component has been many, many people have insurance they have not been able to get before. Our uninsured rate is at an all-time low. More than 133 million Americans with preexisting conditions protected after being denied coverage.

This has been typical of many, many States. And one of the key things we can all agree on is the benefit to eliminating the lifetime caps and the creation of out-of-pocket cost caps.

Before the ACA, insurance plans were not required to limit enrollees' total cost, and almost one in five people with employer coverage had no limit on out-of-pocket cost even when they were exposed to tens of thousands of dollars in medical bills before they became seriously ill.

Let's not kid ourselves. Before the ACA, the number one reason for bankruptcy in America was health care cost, and it still is today. This is something we have to work on together.

And one last thing for my anti-Choice Republican friends, whom I very much respect. ACA mandated birth control for all young women that wanted it, and we dropped abortions down to the lowest level since Roe v. Wade because of that.

We also dropped the number of teen pregnancies in half. There were a lot of very good things that came out of it, and now we have to fix what did not work.

With that I yield back.

Chairman BUCHANAN. Thank you.

I now recognize the Congresswoman from New York, Ms. Tenney.

Ms. TENNEY. Thank you, Mr. Chairman and Ranking Member.

Thank you so much for your testimony today. This is a really important hearing.

I am a small business owner as well, and as I travel across New York's 24th District, which is up in the big, rural area, one of the largest agricultural districts in the Northeast, I hear the same thing from small businesses and employers who actually dominate our economy, that since Obamacare was enacted, the cost of their health insurance premiums has gone up in many cases 120 to 130 percent and deductibles have gone up similarly.

So you may actually have an insurance card, but you cannot afford to go to the doctor, and that was the big fear that we all had.

Now, I have a constituent who actually reached out to us, a guy named Ted Vermette. He is the owner of Design Concepts in Cen-

tral Square, New York, and this epitomizes the effect this has had on small businesses, and I wanted to share this with some of you.

Before Obamacare, this company provided health insurance to their 38 employees with a premium of $20 a week and a deductible of $20, very affordable.

Now the premium is $120 per week for his workers, and the deductible is $2,600. This is unsustainable, and places enormous pressures on working class families and companies which could use some of this money to hire additional workers, as Ms. Murphy just talked about, or buying more inventory.

And I am also a family business owner, and our business has been around since 1946, but we have seen a lot of our businesses in our community fold because of health care.

So our family insurance plan and plan that we provided to our employees, we did that as a benefit. It was not a mandate, and we have over 50 employees, which means we fall within the mandated health care.

So when some people say, "Well, gee, you know, we had to give up our health care," we do not have that option. We must provide health care under the Obamacare legislation, and some of our increases for family plans are reaching $30,000 a year.

I just got the latest numbers from my brother.

So this is an enormous increase, and you know, it is really putting a burden on us getting quality care, and it also helps us attract great employees because so many of our employees work for government where they have government health care, whereas Dr. Murphy, Congressman, pointed out sometimes hides the actual cost of health care.

One of the first, ask Mr. Blase, because New York was terrible before Obamacare. It is even worse now, and we are treading down a really bad path. In fact, our legislature is considering doing Medicare for All, which would really, really be a problem for New York State. We would probably have even more out-migration, the highest out-migration of people in the entire Nation, by the way, and jobs.

But to Mr. Blase, I just want to ask you. As you know the cost for health care providers have been skyrocketing due to inflation, but these providers are often locked into multi-year contracts. They can only raise their reimbursement fees accordingly for renegotiation.

With that in mind, how long do you think and to what extent will Americans feel the pinch of inflation on their medical bills?

How is this going to change?

Dr. BLASE. Yes. Actually New York should have, in the precursor that kept us from enacting ACA, was price restrictions because the New York's individual market was basically destroyed by a set of regulations which were then put into the ACA, and the reason that the ACA market continues to exist is because of the extraordinarily high level of subsidies.

I think that, you know, health care inflation is likely to continue. I mean, I think if government policy continues to dramatically increase the subsidization, sort of these inefficient set of subsidies, without reforming those structures, without reforming the path

that the Federal health programs are on, I mean, Medicaid and Medicare are both facing severe fiscal challenges.

Medicare's unfunded liabilities exceed $50 trillion. I mean that is a ton of additional government spending that is going to need to be financed by debt, which will translate into higher interest rates and higher inflation.

Ms. TENNEY. Right. And, of course, New York State, there is no incentive to lower our cost for Medicaid because they get the Federal reimbursement for the subsidy.

I thank you for your comments. I appreciate it.

Mr. Niswander, I just wanted to ask you if I could. In your testimony you highlighted the outrageous amount of cost of your practice to offer health insurance to your employees. If your practice was able to access one of these association health plans or another method to access more affordable care, do you think that would impact your employee practice?

Would it help you if you had access to more?

Mr. NISWANDER. Yes, rural America is struggling now to attract the best talent, and just numbers. We cannot get specialists. We cannot get surgeons. We cannot get psychiatrists, not just in my practice but in the hospitals in the counties surrounding me. All of the rural counties in Tennessee are struggling to maintain the labor workforce, which between the expenses of operating a small business or a hospital to hospital and not being a mutual labor workforce, which is forcing so many practices to close, that would definitely help us to retain the best and the greatest surgeons and physicians and nurse practitioners that we can find.

Ms. TENNEY. Thank you so much. My time has expired. I would love to continue this conversation.

Thank you.

Chairman BUCHANAN. I now recognize the Congressman from Utah, Mr. Moore.

Mr. MOORE of Utah. Thank you, Chairman, Ranking Member.

Our witnesses, thank you for being here today, for sticking it out with us even with the bit of an overactive heater as well. You have endured quite a bit today.

When I talk to my constituents from Utah, in particular some of my rural areas, you know, the things that have come back to me, from Cache County, to stagger the cost of his monthly insurance premiums and out-of-pocket costs, a constituent from Brigham City put it simply, "We are just paying more and getting less."

Right? That has just been a consistent theme that we have seen.

This is a really unique opportunity to be on the Health Subcommittee in this really important Committee, Ways and Means.

Health care, any expenditures related to health are our Nation's number one expense, when you put it all together, and the topics that we talked about today and Dr. Murphy's testimony, it is not going to get played on the loop today on cable news. It is not what people are interested in. It is not the most vibrant topic to put out there in the world. It is the most important thing. And every single business owner and family recognizes that.

So we have a real opportunity to do something here and avoid the platitudes that we oftentimes hear, and there are going to be

a couple of platitudes that I am going to mention, and Mr. Blase, I am going to ask you to address it.

Sometimes you hear that some of these overarching issues get mentioned without a lot of context. I am going to ask you to put a little bit of meat on the bones to the concept of price transparency and improved quality transparency.

What would you add to that, what that can do to lower health care cost?

You mentioned that Congress should trust people to make health decisions for themselves and that price transparency will encourage more consumers to shop and obtain lower prices.

Patients do not always shop for their health care. This is a complex system.

So put some context to those two overarching concepts, the price transparency and quality transparency.

Dr. BLASE. Yes. So thank you, Congressman. That is a great question.

