The Alliance to Fight for Health Care

Advancing employer-provided coverage

Comments Submitted to the Healthy Future Task Force Affordability Subcommittee RFI

The Alliance to Fight for Health Care submitted the following comments to the Healthy Futures Task Force Subcommittee on Affordability on February 4, 2022. Included below are the questions from the Affordability Subcommittee's webform and the answers provided by the Alliance.

Teal = question from the webform document; **Black** = The Alliance's response.

I. Improving Healthcare for America's Workers and Small Business Owners.

The centerpiece of small business health insurance relief in the Affordable Care Act (ACA) was the Small Business Health Insurance Tax Credit. Proponents of the ACA claimed the credit would assist millions of small businesses in offering affordable coverage to their employees. CBO estimated that the credit would peak at $6 billion in utilization. Yet, the promises of this benefit never came to fruition. Despite the affordability crisis growing worse after ACA passage, data on the credit from the Internal Revenue Service shows that utilization peaked at around $555 million in its early implementation before steadily declining to just $30 million in the last year data is currently available from Treasury.

a. What are the primary factors contributing to the low utilization of the Small Business Health Insurance Tax Credit?

Employers of all sizes offer health coverage to their employees. However, small employers have had a more difficult time providing coverage due to cost, access, and complexity. Several proposals have been offered to provide small employers a tax incentive to sponsor health insurance for their employees. In 2010, the Affordable Care Act (ACA) enacted a much-needed tax credit to offset the cost of health insurance offered by a small business. Unfortunately, the tax credit as enacted was poorly designed, complicated, only available for a limited time and has not been used by many taxpayers. Small business groups, including the National Federal of Independent Businesses (NFIB), have testified that the small business credit is ineffective and in need of reform (NFIB March 22, 2016 Ways & Means Hearing Testimony).

The main reasons for this lack of effectiveness stem from its reliance on exchange coverage through the Small Business Health Options Program (SHOP) and includes complicated and overly narrow rules for qualification.

b. What kind of credit design would help incentive small businesses to offer or maintain coverage given the availability of highly subsidized coverage on the individual market? Who would benefit from an improved small business tax credit, and would increasing government spending on this type of credit result in savings to other government programs?

To increase the effectiveness of the credit and better incentivize small businesses to provide health insurance to employees the credit should be modified to (1) broaden the insurance options employers can provide; (2) allow access for more than two consecutive years; and (3) increase the size of small employer that qualify while simplifying the calculation, as outlined below:

Broaden the Insurance Options to Qualify for Credit -- The tax credit is only available for insurance purchased on the ACA established federal or state exchanges (chiefly SHOP exchange plans). In more than half the states, there are no insurers offering a SHOP plan, leaving small businesses in those states with no access to the tax credit. (CRS Report, *Overview of Health Care Exchanges*, April 29, 2021). Thus, for many small employers that may wish to offer insurance the tax credit is of no effect and does not provide any incentive. *To correct this problem, the tax credit should be amended to remove the requirement that the tax credit is only available for purchases of insurance on an exchange (i.e., SHOP plans). By expanding qualified insurance to include private insurance plans, more small businesses would both qualify for the credit and be more likely to offer health insurance making it much more effective as an incentive to expand health care coverage to workers.*

Permit the Credit for More than Two Consecutive Years – An eligible employer may claim the credit no more than two consecutive tax years, which also hinders adoption. The statute should be amended to permit the credit for more than two consecutive years for coverage offered through a health insurance exchange or outside a health insurance exchange.

Increase the Number of Employees for Qualification and Remove the Overly Complicated Wage Formula – The tax credit is currently limited to businesses with 25 or fewer full-time employees and requires a complicated formula based on average wages of the small business employee for qualification. *The credit should be amended to increase the size of a small business that can qualify to 50 or fewer full-time employees and the phase-out of the credit should be based simply on the number of individual employees and not on a complicated formula based on wages.*

Expanding coverage of private insurance for small employers has many positive effects. Employers on average subsidize nearly 80% of the cost of employer sponsored health coverage. While the subsidized amount can be lower for small employers, the tax credit requires the employer to contribute at least 50% towards the cost of employee health care. Thus, by expanding the number of individuals that are covered by an employer plan it would reduce the cost incurred by the government to subsidize individual health insurance of those employees through other means (such as individual tax credits) and lessen the cost borne by the health system, state and federal government programs for individuals that may go uninsured.

