American Hospital Association™
Advancing Health in America

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October 13, 2023

The Honorable Michael C. Burgess, M.D.
Chair, Health Care Task Force
Budget Committee
U.S. House of Representatives
Washington, DC 20515

The Honorable Drew A. Ferguson IV
Health Care Task Force
Budget Committee
U.S. House of Representatives
Washington, DC 20515

The Honorable Llyod Smucker
Health Care Task Force
Budget Committee
U.S. House of Representatives
Washington, DC 20515

The Honorable Earl L. "Buddy" Carter
Health Care Task Force
Budget Committee
U.S. House of Representatives
Washington, DC 20515

The Honorable Blake D. Moore
Health Care Task Force
Budget Committee
U.S. House of Representatives
Washington, DC 20515

The Honorable Rudy Yakym III
Health Care Task Force
Budget Committee
U.S. House of Representatives
Washington, DC 20515

Dear Chair Burgess and Representatives Ferguson, Smucker, Carter, Moore and Yakym:

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, two 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 in response to the questions posed by the House Budget Committee Health Care Task Force. We support your efforts to reduce health care spending, encourage innovation and ensure patients receive quality, affordable health care.

In recent years, health care spending growth has largely been driven by increased use and intensity of services. In other words, more people are getting care, and the care they are getting is more involved than in the past. Much of this is the result of expansions in health care coverage, improved efforts to connect people to needed care, advances in medicine and technology and increased prevalence of chronic disease.

Hospital care requires a range of inputs such as wages for clinical and other personnel, prescription drugs, administrative software and other technology, food, medical devices, utilities and professional insurance. Steep increases in the prices for certain inputs, such as drugs and administrative processes mandated by health plans, can undermine hospitals’ efforts to reduce the cost of care.

Despite the challenging financial situation many hospitals and health systems are experiencing, we will continue to seek options to improve the affordability of health care in ways that will not compromise access to high quality, safe care.

Thank you for your interest in addressing these important issues. Our recommendations are in the following attachment.

Sincerely,

/s/

Lisa Kidder Hrobsky
Senior Vice President
Advocacy and Political Affairs

Attachment: AHA Recommendations

CC: The Honorable Jodey Arrington, Chair, House Budget Committee

ATTACHMENT

1. **Regulatory, Statutory or Implementation Barriers that Could Be Addressed to Reduce Health Care Spending**

Address Insurance Company Actions. The AHA encourages Congress to ensure medical professionals, not the insurance industry, are making the key decisions in patient care. Efforts to eliminate, streamline or standardize commercial health insurer administrative practices would reduce unnecessary and low-value services, improve patient care and outcomes and reduce health system costs. More details on the actions commercial health insurers take that add costs to the system — including prior authorization requirements, use of step therapy or fail-first policies, stringent medical necessity criteria and white bagging — are detailed in an AHA report, “Commercial Health Plans’ Policies Compromise Patient Safety and Raise Costs.”[1] The AHA supports the Improving Seniors’ Timely Access to Care Act, which passed the House last year and the Ways and Means Committee this year, to modernize the Medicare Advantage prior authorization process.

Review Regulatory Processes. Every day, hospitals and health systems confront the daunting task of complying with a complex set of federal regulatory requirements, many of which have outlasted their relevance. The associated burden contributes to clinician burnout and increases the cost of delivering care. We encourage Congress to pass AHA-supported H.R.1565, the Critical Access Hospital Relief Act, which would permanently remove the 96-hour physician certification requirement for Critical Access Hospitals (CAHs) and allow CAHs to serve patients needing critical medical services that have standard lengths of stay greater than 96 hours. Enforcement of this requirement has resulted in CAHs either refusing care, forgoing payment or being forced into an unnecessary and expensive transfer of a patient to a larger facility. We also suggest Congress change the 96-hour annual average length of stay requirements given ongoing capacity issues at CAHs and the critical role they play in providing care in rural communities. Patients who can be safely and effectively treated and require more than a 96-hour stay in their local hospital should be afforded the option of receiving care closer to their homes, families and usual doctors.