You know, people know prices when they shop for everything else, and they are able to figure things out. So I think they can figure things out in health care as well, but they need to know what the prices are.

So the Trump Administration finalized two rules, one that requires hospitals to provide price information, another rule that requires insurers to provide price information.

The hospital insurers are beginning to comply with those provisions, and I think we can see when consumers have price information, when they have incentives to act on the price information, such as they have a health savings account, they shop and they make wise decisions. They save money. They do not skimp on anything that would reduce their health care.

I think for employers, employers need price information as well. Like they are contracting with insurers to manage their benefits, and a lot of insurers have not negotiated great rates for those employers.

I think the price information is going to help employers better monitor how the insurers are functioning.

And on quality information, I think one of the things that is very clear is that there is a wide variety of outcomes that come from health care providers, and patients should know the quality of the providers that they are seeing.

So, you know, if they are going in for cardiac care, they are going to providers that have low competition rates.

Mr. MOORE of Utah. We used to take a job in this country with allowing or industries and consumers to dictate where things go with our typical economic principles of supply and demand.

We have over-complicated this system to the extent that we are not giving the power back to the consumers, and so I appreciate that context.

One of the last topics, you know, just to have you touch on is overcompensation, overconsumption. The overconsumption, you talked about turning the tide on red ink in your report and described how insurance can be designed to protect consumers from this catastrophic harm while not facilitating over-consumption.

That drives up cost. Share just a little bit more just on specific, plain terms on what this means.

Dr. BLASE. Yes, the analogy is if your auto insurance pays for your oil change, you are not going to be sensitive to the cost of that oil change.

There are many things in health care. Health insurance is great. It provides financial protection for low probability, high expense events, but insurance is not the most appropriate way to pay for every health care expenditure. It discourages individuals to care about what the cost of those expenditures are, which again increases prices , which increases what we all are paying because of how heavily the government is subsidizing health care and health insurance.

Mr. MOORE of Utah. Thank you, Dr. Blase.

And I yield back.

Chairman BUCHANAN. I now recognize the Congresswoman from California, Mrs. Steel.

Mrs. STEEL. Thank you, Mr. Chairman.

And thank you for all being here today.

My constituents are anxious about the economy and for a good reason, for the Biden's inflation, prices have impacted everything, the cost of groceries to the price at the pump and even health care spending.

Medical inflation has led to 43 percent of our dollars or their family members to put off or postpone needed health care due to increased medical cost, severely impacting Hispanic and AAPI communities, the most according to recent data from the Kaiser Family Foundation.

So we have been hearing from the other side of the aisle about how important this permanent telehealth bill is. I introduced while I was not even a member of Ways and Means Committee at the time; I introduced the permanent telehealth bill in 2021. The other side of aisle only extended one year and failed to extend the first dollar coverage of high deductible health savings plan for the first three months in 2022.

I introduced again last year that another permanent telehealth bill in 2022. The other side of the aisle extended only two years last year.

Now I hear from Congressman Thompson on the other side of the aisle that he agrees this telehealth bill is very important and to make it permanent.

So I will introduce this telehealth bill again for the American people. So I do that and hopefully it is going to be agreed by the other side of the aisle.

So I am asking Ms. Kerrigan if this were to expire again, how would this impact your members.

Ms. KERRIGAN. I think it can expire. You are talking about the telehealth, correct?

Mrs. STEEL. Right.

Ms. KERRIGAN. I mean, one of the silver linings of the pandemic was, you know, sort of again that everyone to technology, and we saw 35 million Americans using telehealth, you know, to get their health care, whether families, individuals, senior Americans.

And it is a very, very important piece, I think, to maintain as part of the health care system. I think particularly, again, for those people who cannot travel to the doctors, for rural America, once we get them broadband, all areas of the country broadband.

So it would negatively impact a lot of lives, individuals and businesses. It saves times. It saves money, and it would be a backwards step if we did not move forward with permanency.

Mrs. STEEL. Thank you so much.

In California, we shut down all the businesses and all the schools actually in Los Angeles County. Today is the third day that kids cannot go back to school. So this is what is going on in California.

We really needed this telehealth bill to permanently pass and that, you know, we can work on it.

So CalCAN, Dr. Niswander, CalCAN recently witnessed Madera Community Hospital's closure, impacting hardworking taxpayers the most with very limited options nearby that you talked about a little bit about the hospitals.

With medical inflation, supply chain issues, and major expenses, what are the consequences of major practice closures?

And with your experience, how do closures combined with rising medical cost impact?

You have been talking about your businesses. How about the patients?

Mr. NISWANDER. Yes. I appreciate the promotion calling me doctor, but I am a family nurse practitioner. Thank you.

So talking a lot about quality measures and lots of studies have actually looked at that and they have shown that as Medicaid enrollment increased, quality of care did not equal or increased Medicaid enrollment did not equal more utilization or higher quality of care.

The Bureau of Labor Statistics have many studies showing if somebody spends more than five percent of their out-of-pocket expenses on health care costs, they are considered uninsured.

We are talking about the $5,000 premium per year, a $14,000 deductible for somebody who makes $36,000 a year. That is uninsured even though they have got a card with their name on it.

This is like setting up a hamburger stand in a town full of vegans. They are just not going to use it.

The access to care is definitely a problem, and we need to find a way to change that. The access is the issue.

In Tennessee, rural hospitals and physicians' offices are closing left and right. The patients are the ones suffering from these increased premiums, the increasing deductibles that they cannot afford to pay, working families like me, but they cannot find a provider that even takes that insurance in our area.

Mrs. STEEL. Thank you so much.

Mr. Chairman, I yield back.

Chairman BUCHANAN. Thank you.

I now recognize the Congresswoman from Alabama, Ms. Sewell.

Ms. SEWELL. Thank you, Chairman Buchanan and Ranking Member Doggett.

I want to thank all of our witnesses today.

Today is the 13th anniversary of the Affordable Care Act, and thanks to the Affordable Care Act, millions of Americans are able

to afford health coverage that was completely out of reach before its passage 13 years ago.

I have testimony for the record from over 30 patient groups, including ARS Association, the American Cancer Society, and the American Diabetes Association, to name a few, stating the importance of the expanded health care coverage that the ACA provided to more than 120 million people with preexisting conditions.

And I would like Mr. Chairman, to include it in the record.

My constituents in Alabama are disproportionately impacted by chronic health conditions, including diabetes, heart disease, and cancer.

Sonya, a constituent of mine from Montgomery, Alabama, wrote to me about her father who had been denied coverage prior to the enactment of the Affordable Care Act's preexisting condition protection due to his cancer diagnosis.

Sonya wrote that her family prayed that it would stay in place because of the security this protection offered her and her family.

For millions of low-wage workers the ACA expanded access and affordability through Medicaid expansion, making this one of the most transformational policies of our time.

Uninsured rates in expansion States plummeted in the years following the ACA's implementation. Medicaid expansion has helped patients access preventive care like cancer screenings, increased access to transplants, and made diabetes medication more affordable.

Unfortunately, millions of Americans have experienced none of these gains simply because of where they live.

You see, my State, the State of Alabama, has not expanded Medicaid, and I think about the many hospitals that have closed in the rural parts of my district.

I was not surprised, although I was shocked that 85 percent in the last ten years of rural hospitals that have been closed have been closed in States that did not expand Medicaid.

The Affordable Care Act is the law of the land. I believe in this great country, that no person, no person should not be able to have access to affordable and quality health care. I believe it should be a right.

The fact that we are the last of the industrialized countries in the world to not have, you know, universal health care as a part of our DNA, it really does sadden me. And it saddens me because we get caught up in names and titles.

I think about my constituent Hank, and Hank is a farmer, a fifth-generation farmer, and had farmed all his life, and his dad farmed. His grandfather farmed. He was a third-generation farmer who never was able to afford health care.

In 2014, a navigator named Doug visited Hank on his farm to get him and his family enrolled in the Affordable Care Act, and even though Hank was not a supporter of President Obama, he signed up for a Blue Cross plan that cost him only $100 a month, thanks to the premium tax credits and cost sharing reductions.

The following summer, Hank was working on his farm when his hand got caught in his hay baler. When he tried to pull his right hand out, his left hand got stuck as well.

The family's plan, which they had had for less than a year, covered the emergency air flight and his hospital bill. Hank was able

to avoid a financial catastrophe like so many Americans experience who are uninsured.

Clearly, Hank's story serves as an example of how the Affordable Care Act does protect millions of Americans from devastating medical debt.

The sad part about it, and Hank has admitted to me, when the navigator knocked on his door, he said, "Do you want to have health care insurance, affordable health care insurance?"

He did not say, "Do you want to be enrolled in Obamacare," and Hank admitted to me had he said, "Do you want to be enrolled in Obamacare?" he probably would not have had this lifesaving insurance that literally saved his family from catastrophe.

Mr. Chairman, I hope that we can put politics aside and really think about what is in the best interest of all the people. I am talking specifically to my State. I really hope that they will take an opportunity to expand Medicaid so that more and more people can get insured.

In fact, for the 2022 coverage, over 200,000 Alabamians enrolled in the exchange. Guess how many would have also enrolled had we expanded Medicaid.

Thanks.

Chairman BUCHANAN. Thank you.

I want to thank all of our witnesses. You do not realize how big of a positive impact you have on the panel like this because a lot of people do not understand sometimes the real world.

And I can tell you I chaired our local Chamber in Sarasota. We had about 2,600 businesses at the time, and they told me—I was kind of shocked—90 percent were 20 employees or less.

That is America, and we have got to do more to help you not just in the health care space, regulation, and other things, to make it simpler for you and keep your taxes low.

Because people say, "Why do you always talk about the small business or medium business?"

I said, "Because they are the job creators. The better you do, the better America does."

That is the mindset some of us have. I know my good friend Mike and others and Carol have the same mindset, that if you are in business, but again, the better you do the better the country does.

So I really appreciate you being here. It has made a big difference. You guys were all very impactful.

Please be advised that members have two weeks to submit written questions to answer later in writing. Those questions and your answers will be made part of the formal hearing record.

With that, the committee stands adjourned.

[Whereupon, at 4:44 p.m., the subcommittee was adjourned.]

PUBLIC SUBMISSIONS

Statement for Hearing on
"Health Subcommittee Hearing on Why Health Care is Unaffordable: The Fallout of Democrats' Inflation on Patients and Small Businesses"

House Committee on Ways and Means
Health Subcommittee

April 6, 2023

AHIP is the national association whose members provide health care coverage, services, and solutions to hundreds of millions of Americans every day. We are committed to market-based solutions and public-private partnerships that make health care better and coverage more affordable and accessible for everyone. We appreciate the subcommittee's interest in examining the effect high health care costs can have on patients and employers.

As the costs of medical care rise — for care, services, therapies like prescription drugs, hospital stays, and doctor visits — health insurance premiums must necessarily rise to reflect and keep pace with those underlying costs and provide adequate coverage for their population of members. That is why health insurance providers are committed to negotiating lower prices with doctors, hospitals, and drug manufacturers, which in turn enables them to make premiums and out-of-pocket costs more affordable for everyone. AHIP believes that robust private-market competition is the best solution to ensure that all Americans have more health care choices and high-quality care at lower costs.

Employer Provided Coverage (EPC) Remains Essential and Popular
Businesses of all sizes provide comprehensive health coverage to employees and their families, covering the majority of Americans with health insurance– nearly 180 million people. EPC empowers employees to maintain and improve their health and helps ensure financial security for them and their loved ones. On average, employers pay 83% of the coverage costs for a single person, and 72% of the coverage costs for a family.[1] Furthermore, more than 70% of Americans are satisfied with the health insurance they get through work.[2]

EPC provides a strong return on investment, both for American taxpayers and businesses. EPC provides a net benefit of $1.5 trillion to Americans through its value to employers and employees

[1] https://www.kff.org/report-section/ehbs-2021-summary-of-findings/
[2] https://www.ahip.org/resources/polling-the-value-of-employer-provided-coverage

and its role in driving down the prices charged by health care providers.[3] For businesses, EPC will provide an estimated 47% return on investment (ROI) to employers with 100 or more employees in 2022 and a 52% ROI in 2026.[4]

In addition, more than 16 million Americans receive their health care coverage through the Marketplaces.[5] Last year, health insurance providers expanded their offerings with more than 200 organizations offering coverage through the marketplaces. Consumers have more choices with access to, on average, six to seven Qualified Health Plan (QHP) issuers and over 100 plans to choose from in every state, both of which are greater than all previous years.[6]

Health Insurance Providers Are Responsible for Actuarially Sound Premiums
Health plan actuaries generally develop proposed premiums based on actual and projected medical claims and administrative costs for pools of individuals and groups with insurance. Projected medical claims reflect unit costs and utilization levels, as well as the mix and intensity of services, all of which can vary by geographic area and from one health plan to another.

Risk pool composition is also important, as medical claims reflect the health status of individuals in the risk pool. Relevant laws and regulations that govern various aspects of insurance plans can affect the composition of risk pools and projected medical spending.

Medical Loss Ratio (MLR) is a financial metric used in the health care industry and is required by law to measure the percentage of premium dollars that health insurance providers spend on medical claims and quality improvement activities. Health insurance providers are mandated to spend at least 80% of premium dollars collected on medical claims and quality improvement activities in the individual and small group markets, and 85% in the large group market. This means that no more than 15% or 20% of premiums can be used for all administrative expenses and profits. If a health insurance provider's medical care and services spending falls below that MLR ratio requirement, rebates are issued to their policyholders, as required by federal law.

Where Americans' Premium Dollars Go
To better understand the distribution of growing health care costs, AHIP analyzed data from commercial health insurance plans between 2018 and 2020 to determine how payers allot their enrollees' premiums. During this 3-year span, 83.2 cents of every health care premium dollar went toward prescription drugs and medical services.

The largest driver of cost was care provided by hospitals which totaled 42.2 cents per premium dollar, including the 19 cents for in-patient hospital costs, 19.9 cents for out-patient hospital costs, and 3.3 cents for emergency room costs. Total hospital costs were followed by prescription

---

[3] https://www.ahip.org/news/articles/wsj-op-ed-praises-the-value-of-employer-provided-health-insurance
[4] https://www.uschamber.com/assets/documents/20220622_Chamber-of-Commerce_ESI-White-Paper_Final.pdf
[5] https://www.cms.gov/newsroom/fact-sheets/marketplace-2023-open-enrollment-period-report-final-national-snapshot
[6] https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2022QHPPremiumsChoiceReport.pdf

drug expenses at 22.2 cents from every premium dollar, including the calculations for rebates negotiated by health insurance providers and their partners.[7] Of note, after accounting for medical costs and administrative costs, including premium taxes and fees, cost containment expenses, and quality improvement activities, health plan profits equated to only 3.6 cents per premium dollar.

Competition-Based Solutions to Reduce Costs

To make premiums more affordable for Americans, we must work together to improve competition among drug manufacturers, hospitals, and health care systems. Health insurance providers are Americans' bargaining power, fighting for lower prices for Americans by using free-market tactics to negotiate lower prices with doctors, hospitals, and drug manufacturers and passing those savings along through decreased premiums and out-of-pocket costs. By improving competition in a few key areas of our health care system we can improve affordability and access for everyone. Health insurance providers are committed to working with federal lawmakers to take decisive action and to advocate for the laws, regulations, and needed enforcement actions to promote competitive healthcare markets. Americans deserve no less.

1. Advance Site-Neutral Payments to Defend Patients from Overpaying

Patients can go to a variety of care settings to receive comparable care, but their financial costs may differ dramatically depending on the setting in which their care is delivered. Most patients, however, do not know about the cost difference until after the care is provided and they receive a bill.

Historically, Medicare has paid a higher amount for comparable services that are provided in a hospital outpatient department than in a physician's office. For example, medical imaging services are typically priced significantly higher in hospital settings versus other settings, such as outpatient imaging centers. This higher payment structure has created a perverse incentive for hospitals to acquire physician practices and convert them to off-campus, provider-based hospital outpatient departments and has thus allowed providers to charge patients more money with no demonstrable difference in care or outcomes.

These practices make premiums and out-of-pocket costs less affordable for patients and consumers. Solutions that permit comparable payment for comparable services encourage an efficient and competitive market that works for everyone.

Legislative Recommendations:

- Require separate national provider identifier enumeration for provider-based, off-campus hospital outpatient departments to protect patients from being directed to more expensive sites of care.
- Prohibit the assessment of facility fees unless a special exception applies, which will ensure that patients are not surprised by additional non-care related fees.

[7] https://www.ahip.org/resources/where-does-your-health-care-dollar-go

2. Bring Much-Needed Transparency to Private Equity's Monopoly Power

Private equity firms' acquisition of providers of certain health care services undermines affordability, access, and choice. These growing monopolies, in fields like air ambulance, emergency room care, and certain specialty markets have the predictable effect of refusing to participate in networks in order to demand higher prices from patients and payers, which results in higher premiums and costs for everyone. By 2018, private equity represented 45% of all health care mergers and acquisitions. Many of these firms borrow heavily from banks and others using the funds to acquire private entities with the goal of turning a profit in a relatively short time.[8]

Raising prices to command higher reimbursement has been a common strategy after an acquisition by a private equity firm. Studies have found that hospitals have increased their prices after being acquired by private equity firms.[9] Unfortunately, these higher prices and costs do not correspond with improved patient outcomes, as the private equity model focuses more on profits than wellness.[10]

Legislative Recommendation:

- Enact legislation to require public reporting of all private equity or hedge fund purchases of air or ground ambulance providers or facilities, emergency room physicians, and other specialty medical groups where there is evidence of high levels of concentration or low levels of network participation.
- Public reporting should include notification to existing patients and health insurance providers with existing contracts. These transparency measures will ensure patients and payers are not surprised and will hold purchasers accountable for their drastic and unjustifiable price increases.

3. Stop Consolidated Health Systems from Stifling Negotiation and Innovation

In concentrated health systems and provider markets, prices do not result from competitive negotiations; instead, they are the result of the outsized leverage and monopoly-like market power for the systems. Overly concentrated markets make it increasingly unlikely that they will participate in negotiations for more affordable prices.

Some health systems leverage their dominant market share and power – sometimes the result of private equity driven acquisitions – by requiring contracts with all affiliated facilities and preventing steering patients to lower-cost, higher-quality care. These anti-competitive contract

---

[8] https://www.ineteconomics.org/research/research-papers/private-equity-buyouts-in-healthcare-who-wins-who-loses

[9] https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2769549

[10] june-2021-report-to-the-congress-medicare-and-the-health-care-delivery-system

terms, in the form of "anti-steering," "anti-tiering," and similar contract provisions bolster providers' high inflated costs – costs that lead to higher premiums and out-of-pocket costs.[11]

Legislative Recommendations:

- Address anti-competitive contract terms—for example, by enacting provisions such as those in the *Healthy Competition for Better Care Act* (S. 3139 in 117th Congress). These provisions would crack down on anti-competitive practices and make health care better for patients by ensuring that contracts between health insurance providers and health systems do not restrict price transparency.
- Any legislative solutions should also recognize there are beneficial forms of integration of provider and payer functions, which should be outside the scope of such legislation and instead should be fostered to promote efficient, high quality care models.[12]

4. Support Patient's Choice of Telehealth

While telehealth use was growing even before the pandemic, the COVID-19 crisis led to exponential growth.[13] Patients and providers alike found telehealth to be a safe, effective and convenient way for people to get care. As the public health emergency concludes next month, telehealth still represents new opportunities for health care improvement – providing an avenue for lowering delivery and administrative costs, increasing availability of providers, and providing patients with more choices of doctors and clinicians. All of these telehealth features would create further competition and could result in a decrease in premiums.

Legislative Recommendation:

- Pursue policies that increase broadband access in rural and other underserved areas, which would increase the number of vulnerable Americans who have access to telehealth services and a greater network of provider options.

5. Stop Drug Manufacturers from Engaging in Patent Games

Patents represent an important sacrifice and tradeoff by society to promote and preserve innovation. In exchange for granting patents, the government provides an exclusive benefit to patent holders (i.e., government-granted monopoly) for a set amount of time and forgoes the many benefits of direct competition. Drug manufacturers that obtain patents, however, have increasingly abused that exclusivity period to set ever-escalating prices. To keep competitors out of the market for even more extended periods and prices high, some manufacturers engage in complex schemes to bypass the rules and effective extend their government-granted monopolies

---

[11] https://www.milbank.org/wp-content/uploads/2021/09/Mitigating-the-Price-Impacts-of-Health-Care-Provider-Consolidation_2.pdf

[12] https://www.ahip.org/resources/looking-ahead-policies-to-support-future-telehealth-innovation

[13] https://www.ahip.org/resources/telehealth-coverage-during-the-covid-19-pandemic

well beyond the original patent period. They do so to maintain and grow revenues without adding any meaningful innovation.[14]

While these actions provide additional benefits for the manufacturers, they provide no meaningful benefits for Americans. Product hopping from just five prescription drugs alone costs the U.S. health care system $4.7 billion annually.[15] AHIP asks Congress to pursue legislation that lowers health care prices for Americans by preventing anti-competitive patent practices by the pharmaceutical industry.

Legislative Recommendations:

- Pass legislation ending pay-for-delay agreements which the Federal Trade Commission estimates costs Americans $3.5 billion in higher drug costs each year.[16] Ending this practice would allow for more generic drugs to enter the market to increase competition and lower the costs.
- Take action to curb patent evergreening – drug manufacturers' practice of making minor modifications to an old drug to obtain a new patent and extend their monopoly.
- Take steps to limit, and address harm caused by, product hopping – drug manufacturers' practice of moving patients from a product that is nearing the end of its patent exclusivity to a reformulation of the drug that has longer exclusivity.

Conclusion

Every American deserves access to affordable, comprehensive, high-quality coverage and care. Health insurance providers are committed to delivering more choices, better quality, and lower costs. AHIP and our members look forward to working with members of the subcommittee to advance policy changes that will spur more robust competition and provide all Americans with more health care choices and better quality at lower costs.

[14] https://www.ahip.org/resources/gaming-the-system-how-big-pharma-drives-its-higher-revenues-through-patent-gaming-and-extending-exclusivity

[15] https://www.affordableprescriptiondrugs.org/resources/the-cost-of-brand-product-hopping/

[16] https://www.ftc.gov/sites/default/files/documents/reports/pay-delay-how-drug-company-pay-offs-cost-consumers-billions-federal-trade-commission-staff-study/100112payfordelayrpt.pdf

The Alliance to Fight for Health Care

Advancing employer-provided coverage

March 23, 2023

The Honorable Jason Smith
Chairman
Ways & Means Committee
United States House of Representatives
Washington, DC 20515

The Honorable Richard Neal
Ranking member
Ways & Means Committee
United States House of Representatives
Washington, DC 20515

The Honorable Vern Buchanan
Chairman, Subcommittee on Health
Ways & Means Committee
United States House of Representatives
Washington, DC 20515

The Honorable Lloyd Doggett
Ranking member, Subcommittee on Health
Ways & Means Committee
United States House of Representatives
Washington, DC 20515

Dear Chairman Smith, Chairman Buchanan, Ranking Member Neal, and Ranking Member Doggett:

Thank you for the opportunity to submit the following comments for the hearing record in connection with the March 23, 2023, Ways & Means Subcommittee on Health hearing on "Why Health Care is Unaffordable."

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.

Employer-provided health care coverage is the backbone of the U.S. health care system— covering more than 178 million workers and their families. 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 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 Congress this year 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. For example, Congress could reduce cost and improve health outcomes for 178 million workers and their families 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, such as the Healthy Competition for Better Care Act, 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 ("HOPD") – 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 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).

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 to advance public policy 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

American Hospital Association
Advancing Health in America

Washington, D.C. Office
800 10th Street, N.W.
Two CityCenter, Suite 400
Washington, DC 20001-4956
(202) 638-1100

March 23, 2023

The Honorable Vern Buchanan
House Ways and Means Committee,
Health Subcommittee
U.S. House of Representatives
Washington, DC 20515

The Honorable Lloyd Doggett
House Ways and Means Committee,
Health Subcommittee
U.S. House of Representatives
Washington, DC 20515

Dear Chairman Buchanan and Ranking Member Doggett:

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 provide the subcommittee with information for its hearing on "Why Health Care is Unaffordable: The Fallout of Democrats' Inflation on Patients and Small Businesses."

FINANCIAL AND INFLATION PRESSURE ON HOSPITALS AND HEALTH SYSTEMS

America's hospitals and health systems are facing a crisis: a tsunami of financial challenges that are exerting tremendous pressure on their ability to deliver care. Specifically, financial constraints on hospitals impede their ability to recruit and retain the workforce they need to maintain access to care.

Expenses continue to rise across the board, with hospitals facing increasing costs for labor, drugs, purchased services, personal protective equipment and other medical and safety supplies needed to care for patients. An April 2022 report by the AHA highlights the significant cost growth in hospital expenses across labor, drugs and supplies, as well as the impact that rising inflation is having on hospital prices.[1] According to a recent report by Syntellis Performance Solutions and the AHA, hospital labor expenses per adjusted discharge were up by 24.8% by the end of 2022 compared to pre-pandemic levels in 2019.[2] The staggering growth in labor expenses in 2022 alone were projected

[1] https://www.aha.org/costsofcaring
[2] https://www.syntellis.com/sites/default/files/2023-03/AHA Q2_Feb 2023.pdf

to increase hospitals' labor costs by $135 billion according to a report published by Kaufman Hall in September 2022.[3]

The same report found that more than half of hospitals were projected to close the year with negative operating margins, the highest proportion in recent years. Among other implications, this has resulted in credit rating agency Fitch Ratings to revise its mid-year 2022 outlook to "deteriorating" for the nonprofit hospital sector due to "more severe-than-expected macro headwinds."

Elevated labor costs are affecting the entire continuum of care delivery settings, including in post-acute care. For example, one member reported that from the first quarter of calendar year 2019 to the first quarter of calendar year 2022, salaries across their long-term acute care hospitals (LTCHs) rose by 35% for registered nurses, 46% for nurse aides and 39% for respiratory therapists. Overall, their labor costs during this time period rose by 27%. Another of AHA's LTCH members reported that during the same time period, salaries rose by 56% for registered nurses, 39% for licensed practical nurses and certified nursing assistants, and 31% for respiratory therapists.

TRAVEL NURSES, TEMPORARY LABOR ISSUES

Long building structural changes within the health care workforce, combined with the profound toll of the COVID-19 pandemic, have left hospitals facing often severe short- and long-term staffing challenges. Taken together, these factors have all contributed to rapid and unsustainable rises in labor costs. For example, just within the week of March 9, Department of Health and Human Services data showed that 601 hospitals (or 16.3% of reporting hospitals) anticipated a critical staffing shortage. Longer term, projections from the Bureau of Labor Statistics estimate U.S. health care organizations will have to fill more than 203,000 open nursing positions every year until 2031. There also are significant projected shortages of physicians and allied health and behavioral health care providers, which will likely be felt even more strongly in areas serving structurally marginalized urban and rural communities.

To help offset the critical shortage of workers and maintain appropriate levels of care for patients, nearly every hospital in the country was forced to hire temporary staff at some point during the pandemic, including contract or travel nurses.[4] Hospitals' reliance on travel nurses and the inflated associated costs to employ them has grown significantly since the start of the pandemic. This notably peaked in 2022 during the omicron surge. Data from the Syntellis Performance Solutions/AHA report show that the share of total

---

[3] https://www.aha.org/system/files/media/file/2022/09/The-Current-State-of-Hospital-Finances-Fall-2022-Update-KaufmanHall.pdf
[4] https://www.amnhealthcare.com/siteassets/amn-insights/surveys/amn-survey-of-temporary-allied-healthcare-professional-staff-trends-2021.pdf

hours worked that were for contract employees rose 133% from 2019 to 2022. Because the rates that contract staffing firms charge hospitals has grown so fast, total contract labor expense grew 257.9% in that same period.[5] In addition, the rates these firms charge hospitals grew much faster than the rates the firms actually paid the staff, meaning the firms pocketed more at the time of greatest need.[6]

The use of contract labor for travel nurses specifically continues to remain much higher than pre-pandemic levels, which has led to increased labor expenses overall for hospitals and health systems. The Syntellis Performance Solutions/AHA report shows that travel nurse full time equivalents (FTEs) per patient day rose over 183.4% from 2019 to 2022. Though travel nurses are often the bulk of contract labor, similar trends have affected clinical specialties and departments across hospitals. For example, emergency service contract FTEs per emergency department visit rose 187.2% over the same time period. As a result, contract labor as a share of total labor expenses rose 178.6% from 2019 to 2022. A Kaufman Hall report projected that total contract labor costs were $29 billion higher in 2022 than 2021.