The Alliance has generated legislative proposals to achieve this goal. We would welcome the opportunity to share changes to the statue to improve access to health coverage for small

employers and their employees, please email alliancetofightforhealthcare@gmail.com should you be interested in additional detail.

II. Promoting Employer Programs to Lower Costs and Improve Care

Many large employers are participating in innovative initiatives to lower costs and improve care such as direct contracting, high performance networks, and centers for excellence; however, midsize and smaller employers often face barriers such as establishing "critical mass" to utilizing these programs. The goal of the following questions is to 1) identify barriers that exist for employers which prevent them from entering these programs, and 2) work towards achieving policy solutions to help employers of all sizes and in all geographic regions provide health care at a lower cost and higher value to their employees.

a. In what ways can the federal government help midsize and smaller employers enter the programs listed above?

The Alliance aims to support continued employer innovation while taking on health care costs directly by implementing policies that make health care more affordable, strengthens job-based coverage, and improves the health care system for all patients. This includes polices aimed at removing barriers to innovative employer programs and incentivizing greater uptake and collaboration across all employers – regardless of size.

First, we support advancing legislation that bans anticompetitive terms in facility and insurance contracts that restrict access to higher quality, lower cost care (e.g. S. 3139, the Health Competition for Better Care Act). 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 such legislation would enable more group health plans or a health insurance issuers to enter into agreements with providers that steer enrollees to high-value providers and provide incentives to encourage enrollees to seek higher-quality, lower cost care. High-performance networks can encourage providers to improve their quality and lower their prices, result in savings for both patients and employers, and lead to higher-quality care across the board. Legislation should recognize that there are also legitimate forms of integration of provider and payer functions that can promote more efficient, higher quality care models.

Second, 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 payors will accelerate beneficial changes for all participants. Creating pathways for employers to participate 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. While CMS leadership has suggested that multi-payer alignment is critical to achieving long-term success, there are currently limited ways in which CMMI engages with employers. For example, in the Primary Care First model, payer "partners" commit to aligning with the model's payment, quality measure, and data-sharing methodologies, however, there are not adequate incentives to encourage participating providers to commit to

similar payment structures for non-Medicare payers. Due to that fact, it will be difficult for employers and smaller payers to participate. CMS and Congress should consider ways to drive provider participation and alignment across innovative payment models. Similar to the motivation behind CMS's All-Payer Advanced Alternative Payment Models (APMs), the federal government should work toward solutions that incentivize providers to participate in value-based models with multiple payers, including employers and others in the commercial market.

Unfortunately, public and private payers too often work in silos despite many times working towards the same goal. Employers 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.

Third, we support allowing plans and employers to offer more high-value care pre-deductible. Current limitations in the type of care that can be provided before the deductible limits consumer access to high-value care that can both improve health and reduce costs. This includes supporting:

- The Chronic Disease Management Act (H.R. 3563/S. 1424), which allows greater flexibility to offer pre-deductible coverage for chronic disease prevention.
- The Telehealth Expansion Act (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.
- Creation of a safe harbor based on actuarial value such that individuals enrolled in plans below a specified actuarial value may make and receive contributions to Health Savings Accounts (S. 2099).
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You can find a list of our recommended policies – including the barriers they aim to address – on our website at www.fightforhealthcare.com.

c. Are there any state or federal regulations that disincentivize employers, payors, or providers from entering into these programs?

As alluded to above, current laws and regulations limiting what items and services may be offered pre-deductible are barriers to employers and plans utilizing value-based payment reforms and benefit designs that steer patients to the highest value providers operating in the highest value settings. Specifically, laws and rules limiting pre-deductible coverage for chronic disease prevention, onsite medical clinics and access to telehealth inhibit employers' ability to offer high-value and potentially life-saving care to their employees on an equitable basis. Currently, a limited IRS definition of preventive care inhibits plans and employers from offering more chronic treatments pre-deductible for chronic disease prevention. In addition to the notable access and downstream cost management benefits, people with chronic physical conditions are also more likely to suffer from mental health problems. Research suggests that people who have depression and other medical illness tend to have more severe symptoms of both illnesses and that a collaborative care approach can improve overall health. Because of this critical link, the Alliance supports legislation

such as the Chronic Disease Management Act (H.R. 3563/S. 1424), which allows greater flexibility to offer pre-deductible coverage for chronic disease prevention.

