Health Care Cost Transparency Board testimony

A prescription for greater health care and insurance affordability

November 20, 2025

- Thank you for the opportunity to testify.
- Who am I and what is NFIB?
- Given the late hour and limited time to discuss a very complex issue, NFIB has submitted additional written comments.

The small group and individual health insurance markets nationally and in our state face grave challenges. We've outlined some key factors and findings in our written comments, but you are already aware of most of them.

Double-digit rate hikes have become the norm.

While it is easy to cast blame on Washington, DC, for the 20% jump in individual health plan rates for 2026 in the Exchange, our own state actions are directly inflating insurance costs to our own residents. Yesterday's small group market rate announcement **is astounding**. The insurers' nearly 10% average rate increase request for small-business plans was painful enough. To learn the OIC granted them 30% more, on average, than they requested is mindboggling. When digging deeper, the fact that nearly half the covered lives in that market will be hit with rates increases 57% higher than the insurer asked for is unconscionable.

Sadly, government-driven cost increases are nothing new and only one of several factors making health insurance and health services less and less affordable.

NFIB's recommendations today will focus on several potential policy changes this Board, its participating agencies, and the Legislature could undertake to improve the health of these markets and reduce costs to **small employers**, the **families** and **individuals** we support.

First and foremost, NFIB will reiterate its belief that greater transparency—a central fixture of this Board's identity—is essential to any meaningful progress in addressing access and affordability. **We must shine more light on the dark corners of the healthcare industry**.

Specifically, more must be done to expose **the**:

- Practices and resulting cost-drivers of Pharmacy Benefit Managers (**PBMs**);
- Continuing growth of **not-for-profit insurers' unrestricted surpluses** or "unassigned funds" that total $3.4 billion as of the 3rd quarter of this year;
- Extent to which **charity care and community benefit requirements** of non-profit hospitals and systems are actually reaching the patients and communities intended; and
- Growing number of alarming reports about misuse and other excesses in the **340B prescription drug program**.

The small group health insurance market in our state is already anemic. Just 206,000 individuals receive coverage there, compared to the nearly 700,000 small business owners in this state and the 1.5 million workers we employ.

This board may be in a unique position to convene stakeholders—legislators, agencies, the Exchange, insurers, small employers, agents and brokers—to delve into the barriers preventing small businesses from obtaining coverage in this market.

We also urge the Exchange to revisit the SHOP. Engage with insurers, small employers, and small business advocates to see what changes, if any, could lead to establishing a functioning, statewide SHOP.

Meanwhile, the Exchange, OIC, and lawmakers should review any regulatory hurdles or administrative policies that may inhibit the use of **Individual Coverage Health Reimbursement Arrangements** (ICHRAs) inside or outside of the Exchange. Similarly, more should be done to promote and perhaps require the coupling of **Health Savings Accounts** with Bronze-tier plans or other High Deductible Health Plans outside of the Exchange.

When it comes to plan design, NFIB believe the "**all plans should be standard plans**" inside the Exchange is exactly the wrong prescription. As one small business owner explained in our written comments, when cost is an issue, unnecessary items are the first to go. Similarly, **one-size-fits-all benefit add-ons** mandated in Exchange plans drive up premiums, deductibles, and other cost-sharing requirements, contrary to the intent of standard plan designs. Instead, we urge the Exchange to thoroughly review **benefit utilization** to see whether a less expansive plan, still meeting Essential Health Benefit and actuarial value requirements is possible, particularly at the Silver tier level.

Provider consolidation and resulting **fee add-ons** must also be subjected to greater scrutiny by state regulators.

Independent medical practices are small businesses. As such they face the same challenges of providing affordable health coverage to their employees. In addition, a myriad of other increasing costs and, in many cases, **decades-long stagnation in reimbursement rates**, too often **force them to sell to hospitals, larger practices, or even private equity firms**. This takes decision-making out of local hands, priorities profitability over patient needs, reduces choice and competition, and often leaves our communities poorer for it.

While we understand the motivation of hospitals to expand and absorb other provider groups to improve their bargaining power against the insurers, as well as the financial challenges driving independent providers to sell to hospitals, unbridled consolidation is proving too costly to consumers.

Similarly, the market distortions caused by the growth in mergers, acquisitions, and wholly owned subsidiaries among insurers, PBMs, and health systems should be cause for alarm. Vertical integration and self-dealing can result in opaque pricing strategies that allow insurers to increase profits outside of the MLR, and drive consumer prices higher.

Finally, OIC's recent affordability report invites a reexamination of **Medical Loss Ratios**. That report details how **increasing MLRs to 88%** across the board presents intriguing opportunities to lower premiums, increase provider reimbursements, generate $144 million in increased state tax receipts over four years, or some combination thereof.

In addition, this Board, the OIC, and others should investigate how widespread the practice of insurers including internal charges and transactions with wholly owned subsidiaries as part of their MLR expenditures has become. Allowing an insurer to spin off prior authorization, utilization review, "payment accuracy," IT and analytics, and other services and then effectively charge themselves for those services does little more than inflate system and premium costs, and undermines the intent of the medical loss ratio to limit profits and direct premium dollars to actual medical care. If such practices are in fact contributing to higher costs, the Legislature should consider limiting or prohibiting them.

Thank you. Happy to answer any questions.