It is unstainable for hospitals to continue to make up workforce gaps through staffing agencies in light of the exorbitant costs associated with these short-term workers. The financial burden of relying on travelers reinforces the financial stress that challenges hospitals' ability to recruit a more stable, long-term workforce.

WORKFORCE SHORTAGES AFFECT PATIENT ACCESS TO CARE

The workforce challenges experienced by hospitals are being mirrored throughout the entire health care delivery continuum, creating a cascade of potential access challenges for many different types of care. Most notably, significant workforce shortages in post-acute and behavioral health care facilities have left them unable to accept new patients, and in turn, led to significant delays in discharging patients from acute care hospitals, LTCHs and inpatient rehabilitation facilities (IRFs). As noted in a recent Modern Healthcare article, patients discharged from inpatient hospitalization were turned down from admission to a skilled nursing facility 91% of time in the first quarter of 2022.[7] Similarly, hospitalized patients were denied admission to home care 71% of the time in the second quarter of 2022. Hospitals experienced similar challenges for patients awaiting placement in behavioral health facilities.[8]

---

[5] https://www.syntellis.com/resources/report/hospital-vitals-financial-and-operational-trends-0
[6] https://www.aha.org/costsofcaring
[7] https://www.modernhealthcare.com/post-acute-care/hospitals-battle-bottlenecks-post-acute-staffing-gaps
[8] https://www.modernhealthcare.com/article/20190128/NEWS/190129944/emergency-rooms-fill-up-with-psych-patients-and-then-they-wait

While hospitals and post-acute care facilities continually work to find placement for discharged patients, the delays in placement mean a delay in receiving the care that can optimize both their care outcomes and their quality of life. Moreover, the delays create access challenges for patients needing acute hospital care as patients remain in inpatient beds longer than is medically necessary awaiting a successful discharge. This, in turn, can lead to longer waits for placement in inpatient acute care beds, which in turn can lead to longer wait times and higher volumes to manage in hospital emergency departments. IRFs and LTCHs also report similar patient bottlenecks with difficulties discharging their patients to other post-acute care providers, such as skilled nursing facilities (SNFs).

These delays also put incredible strain on hospitals and health systems as they must bear the costs of caring for patients during those excess days without appropriate reimbursement, and they also add burden on an already thin workforce. In other words, hospitals are incurring more costs to care for sicker patients for longer periods of time while facing reimbursement levels that fall short of these higher costs.

Data from Strata Decision Technology, a health care technology and consulting firm, show that the average length-of-stay (ALOS) in hospitals increased 19.2% across the board for patients in 2022 as compared to 2019 levels. The increase is more pronounced for patients being discharged to post-acute care providers — with an increase in ALOS of nearly 24% from 2019 to 2022. This remains true even after accounting for patients being sicker and requiring more complex and intensive care now as compared to pre-pandemic levels, as measured by the case mix index (CMI). CMI-adjusted ALOS has increased for patients being discharged from acute care hospitals to post-acute care providers, with a 12.6% increase for patients being discharged to home health agencies and a 20.2% increase for patients being discharged to SNFs. Similarly, patients being discharged from acute care hospitals to other hospital settings have also seen increases, such as a 28.9% increase for discharges to psychiatric hospitals.

CONCLUSION

The AHA appreciates the opportunity to provide information on how inflation has affected labor and other costs for hospitals and health systems, exacerbating workforce shortages and affecting patient access to care. The AHA looks forward to working with the subcommittee to address these challenges. The AHA's 2023 advocacy agenda includes a range of policy ideas for improving hospital financial sustainability and strengthening the health care workforce over the short and long term.[9] We must work together to solve these issues so our nation's hospitals and health systems, post-acute and behavioral health care providers can continue to care for the patients and communities they serve.

Sincerely,

/s/

Lisa Kidder Hrobsky
Senior Vice President, Advocacy and Political Affairs

---

[9] https://www.aha.org/advocacy-agenda

March 22, 2023

Statement by
Employers Council on Flexible Compensation
For the Committee on Ways and Means
United States House of Representatives
Subcommittee on Health Hearing
"Why Health Care is Unaffordable:
The Fallout of Democrats' Inflation on Patients and Small Business"

The Employers Council on Flexible Compensation (ECFC) appreciates this opportunity to submit a written statement to the Ways and Means Subcommittee on Health regarding the impact of increased out-of-pocket expenses on employees and other individuals with health insurance coverage and to suggest legislative changes that could help reduce the economic impact of these higher out-of-pocket costs.

ECFC is a membership association dedicated to preserving and expanding employer-provided tax-advantaged benefit choices for working Americans, including account-based plans which provide benefits in areas such as health care, childcare, and commuting. These benefits provide families with the support they need to meet their everyday living expenses and remain productive members of the workforce. ECFC's members include employers and companies who provide administrative and consulting services to employer sponsors of employee benefit plans, including health savings accounts (HSAs), health flexible spending arrangements (FSAs), dependent care assistance flexible spending arrangements (DCFSAs), and health reimbursement arrangements – including individual coverage health reimbursement arrangements (ICHRAs), commuter and parking benefits, and COBRA continuation coverage. These accounts are funded by employees and/or employers and are used to pay or reimburse qualified healthcare and other expenses that employees incur and are not covered by the employer's health plans. ECFC member companies assist in the administration of cafeteria plan and health benefits for over 33 million employees.

Employees and Other Health Care Consumers Are Subject to Larger Out-of-Pocket Costs

[1]Consumers are subject to higher deductibles and out-of-pocket expenses not covered by health insurance; therefore, they have to dip into their after-tax savings to cover costs, and many would have to cut back on essential health and dependent care services. The Kaiser Family Foundation Employer Health Benefits 2022 Annual Survey[2] data states that the average deductible for health coverage provided by small employers is $2,543 and $1,493 for large firms. In addition, the Commonwealth Fund Biennial Health Insurance Survey, 2020 found that forty percent of US adults aged 19 to 64 face unsustainable out-of-pocket health costs in relation to their income.[3] The rise in out-of-pocket costs that are shouldered by individuals with health insurance coverage is a problem and ECFC appreciates that the Subcommittee on Health is addressing this issue.