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[1] https://www.aha.org/system/files/media/file/2022/07/Commercial-Health-Plans-Policies-Compromise-Patient-Safety-White-Paper.pdf

Advance the Use of Digital Health. Digital health, such as telemedicine, remote patient monitoring and wearable devices, have provided new ways for clinicians and patients to connect in the prevention, management and treatment of health conditions. Additionally, the use of advanced technologies such as artificial intelligence and precision medicine have the capability of fundamentally transforming care delivery. For example, Congress could take action to expand access to care via telehealth, including:

- allowing the originating site to be any site at which the patient is located, including the patient's home;
- allowing Federally Qualified Health Centers and Rural Health Clinics to furnish telehealth services;
- repealing the in-person visit requirements for behavioral telehealth services; and
- expanding eligible telehealth practitioners to include occupational therapists, physical therapists, speech-language pathologists and audiologists.

In addition, there is a need for funding of the broadband network to support high-speed internet access which is essential in using digital health technology.

Reform the Medical Liability System. Congress could reduce unnecessary costs in the health care system by passing comprehensive medical liability reform. The Congressional Budget Office estimated that enacting federal legislation that caps noneconomic damages at $250,000 and caps attorneys' fees would reduce direct federal spending by about $20 billion and would have a net effect of reducing the deficit by about $28 billion over 10 years.[2]

Address the High Cost of Prescription Drugs. Efforts to rein in the rising cost of drugs should include taking steps to increase competition among drug manufacturers, improving transparency in drug pricing and advancing value-based payment models for drugs. At the same time, it is important to protect the 340B drug savings program to ensure structurally marginalized communities have access to more affordable drug therapies by reversing harmful policies and holding drug manufacturers accountable to the rules of the program, especially with respect to community pharmacy arrangements.

[2] https://www.cbo.gov/system/files/2019-04/55104-Medical%20Malpractice_WP.pdf

2. **Efforts to Promote and Incorporate Innovation into Programs like Medicare to Reduce Health Care Spending and Improve Patient Outcomes**

Accelerate Payment and Delivery System Reforms. Increasing incentives for providers to move to risk-based arrangements under Medicare and Medicaid, in certain circumstances, would improve coordination of care, reduce unnecessary utilization and allow earlier intervention to support overall improvements in health. It also could increase predictability for the government, as spending could move toward being population-based rather than utilization-based. In rural areas, innovations could include exploring rural pre-payment models, supporting additional inpatient/outpatient transformation strategies, promoting virtual care strategies, allowing innovative partnerships and refining existing models that support hospitals serving historically marginalized communities.

Continue the Hospital-at-Home Program. The AHA supports the hospital-at-home program, which served as a critical mechanism in expanding hospital capacity while limiting risk of exposure during the COVID-19 pandemic. These programs have demonstrated high levels of patient satisfaction, strong health care workforce buy-in and engagement and opportunities to provide care that is better informed by the patient's home environment. In addition, hospital-at-home patients frequently experienced decreased recovery times and fewer adverse events related to the care they received. The conditions of participation waivers allowing for hospital-at-home programs to operate were extended for two years in the Consolidated Appropriations Act of 2023 but additional action will be necessary to secure the program's long-term permanency and demonstrate investment and confidence in new care delivery models. We urge Congress to develop a permanent hospital-at-home program.

Revamp Care for Vulnerable Populations. In any given year, a small portion of the population is responsible for a large percentage of total health care spending. In fact, about half of all health care spending is used to treat just 5% of the population.[3] Better care coordination for our most complex, vulnerable patients — low-income children, dual eligibles, historically marginalized communities and high utilizers of health care — could help bend the cost curve.

[3] https://www.kff.org/slideshow/how-health-expenditures-vary-across-the-population-slideshow/

3. **Examples of Evidence-based, Cost-effective Preventive Health Measures or Interventions that Can Reduce Long-term Health Costs**

Engage Individuals in their Health and Health Care. Unhealthy behavior, such as smoking, poor diet and sedentary lifestyles, accounts for up to 40% of premature deaths in the U.S.[4] Encouraging patients, families and communities to take responsibility for their health and health care could result in decreased costs and improved wellness and health outcomes.

Promote Preventive Services and Population Health. According to the Centers for Disease Control and Prevention, chronic diseases such as heart disease, cancer and diabetes are the leading cause of death and disability in the U.S. and cost the nation $4.1 trillion in annual health care costs.[5] Six in 10 adults in the U.S. have a chronic disease, and four in 10 adults have two or more. Many chronic diseases are linked to tobacco use, poor nutrition, physical inactivity and excessive alcohol use. Better managing the health and health care of individuals using data-driven population health strategies could result in lives saved and decreased health care costs.

Examine the Social Drivers of Health. An individual's health is influenced by many factors beyond health care. