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

Statement

of the

American Hospital Association

for the

Special Committee on Aging

of the

United States Senate

"Health Care Transparency: Lowering Costs and Empowering Patients"

July 11, 2024

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) writes to share the hospital field's comments on health care costs and transparency.

OVERVIEW OF NATIONAL HEALTH SPENDING

America's hospitals and health systems — physicians, nurses and other caregivers — understand and share concerns regarding the high cost of health care and are working hard to make care more affordable by transforming the way health care is delivered in our communities. Real change will require an effort by everyone involved, including providers, the government, employers and individuals, device makers, drug manufacturers, insurers and other stakeholders.

The AHA's most recent "Cost of Caring" report provides greater details on the challenges hospitals face with respect to treating patients with higher acuities while dealing with financial instability. The issues include workforce shortages and increasing supply chain costs, coupled with inadequate reimbursement from government payers and increased administrative burden related to commercial insurance efforts to reduce compensation. Taken together, these factors create an environment of financial uncertainty in which many hospitals and health systems are operating with little to no margin.

For this statement, we highlight two of the cost drivers incurred by hospitals and health systems: commercial insurer operating methods and prescription drug costs.

Commercial Insurer Practices

To truly reduce health care costs, we urge Congress to address practices by certain commercial health insurers. For example, additional oversight is needed to ensure that Medicare Advantage (MA) plans can no longer engage in tactics that restrict and delay access to care while adding burden and cost to the health care system.

While MA plans were designed to help increase efficiency in the Medicare program, data from the Medicare Payment Advisory Commission (MedPAC) found that MA plans will be responsible for $88 billion in excess federal spending this year, due in part to inappropriate upcoding practices, whereby plans report enrollees as having more health conditions and being sicker than they are to receive higher reimbursements. At the same time, health insurance premiums continue to grow — in fact, annual insurance premiums increased nearly twice as much as hospital prices over a 10-year period.[1]

Additionally, inappropriate denials for prior authorization and coverage of medically necessary services remain a pervasive problem among certain MA plans. A 2022 report from the Department of Health and Human Services (HHS) Office of Inspector General found that MA plans are denying at a high rate medically necessary care that met Medicare criteria.[2] The report highlights that 13% of prior authorization denials and 18% of payment denials met Medicare coverage rules and therefore should have been approved. In a program this size — covering more than half of all Medicare beneficiaries — improper denials at this rate are unacceptable. However, because the government pays MA plans a risk-adjusted per-beneficiary capitation rate, there is a perverse incentive to deny services to patients or payments to providers to boost profits.

These practices delay access to care for seniors and add financial burden and strain on the health care system through inappropriate payment denials and increased staffing and technology costs to comply with plan requirements. They also are a major burden to the health care workforce and contribute to provider burnout. To address these issues, the AHA supports regulatory and legislative solutions that streamline and

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[1] https://www.medpac.gov/wp-content/uploads/2023/10/MedPAC-MA-status-report-Jan-2024.pdf
[2] https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf

improve prior authorization processes, including the Improving Seniors' Timely Access to Care Act (S. 4532), which would codify many of the reforms in the Interoperability and Prior Authorization Final Rule.

Though issues with denials are often felt most acutely with MA and Medicaid managed care plans, these practices also are followed by other commercial payers, where claims denials increased by 20.2% in 2023. Moreover, the time taken by commercial payers to process and pay hospital claims from the date of submission increased by 19.7% in 2023, according to data from the Vitality Index. For hospitals and health systems, these practices, which require hospitals to divert dollars away from patient care to instead focus on seeking payment from commercial insurers, result in billions of dollars in lost revenue each year.[3] Without further intervention, these trends are expected to continue and worsen. National expenditures on the administrative costs of private health insurance spending alone are projected to account for 7% of total health care spending between 2022 and 2031 and are projected to grow faster than expenditures for hospital care.[4]

Prescription Drug Prices

Congress also should address the high costs of prescription medications, given the regular increases in costs, as this impacts expenses for all providers, including hospitals. For instance, a report from earlier this year noted pharmaceutical companies raised list prices on 775 brand name drugs during the first half of January 2024, with a median increase of 4.5%, though the prices of some drugs rose by 10% or higher.[5] These increases were higher than the rate of inflation, which was 3.4% in December. A report by the HHS Assistant Secretary for Planning & Evaluation (ASPE) found that between 2022 and 2023 drug companies increased drug prices for nearly 2,000 drugs faster than the rate of general inflation, with an average price hike of 15.2%.[6]

Moreover, recent drug shortages also have fueled further expense growth. An ASPE report found up to a 16.6% increase in the prices of drugs in shortage; in many cases, the increase in the price of substitute drugs were at least three times higher than the price increase of the drug in shortage.[7] The costs incurred as a result of drug shortages are compounded by staff overtime needed to find, procure and administer alternative drugs, to manage the added challenges of multiple medication dispensing automation

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[3] https://www.ama-assn.org/practice-management/prior-authorization/health-systems-plagued-payer-takeback-schemes-110000#:~:-%20text=authorization%E2%80%99s%20financial%20impact-,Prior%20authorization%E2%80%99s%20financial%20impact,an%20increase%20of%2067%.%E2%80%9D

[4] AHA analysis of NHE projections of 2022-2031 expenditures.

[5] https://www.wsj.com/health/pharma/drugmakers-raise-prices-of-ozempic-mounjaro-and-hundreds-of-other-drugs-bdac7051

[6] https://aspe.hhs.gov/reports/changes-list-prices-prescription-drugs

[7] https://aspe.hhs.gov/reports/drug-shortages-impacts-consumer-costs

systems and changing electronic health records and to undergo training to ensure medication safety using alternative therapies.[8]

MEDICAL DEBT

Hospitals and health systems are very concerned about patients' medical debt, which is a consequence of patients not paying some or all their health care bills. While health insurance is intended to be the primary mechanism to protect patients from unexpected and unaffordable health care costs, for too many that coverage is either unavailable or falling short.

Trends in health insurance coverage that are driving an increase in medical debt include inadequate enrollment in comprehensive health care coverage, growth in high-deductible and skinny health plans that intentionally push more costs onto patients and misleading health plan practices that confuse patients' understanding of their coverage. These gaps in coverage leave individuals financially vulnerable when seeking medical care. The primary causes of medical debt are:

- **There are still too many uninsured Americans.** Affordable, comprehensive health care coverage is the most important protection against medical debt. While the U.S. health care system has achieved higher rates of coverage over the past decade, gaps remain.

- **High-deductibles subject many Americans to cost-sharing they cannot afford.** High-deductible plans are designed to increase patients' financial exposure through high cost-sharing in exchange for lower monthly premiums. Yet many individuals enrolled in high-deductible plans find they cannot manage their portion of health plan expenses. A Federal Reserve report found that 37% of adults would not be able to afford a $400 emergency,[9] an amount $1,000 less than the average general annual deductible for single, employer-sponsored coverage.

- **Certain health plans provide inadequate benefits and frequently lead to surprise gaps in coverage.** Short-term, limited-duration health plans and health sharing ministries cover fewer benefits and include few to no consumer protections, such as required coverage of pre-existing conditions and limits on out-of-pocket costs. Patients with these types of plans often find themselves responsible for their entire medical bill without any help from their health plan, including for critical services such as emergency medical and oncology care. These denials can lead to an accumulation of significant medical debt.[10]

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[8] https://link.springer.com/article/10.1007/s13181-023-00950-6#:~:text=Shortages%20compromise%20or%20delay%20medical,morbidity%20%5B1%2C%202%5D.
[9] https://www.federalreserve.gov/publications/2023-economic-well-being-of-us-households-in-2022-expenses.htm
[10] https://kffhealthnews.org/news/sham-sharing-ministries-test-faith-of-patients-and-insurance-regulators/

- **Complex health plan benefit design and misleading marketing can expose patients to unexpected costs.** Many health plans have complex benefit designs that are not transparent to patients, such as what is covered pre-deductible, the interaction between point-of-service copays, coinsurance and deductibles and poor communication and education about what the plan covers. For example, a recent National Association of Insurance Commissioners report found significant gaps and inconsistencies with the way that insurers share information about pre-deductible, no cost-sharing preventive services with their members, resulting in a "meaningful barrier to effective understanding and use of preventive service benefits."[11]

Hospitals are the only part of the health care sector that provide services to patients regardless of their ability to pay. They underscore that commitment by offering financial and other assistance, including helping patients qualify for federal and state health care programs, such as Medicaid. In doing so, patients can receive regular preventive care, not just episodic care for serious injuries or illness. In addition, hospitals absorb billions of dollars of losses for patients who are unable to pay their bills, mainly due to inadequate commercial insurance coverage; in 2020, the latest figure available, hospitals provided more than $42 billion in uncompensated care.[12]