Consumer-Directed Health Plans Can Make Higher Out-of-Pocket Costs Affordable

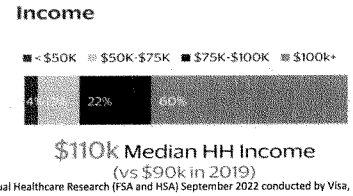
Consumer-directed health plans provide a means for individuals to put aside funds to meet higher out-of-pocket medical costs. Health FSAs (FSAs) and HSAs are two types of arrangements that assist individuals in meeting these higher out-of-pocket costs.

Health FSAs are an employer-provided account that allows employees to contribute pre-tax dollars to pay for qualified medical expenses that are not covered by health insurance. These contributions are not subject to either federal income tax or payroll tax, so employees at all income levels receive a tax benefit for contributing to an FSA. Limits were placed on the amount that could be contributed to an FSA by the Affordable Care Act; the contribution limit for 2023 is $3,050 and that amount is indexed annually to reflect inflation. FSAs are a middle-class benefit, with the median household income of individuals contributing to an FSA is $110,000.

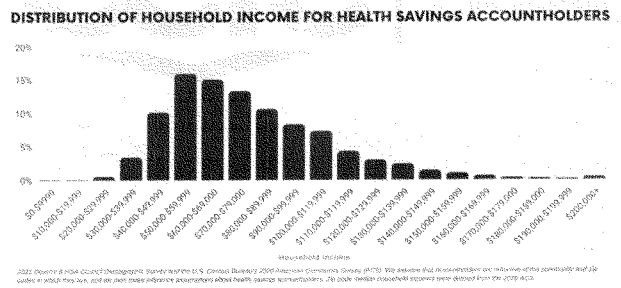
[1] Annual Healthcare Research (FSA and HSA) September 2022 conducted by Visa, Inc

[2] https://files.kff.org/attachment/Report-Employer-Health-Benefits-2022-Annual-Survey.pdf

[3] U.S. Health Insurance Coverage in 2020: A Looming Crisis in Affordability — Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2020



HSAs allow employees to set aside pre-tax dollars to pay for qualified medical expenses. They are a means for consumers to have a tax-effective way to fund these expenses since the contributions made to an HSA are tax-advantaged for both income and payroll tax purposes. An individual can contribute to an HSA if they are covered by high deductible health coverage; individuals covered by Tricare, the Veterans Administration, Indian Health Service, Medicare, or Medicaid not being eligible to contribute. HSAs are a decidedly middle-class benefit, with the average household income of those with an HSA at $78,000.



Distributions from both FSA and HSA accounts for qualified medical expenses are not taxed, meaning that the individual is not taxed on either the contributions made to these accounts and the distributions used to pay for or reimburse qualified medical expenses. In short, both FSAs and HSAs help families afford necessary expenses by

stretching the value of their money. Out-of-pocket medical costs must be paid, FSAs and HSAs make paying these expenses more affordable.

Congress Should Address Limits on Contributing to FSAs and HSAs

To help families cope with the impact of higher medical costs and the resultant increases in out-of-pocket medical expenses, ECFC believes that Congress should remove impediments to individuals contributing to FSAs and HSAs.

Increase or Eliminate the FSA Contribution Limit. The amount that an employee can contribute to an FSA is limited under the Internal Revenue Code. As long as out-of-pocket medical costs continue to rise, there should be a means for employees to pay for these expenses in a tax-advantaged manner. By increasing the FSA contribution limit, employees will be able to contribute the amounts that they think that they will need to pay for medical expenses that are not covered under their health coverage.

Extend Eligibility for HSAs to Disqualified Seniors, Veterans and Native Americans. The rules under the Internal Revenue Code do not allow individuals who meet all other HSA eligibility requirements from opening and funding an HSA. People participating in Medicare, people receiving benefits under Tricare which provides benefits for US Armed Forces military personnel, military retirees and people receiving benefits under the Veterans Health Administration and the Indian Health Service should be allowed to contribute to an HSA.

ECFC appreciates this opportunity to provide its thoughts on this important matter to the Health Subcommittee. If any member of this Subcommittee or any member of the full Committee has any questions regarding this statement or have any questions regarding consumer-directed benefits in general, please contact William Sweetnam, the Legislative and Technical Director of ECFC.

William F. Sweetnam, Jr.
Legislative and Technical Director
Employers Council on Flexible Compensation
1802 Vernon Street NW, #1035
Washington, DC 20009
wsweetnam@ECFC.org
Direct: 202-465-6397
Office: 202-659-4300
Fax: 202-618-6060

Statement for the House Ways & Means Subcommittee on Health

March 30, 2023

Why Health Care is Unaffordable: The Fallout of Democrats' Inflation and High Health Care Costs on Patients and Small Businesses

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

[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.

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 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 factor in high healthcare costs is 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

[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.

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.[9]

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.[10]

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.[11] 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 individuals and employers alike.

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.[12] 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,[13] 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.[14] 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 poverty, fewer adults with postsecondary educations, more uninsured residents under age 65, and higher rates of mortality.[15]

---

[9] Morning Consult. Coverage and Reforming the System. February 2023.
[10] Schwartz, Hope, et al. How do facility fees contribute to rising emergency department costs? *Kaiser Family Foundation*. 27 March 2023.
[11] Ellis, Phillip. Estimated Savings from Adopting Site-Neutral Payment Policies for Medicare. February 2023.
[12] The Cecil G. Sheps Center for Health Services Research. Rural Hospital Closures.
[13] 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.
[14] Frankhauser, Margaret. Health Disparities in Rural America. *JSI*. 16 November 2022.
[15] The Cecil G. Sheps Center for Health Services Research. Rural Health Snapshot (2017). NC Rural Health Research Program. May 2017.

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

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

Statement on Behalf of Members of the Partnership to Protect Coverage
House Committee on Ways and Means
Health Subcommittee
Hearing on "Why Health Care is Unaffordable"
March 23, 2023

Today marks the 13th anniversary of the Affordable Care Act (ACA). The passage of the ACA resulted in drastic reductions of our nation's uninsured rate and expanded coverage to millions of patients with preexisting conditions. The 31 undersigned organizations represent more than 120 million people with pre-existing conditions in the U.S.

Our organizations 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 we believe are critical components of any discussion aimed at improving or reforming our system of healthcare. We urge you to support the policies that have done so much to protect the health and well-being of our nation, and urge you to enact the changes that we've outlined below to further improve upon the Affordable Care Act.

In early 2017, our organizations agreed upon three principles that we use to help guide our work on health care to continue to develop, improve upon, or defend the programs and services our communities need to live longer, healthier lives.[1] These principles state that: (1) healthcare must be adequate, meaning that healthcare coverage should cover treatments patients need; (2) healthcare should be affordable, enabling patients to access the treatments they need to live healthy and productive lives; and (3) healthcare should be accessible, meaning that coverage should be easy to get, keep, and understand and not pose a barrier to care.

