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

Testimony

of the

American Hospital Association

for the

Committee on Health, Education, Labor and Pensions

of the

U.S. Senate

"Lower Health Care Costs Act"

June 18, 2019

Chairman Alexander, Ranking Member Murray and members of the Committee, my name is Tom Nickels. I am executive vice president of the American Hospital Association (AHA). On behalf of our nearly 5,000 member hospitals and health systems, along with our clinician partners, I appreciate the opportunity to testify today.

We appreciate the Committee's interest in addressing the important issue of health care costs, and recently provided feedback on the Lower Health Care Costs Act of 2019. The cost of health care in America affects all stakeholders, including patients and their families, employers, policymakers and care providers. We all play a role in making care and coverage more affordable. Hospitals and health systems understand the importance of this issue and have been addressing it directly by taking steps to redesign care and implement operational efficiencies.

The Committee has focused its efforts around surprise medical bills, prescription drug prices, health care transparency, public health and health information technology. I address the provisions contained in the Lower Health Care Costs Act, as well as suggest some potential additions to the package, below.

SURPRISE MEDICAL BILLS

No patient should be surprised by a medical bill. Hospitals and health systems are deeply concerned about the effect unanticipated medical bills can have on our patients. These bills can cause patients financial and emotional stress and undermine trust and

confidence in their caregivers. Protecting patients from surprise medical bills is a top priority for the AHA and our members.

The AHA supports a federal-level solution to protect all patients from surprise medical bills, including individuals who receive health care coverage through plans regulated under the Employee Retirement Income Security Act of 1974 (ERISA) and those who live in states that have not yet enacted comprehensive protections.

Our preferred solution is simple: Patients should not be balance billed for emergency services, or for services obtained in any in-network facility when the patient could reasonably have assumed that the providers caring for them were in-network with their health plan. In these situations, patients should have certainty regarding their cost-sharing obligations, which should be based on an in-network amount. Once the patient is protected, hospitals and health systems should be permitted to work with health plans on appropriate reimbursement. We strongly oppose the imposition of arbitrary rates on providers, along with untested proposals such as bundling payments or "network matching," which would significantly increase complexity in the system and may, ultimately, be unworkable. We encourage the Committee to use this opportunity to help simplify the health care system rather than add more complexity.

Notice and Disclosure Prior to Post-stabilization Out-of-Network Service. The committee's discussion draft would require that hospitals, prior to the provision of any out-of-network post-stabilization service, provide the patient with: notice of out-of-network services with the option to affirmatively consent to them; a list of in-network hospitals or practitioners with the option for referral; and the estimated amount such provider would charge for out-of-network services. Hospitals and health systems recognize the importance of patients receiving care from in-network providers; therefore, most hospitals have some form of notice-and-disclosure protocols in place. In addition, many states have laws to require notification of network status, including requiring of estimates of fees for potential out-of-network care. While providing the patient such network status information is important, it is not in and of itself a solution to surprise medical bills. In addition, the provision, as written, should be revised to be a shared responsibility between the providers and the patient's insurer. For example, the out-of-network hospital is not going to have access to information on in-network alternatives, which should be the responsibility of the insurer to provide. We encourage the Committee to focus on fully protecting patients by prohibiting surprise bills and expanding notice-and-disclosure requirements to insurers as part of the solution.

Addressing Payment Disputes. The committee's discussion draft outlines three options to resolve payment disputes between providers and health plans: an in-network guarantee; an independent dispute resolution process; and a benchmark rate.

Option 1 would require that in-network facilities guarantee to patients and health plans that every practitioner caring for the patient in the facility is considered in-network. Some have described this approach as "network matching," where the facility-based

practitioner would be required to contract with every plan for which the facility has a contract.

The AHA opposes this option because it interferes with the fundamental relationship between hospitals and their physician partners and severely limits practitioners' ability to negotiate contract terms with insurers. Providers consider a number of factors besides reimbursement when determining whether to contract with a payer, including whether the payer is a fair business partner in terms of administrative burden and processes. In addition, providers and health plans should be able to develop networks that meet consumers' needs, and neither party should be compelled to enter into a contract based on the decision of a third party. It is also important to note that this proposal represents a prescriptive, national application of an unproven approach that will certainly have negative unintended consequences. In addition, it could result in significant economic harm to rural hospitals and communities.