We also support legislation such as the Telehealth Expansion Act (S. 1704/H.R 5981), which makes permanent the flexibility for HSA-eligible plans to offer telehealth pre-deductible. Other telehealth legislation and flexibilities that enable providers to work across state lines and legislation that allows patients to receive services in their homes are critical to expanding access and bringing care to people who need it, when and where they want to access it.

d. What data barriers exist that prevent employers from entering these types of programs?

Inadequate access to cost and quality data about health care providers makes it difficult for employers to create value-based programs such as high-performance networks, which often depend on access to such data to develop their performance tiers. Additionally, a lack of standardized performance metrics and data collection make it difficult to identify areas for quality improvement and high-value care, as well as increasing reporting burden on health care providers.

d(i). What legislative solutions could Congress offer to help address these barriers?

Specific to the data barriers, we support encouraging and funding for public-private partnerships aimed at harmonized reporting of performance measures by health care providers across all payers, which should include a core set of disparity reduction measures.

e. What innovative tools, like medical decision support tools, can employers offer to help employees navigate the healthcare system and improve convenience?

Employers have long led the way in achieving lower costs and better value, including through innovative arrangements with providers that focus on care coordination, transparent pricing, and cost-effective care delivery. Employers also provide services that empower their employees to make the best decisions about their own care and wellbeing. This includes offering second opinion services, care navigators, collaborative care models, and targeted programs to manage chronic illness. Mercer and the American Benefits Council outlined some of the actions employers are taking in their 2018 report, "Leading the Way: Employer Innovations in Health Coverage" available at: https://www.mercer.us/content/dam/mercer/attachments/north-america/us/Health/us-2018-health-innovation-whitepaper.pdf

IV. Increasing Competition and Identifying Anti- Competitive Consolidation

On November 21, 2018, the Trump administration issued a final rule reducing reimbursement rates for clinic visits at hospital-owned outpatient provider departments by 40%, matching the rates paid for clinic visits in physician offices. CMS estimates that this final rule could save Medicare about $760 million annually. Despite legal challenges, the Biden administration is upholding the rule.

a. How can Congress build on the Trump Administration's site neutral payments rule?

The Alliance supports payment parity across site of service in order to decrease Medicare and commercial spending, ensure patients receive the right care in the right setting, lower taxpayer and beneficiary costs, and increase patient access. Recent studies highlight how such parity could lead to savings across the health care system, depending on the scope of implementation.

Congress can build on site neutral payment reform by requiring Medicare to pay the same rate to all on and off- campus hospital outpatient departments, ambulatory surgery centers, emergency departments, and off-campus physician offices. A recent policy brief by the Committee for a Responsible Federal Budget (CRFB, *Equalizing Medicare Payments Regardless of Site-of-Care*, Feb. 23, 2021), found that advancing site neutral payments for HOPD services that are commonly and safely performed in physicians' offices or ASCs and for which the patient mix is relatively equal – using criteria developed and recommended by MedPAC — could:

- Reduce Medicare spending by $153 billion
- Reduce premiums and cost-sharing for Medicare beneficiaries by $94 billion
- Reduce total national health expenditures by a range of $346 to $672 billion
- Reduce the federal budget deficit by a range of $217 to $279 billion
- Reduce private cost-sharing and premiums by a range of $140 to $466 billion

Across the Medicare program, reimbursement rates vary significantly based on site of service, and private insurance claims data also show increased spending on HOPD services is playing a major role in overall spending growth because of increases in both prices and volume. Using private insurance claims data for about 590,000 active and retired nonelderly autoworkers and their dependents, the Center for Studying Health System Change (CSHSC, *Location, Location, Location: Hospital Outpatient Prices Much Higher than Community Settings for Identical Services,* June 2014 Research Brief) found that the average price for magnetic resonance imaging (MRI) of a knee was about $900 in hospital outpatient departments compared to about $600 in physician offices or freestanding imaging centers. Likewise, the average hospital outpatient department price for a basic colonoscopy was $1,383 compared to $625 in community settings.

We urge Congress to consider ways to encourage site-neutral payments in commercial settings in addition to Medicare. In the aggregate, employers and workers would collectively save $11.2 billion if price differentials between HOPDs and other sites of treatment were eliminated (EBRI Issue Brief, *Location, Location, Location: Cost Differences in Health Care Services by Site of Treatment — A Closer Look at Lab, Imaging, and Specialty Medications*, Feb 18).

Thank you for the opportunity to comment. We hope to work hand in hand toward our joint goal of making health care more affordable for patients and families. Please reach out to alliancetofightforhealthcare@gmail.com with any questions.