The Affordable Care Act and Subsequent Actions Have Made Quality Healthcare More Affordable

People with pre-existing conditions have benefitted from recent increases in federal support for affording health insurance. For example, people with chronic conditions benefitted disproportionately from the passage of the Affordable Care Act. Over the first 5 years of ACA implementation, coverage increased among nonelderly adults with chronic disease by 6.9 percent versus 5.4 for adults without chronic conditions. State-level Medicaid eligibility expansions were associated with a coverage increase among people with chronic conditions of 2.8 percentage points.[2]

At the heart of affordability is Medicaid expansion. Individuals who live in states where Medicaid has expanded saw their medical debt drop dramatically (almost 50%) from 2013-2020; people who live in states that didn't expand Medicaid saw much less decline (only 10%) and in poor communities in non-expansion states, medical debt levels increased.[3] Medical debt – much of which is owed to hospitals – leads to delayed care and poorer health outcomes.
An analysis by the Commonwealth Fund published in the New England Journal of Medicine for the 10th anniversary of the Affordable Care Act found in the first 10 years, the law "reduced the number of uninsured people to historically low levels and helped more people access health care services, especially low-income people and people of color."[4] Quite simply this law is saving lives.

- Improvement in screening rates for colorectal cancer in early Medicaid expansion states translated to an additional 236,573 low-income adults receiving screenings in 2016 and, if the same absolute increases were experienced in non-expansion states, 355,184 more low-income adults would have had colorectal cancer screening as of 2019. Colon cancer screenings in accordance with US Preventive Services Task Force (USPSTF) recommendations have reduced the incidence of colon cancer.[5]

---

[1] Consensus Healthcare Reform Principles: https://www.lung.org/getmedia/0912cd7f-c2f9-4112-aaa6-f54d690d6e65/PPC-Coalition-Principles-FINAL.pdf.
[2] Coverage for Adults With Chronic Disease Under the First 5 Years of the Affordable Care Act - PMC (nih.gov)
[3] https://jamanetwork.com/journals/jama/article-abstract/2782187
[4] https://www.nejm.org/doi/full/10.1056/NEJMhpr1916091
[5] Jeff Legasse, First states to expand Medicaid saw larger screening rate increases, Healthcare Finance, (May 24, 2019), https://www.healthcarefinancenews.com/news/firststates-expand-medicaid-saw-larger-screening-rate-increases (citing Fedewa et al., Changes in Breast and Colorectal Cancer Screening After Medicaid Expansion Under the Case 4:20-cv-00283-O Document 103-2 Filed 11/30/22 Page 14 of 29 PageID 1999 313943270.17 8 Affordable Care Act, Am. J. of Preventive Med., (July, 2019), https://www.sciencedirect.com/science/article/abs/pii/S0749379719301163.).

- The ACA provision expanding dependent insurance coverage to young adults up to 26 was associated with a 3.67 percentage points increase in receipt of blood-pressure measurement among young adults aged 19-25 years.[6]

- An analysis by the Office of the Assistant Secretary for Planning and Evaluation (ASPE) estimated that approximately 137 million Americans with private insurance had access to preventive services without cost sharing in 2015, which increased to 151.6 million by 2020. ASPE attributed the increase to growth in the number of people enrolled in private healthcare coverage subject to USPSTF recommendations, and a decrease in the share of such people enrolled in plans not subject to USPSTF recommendations.[7]

Below are recommendations our organizations have for Congress to make quality healthcare even more affordable:

Make the Enhanced Advance Premium Tax Credits Permanent
The passage of the Inflation Reduction Act in August will keep healthcare affordable for millions of people by extending the enhanced advance premium tax credits (APTCs) through the end of 2025. These tax credits help lower- and middle-income individuals and families afford health insurance purchased through the Affordable Care Act marketplaces. Because of this measure, approximately three million individuals will keep their health insurance and over 10 million individuals won't see their premiums rise.[8] Our organizations urge the Congress to pass legislation that permanently codifies the increased generosity and expanded eligibility for advance premium tax credits (APTCs)

Limit Inadequate Short-Term Limited Duration and Other Non-compliant Plans
The need for adequate, affordable, and accessible coverage has become even more important during the COVID-19 pandemic. Unfortunately, sub-par insurance plans continue to proliferate, confusing consumers and leaving them under-covered, as many of our groups detailed in a recent report.[9] Congress should take action to protect consumers by restricting access to short-term limited duration insurance and other non-compliant plans.

Address Affordability of Health Insurance Out-of-Pocket Costs
In addition to the continued unaffordability of premiums, many people with coverage still cannot access care due to high cost sharing requirements. Congress should take action to ensure that coverage provides meaningful, equitable, and affordable access to care by:

- Shifting the APTC benchmark from silver plans to gold plans to decrease out of pocket exposure for patients;
- Ensuring that actuarial value (AV) of plans accurately reflect the financial risk faced by most consumers enrolled in the plan.[10] This can be achieved through adjusting the standard population used to calculate AV and disregarding claims from outliers[11] ; and

---

[6] Dependent Coverage and Use of Preventive Care under the Affordable Care Act, New England Journal of Medicine (Dec 11, 2014), available at https://www.nejm.org/doi/pdf/10.1056/NEJMc1406586?articleTools=true.
[7] Office of Health Policy: Assistant Secretary for Planning and Evaluation, at p. 6.
[8] https://www.hhs.gov/about/news/2022/06/22/fact-sheet-what-happens-premiums-if-extra-help-american-rescue-plan-expires.html
[9] Under-Covered: How "Insurance-Like" Products Are Leaving Patients Exposed. March 2021. undercovered_report.pdf
[10] A study in published in Health Affairs found that the share of costs actually borne by consumers was typically much higher than would be suggested by the AV. Polyakova, M., Hua, L. M., & Bundorf, M. K. (2017). Marketplace plans provide risk protection, but actuarial values overstate realized coverage for most enrollees. Health Affairs, 36(12), 2078-2084. doi:10.1377/hlthaff.2017.0660
[11] As described in: Center for Medicaid & Medicare Services. (2020, March 6). Final 2021 Actuarial Value Calculator Methodology. Retrieved from https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2021-AVCalculator-Methodology.pdf . pg. 11.

- Taking other actions to address the rising out of pocket costs faced by enrollees in the individual market and employer-sponsored insurance, such as through potentially incorporating deductible and cost-sharing into definitions of affordability.

Support and Expand Medicaid Coverage
Our organizations thank Congress for making continuous coverage eligibility for one year mandatory for children under 19 and encourage you to build upon previous investments in postpartum coverage, as well as make funding for the Children's Health Insurance Program permanent. Additionally, Congress should take action to address coverage for individuals who live in states that haven't expanded Medicaid and fall in the "coverage gap."

Conclusion
We look forward to continuing to work with Congress to improve upon the advancements made by the Affordable Care Act to expand affordable, accessible and adequate healthcare coverage for patients. I

Sincerely,

Alpha-1 Foundation
ALS Association
American Cancer Society Cancer Action Network
American Diabetes Association
American Heart Association
American Kidney Fund
American Liver Foundation
American Lung Association
Arthritis Foundation
Asthma and Allergy Foundation of America
CancerCare
Cancer Support Community
Chronic Disease Coalition
Crohn's & Colitis Foundation
Cystic Fibrosis Foundation
Epilepsy Foundation
Hemophilia Federation of America
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 Kidney Foundation
National Multiple Sclerosis Society
National Organization for Rare Disorders
National Patient Advocate Foundation
Susan G. Komen
The AIDS Institute
The Leukemia & Lymphoma Society

○