This is why hospitals are staunch supporters of ensuring everyone is enrolled in some form of comprehensive coverage. However, we appreciate that closing the remaining coverage gaps may be a longer-term solution and that more immediate steps can be taken. To that end, the AHA has routinely developed patient billing guidelines to help prevent patients from incurring medical debt. The AHA's Board of Trustees adopted the most recent set of guidelines in 2020, which reaffirm the hospital field's commitment to:

- Treating all people equitably, with dignity, respect and compassion.
- Serving the emergency health care needs of all, regardless of a patient's ability to pay.
- Assisting patients who cannot pay for part or all the care they receive.

Notably, several of the guidelines directly address medical debt, including encouraging hospitals to forego adverse credit reporting of medical debt. So far, nearly 2,800 hospitals and health systems have affirmed their commitment to the guidelines, and the AHA revisits them regularly for updating.

PRICE TRANSPARENCY REQUIREMENTS

We appreciate Congress' ongoing interest in hospital price transparency to provide consumers with the price information they need specific to their course of treatment.

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[11] https://healthyfuturega.org/ghf_resource/preventive-services-coverage-and-cost-sharing-protections-are-inconsistently-and-inequitably-implemented/
[12] https://www.aha.org/system/files/media/file/2020/01/2020-Uncompensated-Care-Fact-Sheet.pdf

Hospitals and health systems have invested considerable time and resources to comply with the Hospital Price Transparency Rule, which requires online access to both a machine-readable file and a list of shoppable services. Recent data from Turquoise Health shows that 93.4% of hospitals have met the requirement to post a machine-readable file.

We are concerned, however, with recent legislative efforts to no longer recognize price estimator tools as a method to meet the shoppable services requirement. This change would both reduce access to a consumer-friendly research tool and unfairly penalize hospitals that have spent significant capital to comply with the regulation. These facilities would instead need to develop and maintain a shoppable services spreadsheet, which may be difficult for consumers to navigate and will not reflect the different policies that their insurer may apply to determine the final price for a service. Price estimator tools offer consumers an estimate of their out-of-pocket costs based on their insurance benefit design, such as cost-sharing requirements and prior utilization, as well as the patient's annual deductible. This is an important feature of these tools that is not available from a shoppable services spreadsheet. Eliminating the use of price estimator tools as a method to meet the shoppable services requirement of the Hospital Price Transparency Rule would therefore reduce price transparency for patients. We urge Congress to reject this potential change.

As Congress seeks to make statutory changes to price transparency standards, it is important for legislators to take into consideration the adjustments to the Hospital Price Transparency Rule made by the Centers for Medicare & Medicaid (CMS) on a regular basis. These include changes related to standardization, new data elements, file accessibility, an accuracy and completeness affirmation, as well as changes to CMS' monitoring and enforcement processes. Most notably, CMS now requires hospitals to use a standard format to comply with the machine-readable file requirement, which includes new data elements such as negotiated rate contracting type or methodology, an accuracy and completeness affirmation and (as of January 1, 2025) an "estimated allowed amount." CMS also now requires that hospitals' price transparency information be more easily found on their websites.

Regarding compliance and enforcement, hospitals may be required to have an authorized hospital official certify the accuracy and completeness of the hospital's machine-readable file during the monitoring and enforcement process. CMS also can require hospitals to provide additional documentation at the agency's request, including contracting documentation needed to validate the hospital's negotiated rates and verification of the hospital's licensing status.

In addition, CMS increased its efforts to publicize hospital-specific information on all compliance assessment and enforcement activity, which it now updates regularly on a public website. This includes details related to CMS' assessment of hospital compliance, any compliance actions taken against a specific hospital, the status of the compliance action(s) and the outcome of the action(s). A list of the civil monetary

compliance notices and fines issued to date is available on the CMS website.[13] The fines vary in scope, from $55,000 to nearly $1 million, for those hospitals that have been deemed out of compliance with the Hospital Price Transparency Rule. CMS clearly has the authority and willingness to enforce compliance with the rule and assess significant fines, regardless of statutory activity.

CONCLUSION

Thank you for your consideration of the AHA's comments on issues related to health care expenditures. We look forward to continuing to work with you to address these important topics on behalf of our patients and communities.

[13] https://www.cms.gov/priorities/key-initiatives/hospital-price-transparency/enforcement-actions