In *Option 2*, an independent dispute resolution process would be established for payment disputes above $750. Plans, facilities and/or practitioners would submit their best offer to the arbiter consistent with "baseball-style" arbitration. The arbiter could take into consideration information that would include the median in-network rate for services in the geographic area. The arbiter's decision would be binding and the losing party would pay the arbitration costs. Balance bills valued at $750 or less would be paid at the median contracted rate for that service in the geographic area.

The AHA believes that hospitals and payers should be left to negotiate reimbursement for out-of-network claims without government interference; however, there may be a role for an alternative dispute resolution process for physician claims. Several states have passed laws to establish such a process to mediate out-of-network claims between physicians and health insurers. Prominent among these processes is "baseball-style" arbitration, and New York is one such state that frequently is referenced as having a successful process. One study noted that the New York law reduced out-of-network billing by 34 percent.[1] A more recent study found that, "as of October 2018, IDR [New York's independent dispute resolution entity] decisions have been roughly evenly split between providers and payers, with 618 disputes decided in favor of the health plan and 561 decided in favor of the provider… Additionally, insurers and physicians appear to be making 'a real concerted effort' to work out their payment disputes before filing with IDR." The study also noted that, while it may be too soon to know if the arbitration process leads to higher out-of-network prices, there had not yet been an inflationary impact on insurers' annual premium rates.[2]

[1] Surprise! Out-of-Network Billing for Emergency Care in the United States; Zack Cooper, Fiona Scott Morton, and Nathan Shekita; NBER Working Paper No. 23623 July 2017, Revised January 2018.
[2] New York's 2014 Law to Protect Consumers from Surprise Out-of-Network Bills Mostly Working as Intended: Results of a Case Study; Corlette, S. and Hoppe, O.; Georgetown University Health Policy Institute – Center on Health Insurance Reforms; May 2019
https://georgetown.app.box.com/s/6onkj1jaiy3f1618iy7j0 gpzdoew2zu9

For arbitration to work within the context of a federal solution to surprise medical billing, it would need to be designed effectively and accommodate existing state programs. In our comments to the Committee, we identify several features that are important to include, such as ensuring that patients are removed entirely from the process.

In addition, the AHA appreciates the work done by the Senate Bipartisan Working Group in S.1531 that has developed such a model. We encourage the Committee to look at the features of S.1531, with some modifications, as an option for determining out-of-network reimbursement for physicians. That proposal allows a market-based, flexible and efficient negotiation to take place. However, while much of the structure of the process outlined in S.1531 is positive, we do believe that an automatic payment prior to initiating the dispute resolution undermines a provider's opportunity to negotiate fair reimbursement.

In *Option 3*, the health plan would pay the out-of-network practitioner and/or the facility based on the median contracted rate for services in the geographic area. **We urge committee members to reject a legislative proposal like Option 3 that would have the government dictate rates between two private entities**. Health plans and hospitals have a longstanding history of resolving out-of-network emergency service claims, and this process should not be disrupted. We are particularly concerned that any attempt at setting a reimbursement standard in law will have significant consequences, including by disincentivizing insurers to maintain adequate provider networks. Growth in the use of no-network, reference-based pricing models in the commercial market suggests this already is a growing strategy, and one that would accelerate if the insurer could simply point to a government-dictated rate or methodology. In addition, this proposal does not allow for future adjustments short of another act of Congress.

Also, this approach could be particularly devastating to rural hospitals, which already are operating with thin margins, as it would put further downward pressure on their financial resources, and make it even more difficult to attract and compensate an adequate health care workforce. Medicare and Medicaid made up 56 percent of rural hospitals' net revenue in 2017 and, as these programs already pay less than the cost of care, further reduction on the commercial side will increase the already heavy financial burden rural hospitals are facing. More than 40 percent of rural hospitals have negative total operating margins and 107 rural hospitals have closed since 2010, including 10 this year alone.

