American Hospital Association™
Advancing Health in America

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June 21, 2019

The Honorable Lamar Alexander
Chairman, Committee on
Health, Education, Labor & Pensions
United States Senate
Washington, DC 20510

The Honorable Patty Murray
Ranking Member, Committee on
Health, Education, Labor & Pensions
United States Senate
Washington, DC 20510

Dear Chairman Alexander and Ranking Member Murray:

Thank you for inviting the American Hospital Association (AHA) to participate in the June 18 hearing on the Lower Health Care Costs Act. We would like to follow up on a few issues that were raised during the discussion, as well as comment on the revised version of the bill (S. 1895) that was released June 19.

ENDING SURPRISE MEDICAL BILLING

The AHA applauds the Committee for their continued commitment to protecting patients. The Lower Health Care Costs Act includes critical provisions to hold patients harmless from surprise medical bills, including for air ambulance transport. We support the Committee's efforts to find a federal solution to surprise medical bills that truly protects the patient. **We believe that the solution is simple: protect the patient from surprise medical bills 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, and limit the patient's cost-sharing to an in-network amount. Once the patient is protected, hospitals, providers and plans should be allowed to negotiate fair and appropriate reimbursement without additional statutory interference. Further government involvement is not necessary and this approach would avoid potential widespread, unintended negative consequences.**

While the AHA believes that hospitals and payers should negotiate reimbursement for out-of-network claims without government involvement, there may be a role for a dispute resolution process for physician claims only. As Senator Cassidy noted, a number of states have adopted arbitration with positive results. In particular, the "baseball" style of arbitration implemented by New York State, which does not include

hospitals, appears to be an effective and efficient process. It places the responsibility to initiate the request with the provider or health insurer, and not the patient, and studies have shown a 34 percent reduction in out-of-network billing, with decisions largely split between the providers and payers. We would also note that there has not been a noticeable inflationary impact on insurance premium rates in that state. As a workable approach for determining out-of-network reimbursement for physicians, we urge the Committee to consider the Senate Bipartisan Working Group's arbitration provisions that are included in S. 1531.

However, we oppose S. 1531's use of an automatic payment prior to initiating the dispute resolution because it would undermine a provider's opportunity to negotiate fair reimbursement. We disagree with contention put forward by the American Enterprise Institute's witness that arbitration is a "backdoor" to rate setting. If an arbitration approach is adopted for resolving out-of-network physician claims, then the arbiter should be given sufficient flexibility to determine the most appropriate rates by taking into account a number of factors, including specific local market conditions and the particular circumstance of a given episode of care.

Benchmark Rate-setting. The AHA continues to have significant concerns about establishing a benchmark rate or methodology in statute for out-of-network payments. The discussion during the hearing underscores our concerns that such an approach could undermine network adequacy and put rural and other vulnerable providers at additional financial risk. **We are disappointed that S. 1895 would institute a median in-network rate for out-of-network payments, and we strongly urge the Committee to eliminate this provision.**

Setting a rate in statute gives insurers few incentives to develop robust networks with hospitals and physicians because, if those negotiations fail, insurers would pay a rate that is less than what they pay half of their in-network providers. Consider that many individuals who find themselves in out-of-network facilities are there as a result of an emergency situation and may need high levels of care. The ability to provide tertiary and quaternary care, such as trauma and burn care, requires higher-cost equipment and personnel. Paying at the median in-network rate would surely underpay for these services and create an incentive for insurers to avoid paying fair reimbursement for these services. This approach is an obvious windfall for the insurance industry without any assurance that health plans will pass these savings on to consumers through lower premiums.

Several of the witnesses suggested that, because the benchmark rate specified in the discussion draft was set at the median in-network rate for a particular plan (so, therefore, in the same geographic area), that the rate would be more consistent with a local market's dynamics. We disagree. Different hospitals in the same geographic area may have substantially different costs based on the variety of services they provide and the populations they serve, such as the example above of a facility that can provide

quaternary care. In addition, many hospitals and health systems are entering into value-based payment arrangements with payers. Those contracts may stipulate a low base payment rate that may be supplemented as a result of the hospital's or health system's performance on agreed-upon value-based metrics. It is unclear how such arrangements could impact the median in-network amount.

Setting the wrong rate could be devastating to vulnerable hospitals and health systems, particularly those in rural America. As discussed during the hearing, rural hospitals are closing at a faster pace in 2019 than in previous years, putting access to care in jeopardy for those who live in rural America. Given that the rate methodology would be set in statute, changing it would require an additional act of Congress, something rural hospitals would likely be unable to withstand.

TRANSPARENCY IN HEALTH CARE

Contracting Restrictions. During the hearing, several of the witnesses suggested that restrictions on certain contract requirements would facilitate greater competition and result in lower health care prices. We are disappointed that the contracting provisions remain in the Lower Health Care Costs Act, as we believe these restrictions could lead to even more narrow networks with fewer provider choices for patients, while adversely affecting access to care at rural and community hospitals serving vulnerable communities. **We continue to urge the Committee to remove these provisions from S. 1895.**

The contracting restrictions 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. As we stated in our hearing testimony, commercial insurers cannot be allowed to have it both ways and benefit from transferring more financial risk to providers under a value-based care arrangement while simultaneously undermining them by encouraging 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. 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.

Billing Requirements. The revised bill extends the timely billing requirement from 30 business days to 45 calendar days and includes a safe harbor for providers who do not meet these requirements due to either incorrect patient information or other extenuating circumstances. It also would require health plans and their in-network providers to have business practices in place that ensure claims are adjudicated quickly enough to comply with this policy. We appreciate that the Committee addressed one of our comments by adding in a safe harbor for good faith efforts and other extenuating circumstances. However, we remain concerned that these changes still do not address the fundamental issues with this policy.

Hospitals support the goal of timely billing, and are committed to working with our health plan partners to make the adjudication and billing process go as quickly as possible. There are many factors that go into the claims adjudication process though, which can extend the process beyond 45 days despite the provider and health plan's best intention. For example, hospitals annually have to hold claims for several weeks to allow for Medicare regulatory updates to be programmed by software vendors into various billing platforms and tested. **We reiterate our recommendation that the timely billing timeframe be based on the date the health plan adjudicates a claim and sends remittance information to the provider, rather than on the date of discharge. Waiting for the adjudicated claim ensures that patients are not provided with inaccurate initial bills.**

Disclosure of Cost-sharing Information. As stated in our June 5 letter to the Committee, the AHA supports policies that encourage the continued development of out-of-pocket estimates, when appropriate. **However, we remain concerned about Section 309, despite the revisions made in S. 1895. To begin with, the revised draft failed to address the key issue of defining when such estimates are actually appropriate and can be done with reasonable certainty.** Providers can often only give a high level of certainty for very discreet services and bundles of services for treatments that generally follow a common course of care and are agnostic to patient characteristics. Such items and services may include laboratory and other diagnostic tests, as well as routine procedures where a typical course of care can be reasonably assumed, such as a joint replacement. There are many services 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. Therefore, it is not always possible to provide estimates.

In addition, we are concerned that the revised draft only includes a penalty for providers who do not comply with this policy. In order to comply, providers must work with health plans to obtain all of the information necessary to generate an estimate. This draft does nothing to incentivize health plan compliance but rather leaves providers holding sole responsibility for estimates that require health plan input.

Health Care Price Transparency. There was much discussion at the hearing regarding the role of transparency in improving affordability in the health care system and, specifically, how transparency may help empower consumers to be more involved in their care decisions, as well as enable employers and plans to be better purchasers. As part of this, some suggested that hospitals should disclose privately negotiated rates with health plans.