Air Ambulance Billing. The committee's discussion draft begins to address concerns regarding out-of-network billing for air ambulances; however, the draft only addresses issues regarding price transparency and does not prohibit balance billing by these providers. The AHA believes Congress has a real opportunity to put forward a federal solution to address growing concerns over surprise billing for air ambulance services. **We encourage Congress to address air ambulance service issues while developing legislative solutions related to surprise medical billing.** More specifically, we ask that the Congress extend similar consumer protections from out-of-

network billing to air ambulance services and include air ambulance services in network adequacy requirements.

REDUCING THE PRICES OF PRESCRIPTION DRUGS

The AHA applauds the Committee's continued work to lower the price of prescription drugs for both patients and the providers who care for them, and supports the drug pricing proposals included in the Lower Health Care Costs Act. Each of the proposals in the legislation seek to increase competition and protect access through appropriate market-based solutions.

Specifically, we support the inclusion of provisions aimed at restoring clarity and transparency to both the Purple and Orange Books. Abuse of patent and exclusivity law remains a significant barrier to lowering drug prices, and the Committee's proposals to restore transparency related to patent and exclusivity periods for biological products and small molecule drugs is a critical component of removing those impediments. We thank the Committee for its inclusion of several proposals focused on fostering increased competition, as well as ensuring patient access to affordable medicines on which they rely. In addition, we support the Committee's plan to facilitate the increased utilization of biosimilar products, when appropriate, by requiring that the U.S. Food and Drug Administration (FDA) establish educational tools for both biosimilar and interchangeable products. We also support the Committee's recognition of a longstanding issue concerning the drug approval process – abuse of the five-year New Chemical Entity (NCE) exclusivity. This proposal would rightfully establish a process to properly apply the NCE designation, granting exclusivity to only the most novel drugs that are developed.

However, we suggest the Committee consider additional ways to increase transparency and keep drug prices in check. In particular, we support the Fair Accountability and Innovative Research (FAIR) Act, which would require drug manufacturers to disclose and provide information related to planned price increases. Specifically, this bill would increase transparency around the price of certain drugs by requiring, for the first time, a justification for the price hike, as well as research and development costs, marketing and advertising costs and the net profits attributed to the drug. Hospitals, as well as other stakeholders, already provide a significant amount of similar publicly available data, and it is time to hold drug manufacturers to that same standard.

Hospitals are required by law to submit cost reports in order to receive Medicare payment. Hospitals must send expenditures, charges and other financial information to Medicare to qualify for reimbursement. Specifically, the cost report is a series of forms that collect descriptive (ownership status, type of facility, etc.), financial, cost, charge, wage index and statistical data. Hospitals already submit information similar to what would be asked of pharmaceutical companies through the FAIR Act. Specifically, research expenses are described on line 191 ("Research") of Worksheet A ("Balance of Expenses"). Advertising and marketing expenses are included in "Other

Nonreimbursable Expenses" on line 194 of Worksheet A. Cost report data are public and contained in the Healthcare Cost Report Information System (HCRIS) via the Centers for Medicare & Medicaid Services' website in raw format. There are a number of private vendors that repackage and sell cost report data; however, it is common for analysts to work directly with the raw data.

In addition, non-profit hospitals, must also file Form 990 with the Internal Revenue Service. Among other data, the Form 990 collects information on both advertising and research expenses. Advertising and promotion expenses are described on line 12 of Part IX. Fundraising expenses are also described in several places in the 990: direct expenses of fundraising events are reported in Part VIII, line 8b of the 990; indirect expenses of fundraising events, including advertising expenses, are reported in Part IX, column (D). Descriptions of research activities, including associated expenses and revenues, are included in Part III ("Statement of Program Service Accomplishment").

Increased transparency into drug pricing, such as what is already provided by hospitals, could be used to hold drug manufacturers accountable for fairly pricing products, help calculate the value of a drug, and will play a foundational role in supporting future policymaking.

As the Committee continues its work to lower drug prices for both patients and the providers who care for them, we urge you to consider additional proposals that would be effective. Specifically, we recommend the Committee examine responses to pay-for-delay and ever-greening tactics employed by drug manufacturers, which, contrary to Congressional intent, are used to extend FDA exclusivity and force potential competitors out of the market. We also ask the Committee to consider incorporating existing legislation that would align payment with the most commonly used dosages for drugs. Far too often, hospitals have no choice but to purchase too much of a drug because of manufacturer packaging sizes, resulting in increased waste at a high cost to patients. Further, as the health care delivery system transitions toward more value-based payment models, we urge the Committee to pursue comparative effectiveness testing aimed at demonstrating the value of new drugs relative to other, more affordable options, as well as to consider the implementation of potential risk-sharing models based on patient outcomes.

IMPROVING TRANSPARENCY IN HEALTH CARE

The AHA supports increased consumer access to health care pricing information. However, we have serious concerns with some of the policies proposed.

Provider/Health Plan Contract Requirements. The discussion draft includes a number of new requirements that would severely impede provider and health plan contracting. **We do not support these policies because they would unnecessarily increase costs, discourage commercial health insurers from pursing value-based care arrangements with providers and/or put consumers at risk of being subject to practices that would limit their access to care.** In addition, for some integrated

delivery systems, some of the provisions would be wholly unworkable and result in their dissolution, jeopardizing patient access to high-quality, integrated coverage and care delivery.

The provisions in Section 301 are perplexing; hospitals support providing consumers with tools to understand the extent of their coverage and payment obligations, so it is not clear what the actual issues are that the discussion draft seeks to address. With respect to HIPAA requirements, the underlying legislation and rules provide a consistent and largely workable framework for commercial health insurers or any other legitimate business associate to obtain the information needed to process claims and provide consumers with the services they require. Again, it is not clear what the actual issues are that the discussion draft seeks to address and how it would benefit consumers.

Conversely, a number of the provisions in Section 302 would not benefit consumers and would harm hospitals and hospital systems, including those with integrated health plans. For example, preventing providers from declining unfair tiering and/or steering restrictions imposed by insurers would undermine the basis for value-based care. Put another way, commercial insurers cannot be allowed to have it both ways – that is, enjoy the savings from providers shouldering financial risk under a value-based care arrangement while simultaneously encouraging those same patients to go elsewhere for care.

Likewise, it would be unfair, particularly to rural and urban hospitals, to allow commercial insurers to cherry-pick which hospitals in the system they contract with. There are enormous economic efficiencies and quality benefits associated with contracting with commercial insurers as a system. For example, to promote efficiency and maintain quality, many systems do not duplicate services at every site of care within the system. That means, excluding one or more of those sites would, at best, limit access to care. Moreover, allowing commercial insurers to decline to include system hospitals that serve vulnerable communities, particularly in rural areas, which is the most likely scenario, would put those already vulnerable communities at even greater risk by limiting access to care.

It is incumbent on those who support legislation in the area of private contracting to provide data, rather than mere anecdotes, to justify such intrusion by the government before the Committee adopts such significant change.

We also are deeply concerned about the provisions in Section 309 that would prohibit health plans from contracting with providers unless the provider agreed to provide enrollees their estimated cost-sharing amount at the time of scheduling or within 48 hours of a request. The AHA supports policies that encourage the continued development of out-of-pocket estimates, when appropriate, and many of our members are already undertaking these endeavors. However, restrictions on provider-health plan contracts are not the right approach, especially in light of significant movement in this area by the field.

The AHA agrees that patients should have access to an estimate of their out-of-pocket costs. However, there are a number of challenges to providing accurate and reliable out-of-pocket cost estimates, not least of which is the inherent uncertainty that exists within health care. While there are treatments that generally follow a common course and are agnostic to patient characteristics, there are many others for which the services needed can change over the course of care, depending on how a particular patient responds to a treatment and the evolution of their disease or injury. For those services for which estimates can be generated, hospitals and health systems have typically relied on financial assistance staff to help patients navigate their insurance benefits and develop out-of-pocket cost estimates. While providers are working to develop the ability to provide these estimates in other ways, such as through their websites and other online applications, there is still much work that must be done directly with patients and insurers if complications or questions arise. Therefore, it is not always possible to provide estimates within 48 hours.