As we relayed to the Committee through our written testimony, the AHA is committed to increased price transparency for patients. Our members' long history working directly with patients to provide price estimates for care suggest that patients look for information on their out-of-pocket costs but not, for example, information contained in the chargemaster. Moreover, hospitals hear from patients that more data points are not always better. The addition of supplemental information – such as the chargemaster rates or overly detailed bills – can actually hinder patients' understanding of their costs by clouding over the important information and adding an unnecessary level of confusion. This is why we continue to push for more streamlined and simplified bills. Of course, we agree that patients who are interested in more detailed bills should be able to obtain one upon request.

As we outlined during the hearing, the AHA does not support the broad disclosure of certain private pricing data, which could lead to anti-competitive behaviors that could hurt, not help, patients. We disagree with comments made during the hearing that disclosure of negotiated rates could increase competition.

According to the Federal Trade Commission (FTC), "when [price transparency] goes too far, it can actually harm competition and consumers." Disclosing price information would inhibit competition because it would create a platform for price fixing. Health plans would know what every other health plan was paying and could use that information indirectly to drive prices below competitive levels, thereby reducing the incentives for actual competition in the marketplace, and threatening the viability of some of the nation's most vulnerable hospitals.

The FTC has been clear on this subject. In a letter to Minnesota state legislators, the Commission counseled against disclosure of health plan terms and urged that transparency be limited to "predicted out-of-pocket expenses, co-pays, and quality and performance comparisons of plans or provider." While the FTC focused on the providers' use of such information, a recent challenge to health plan consolidation pointed to the danger that collusion among commercial health plans would impede innovation and drive prices below competitive levels for vulnerable providers without sharing any of savings derived from that illegal conduct with consumers.

REDUCING THE PRICES OF PRESCRIPTION DRUGS

We appreciate the Committee's clear and dedicated focus on curbing the rising price of prescription drugs, and want to thank the Members for the continued efforts to address this critically important issue. The AHA is committed to the availability of high-quality, efficient health care for all Americans. Hospitals, and the clinicians who practice in our facilities, know firsthand the lifesaving potential of drug therapies. However, an unaffordable drug is not a lifesaving drug. Hospitals and health systems continue to see unsustainable increases in their spending on prescription drugs. Between 2015 and 2017, total hospital and health system spending on drugs increased on average by 18.5 percent per admission, including a jump of 28.7 percent per outpatient-adjusted admission. These increases follow record growth in prescription drug spending of 38.7 percent in the inpatient setting from 2013 to 2015. Not only do high launch prices and steep price hikes threaten patient access to care, they also place significant strain on hospitals and health systems. Our members will always put patients first but, as the fastest growing input cost at most facilities, unpredictable and unjustifiable drug prices force hospitals and health systems to invest in costly workarounds, often resulting in the need to cut services or delay critical investments in order to make up that cost.

Drug manufacturers are solely responsible for the price of their products, which is why we are grateful for the Committee's commitment to increasing transparency that will help shed light on an otherwise opaque and shielded process. In addition to the previous draft's language ensuring timely access to generic drugs, increased transparency around generic and biosimilar patent and Food and Drug Administration (FDA) exclusivity information and new chemical entity exclusivity clarification, we appreciate the inclusion of several other provisions in S. 1895, such as additional language to incentive getting generic drugs to market, authorizing the FDA to more promptly approve a follow-on or generic drug, and updates to certain safety labeling requirements for drugs.

In addition, we ask the Committee to look to other policies aimed at ending pay-for-delay and ever-greening tactics employed by brand name manufactures. Finally, because drug therapies can carry such high costs, we urge the Committee to examine aligning payment with the most common dosage of a drug, in order to decrease unnecessary waste for hospitals and health systems. As you continue to discuss policies around drug pricing, we are willing to provide additional feedback and input.

IMPROVING PUBLIC HEALTH AND THE EXCHANGE OF HEALTH INFORMATION

We remain supportive of the Committee's proposals to make important investments in public health, including efforts to improve maternal health outcomes. We also appreciate the Committee's focus on enhancing health information technology while protecting patient privacy.

We look forward to our continued work with the Committee to make health care and coverage more affordable.

Sincerely,

/s/

Thomas P. Nickels
Executive Vice President

CC: Members of the Committee on Health, Education, Labor & Pensions