Finally, providers must work with payers to obtain all of the information necessary to generate an estimate. For example, providers need to know a patient's current eligibility, as well as their specific cost-sharing obligation and where they are within their deductibles. While electronic transaction standards already exist to share this information, we hear from our members that health plans often do not comply fully with these requests. We, therefore, appreciate that Section 501 of the discussion draft would require health plans to provide providers with this information.

All Payer Claims Database. The discussion draft would establish a national all-payer claims database (APCD) and provide grants to states to encourage implementation of their own APCDs. These databases are intended to promote transparency by requiring insurers to submit claims data, which are made available to researchers and policymakers for use in analysis. They also are intended to enable hospitals, health care providers and communities to benchmark their performance against that of others.

The AHA recognizes the potential of APCDs to drive quality improvements and cost-containment, as well as helping to identify and track issues within the health care system. However, to guarantee the integrity of the data and insights that they yield, great care must be taken to protect the privacy and security of the data, that data released be presented in its full context, and that relevant stakeholders be involved in the governance process.

Should the committee move forward with this effort, we recommend that the privacy and security requirements for receiving, storing and transmitting data be strengthened by: requiring privacy and security training for staff and authorized users, including federal agency users; and requiring the APCD contractor in the required annual report to describe the privacy and security standards around receiving, accessing, storing and transmitting data, as well as any privacy or security incidents that have occurred. We would also ask that the data released by the APCD be put in context, as claims data are highly complex and do not always present a full picture of the care and services offered by providers. In order to draw meaningful conclusions from these data, it is important to

understand what is and is not included in the data. This means having a clear understanding of any limitations or gaps in the data, as well as understanding what other factors not represented in the data may impact the findings of analyses. Finally, we request that the governance body developed to oversee the APCDs include dedicated seats for health care providers who could play a valuable role in translating the experience of providing care, what occurs in a clinical setting and what is not captured in administrative claims data.

Provider Network Transparency. Section 304 of the discussion draft would require that health plans establish processes to ensure patients have the most current information on their health care provider's network status. The AHA believes that up-to-date provider directories play an important role in holding health plans accountable for adequate networks. The primary responsibility for ensuring provider directories are accurate is with health plans, and the AHA is pleased that the discussion draft recognizes this dynamic. However, we are concerned that the discussion draft does not hold health plans truly accountable for errors in the provider directory. In fact, the discussion draft holds providers responsible for refunding patients when an error occurs, even though the health plan controls the accuracy of the directory. In addition, providers could be subject to civil monetary penalties for violations except for one safe harbor that would allow the provider to rescind the bill within 30 days of billing. This safe harbor time window could be too restrictive, however, in the event that the patient does not raise an issue with the bill within the allotted timeframe. **The committee should hold health plans accountable for the accuracy of provider directories rather than rely on the patient and the provider to figure out when mistakes are made.** That accountability should extend to civil monetary penalties for plan errors as well.

Billing Requirements. Section 305 of the discussion draft would require providers to give patients a list of the services rendered during a health care visit at the time of discharge and bill the patient within 30 business days of the visit. It also would require providers to allow patients at least 30 days to pay their bills. Though AHA supports the goal of timely patient billing, we have a number of recommended changes to the proposed policy to address underlying issues. **Most critically, the AHA recommends basing the 30-day timeframe for sending timely bills on the date the health plan adjudicates a claim and sends remittance information to the provider, rather than on the date of discharge.** In order for a patient bill to be accurate and reflect the true out-of-pocket cost, the health plan needs to process the claim. Requiring providers to send bills prior to the completion of this process would mean that some patients would inevitably receive statements with inaccurate balances, causing further confusion and directly contradicting the purpose of this legislation.

We also recommend updating "upon discharge" in (a)(1) to "after discharge" and adding "as requested" to this requirement. Often, a full list of services received is not available at discharge because departments wait until after a patient is discharged to submit final charges. Requiring patients to wait until all charges are submitted could delay discharge and unnecessarily increase their length of stay. In addition, this information may not be

of interest to every patient. Itemized bills can be provided upon request but should not be mandated for every patient.

Finally, the AHA recommends clarifying that a good faith attempt is in compliance with this policy. We are concerned that, without clarification, an attempt to comply with this policy could still render our members out of compliance if there is no proof of receipt or if a bill is returned due to a wrong address. One member has reported that between 4 and 6 percent of insured patient bills are returned due to a bad address.

IMPROVING PUBLIC HEALTH

The AHA supports the provisions of the discussion draft that make important investments in public health priorities like maternal health, vaccinations and public health data systems.

Maternal health is a top priority for the AHA and our member hospitals and health systems as we seek to eliminate maternal mortality and reduce severe morbidity. The causes of maternal mortality and morbidity are complex, including a lack of consistent access to comprehensive care and persistent racial disparities in health and health care. As hospitals work to improve health outcomes, we are redoubling our efforts to improve maternal health across the continuum of care and reaching out to community partners to aid in that important effort.

The AHA supported legislation enacted last year, the Preventing Maternal Deaths Act, which provides funding to develop maternal mortality review committees. The Lower Health Care Costs Act builds on this initiative by funding programs that develop and disseminate best practices to improve maternal outcomes and support state perinatal quality collaboratives. Improving maternal outcomes also requires better coordination of services for mothers across the continuum of care, so we are pleased that the legislation establishes programs that promote the delivery of integrated health care services to pregnant and postpartum women.

We commend the Committee on Section 407 of the bill, which would authorize Title VII training grants to address discrimination and implicit bias. We encourage the Committee to also specify training in the areas of cultural and linguistic competence in order to reduce health disparities and require the Secretary to work with professional medical societies to develop recommendations for continuing medical education programs, as many currently practicing medical professionals may have not received training in implicit bias or cultural competency.

In addition, the AHA is pleased that the legislation would bolster efforts to address vaccine-preventable illnesses by authorizing a national educational campaign to increase the awareness of and combat misinformation about vaccinations. We also applaud the provisions that would fund much needed modernization of public health data systems used by the Centers for Disease Control and Prevention and state and local health departments.

IMPROVING THE EXCHANGE OF HEALTH INFORMATION

Requirement to Provide Health Claims, Network and Cost Information. The draft bill requires commercial health plans in the group and individual markets to make certain information easily available, including historic claims, encounter and payment data, network information and individualized out-of-pocket estimates for common procedures and all prescription drugs. As noted in our comments on Improving Transparency in Health Care, this information is critically important for patients as they make decisions about their health and health care. However, it has not always been easily accessible, or even reliably accurate. We applaud the Committee's attention to transparency in regard to a patient's out-of-pocket costs and its recognition that health plans are key players in this effort.

While we are supportive of this policy overall, we are concerned about the privacy and security of a patient's health information when entered into a third-party application – a key tenant of this proposal. We encourage the Committee to extend HIPAA protections to third-party apps that access patient data via these APIs, ultimately promoting the safety and security of this data, regardless of where it resides.

Recognition of Security Practices. **The AHA is pleased the draft legislation would incentivize strong cybersecurity practices by encouraging the Department of Health and Human Services to consider entities' adoption of recognized cybersecurity practices when conducting audits or administering fines related to the HIPAA Security Rule.** Hospitals and health systems understand it is our responsibility to protect patient information and, more importantly, their safety against cyber threats. Despite complying with HIPAA rules and implementing best practices, hospitals and health systems will continue to be the targets of sophisticated cyberattacks, and some attacks will inevitably succeed. The AHA believes that victims of attacks should be given support and resources, and enforcement efforts should rightly focus on investigating and prosecuting the attackers.

CONCLUSION

We thank you for the opportunity to share the hospital and health system field's suggestions and concerns as they relate to the Lower Health Care Costs Act of 2019. We appreciate that the issues of health care costs and affordability are a priority for the HELP Committee, as they are for our patients and members. We look forward to working on legislative solutions that address the issues raised in the Committee's legislative proposal, while preventing unintended negative consequences on the health care system.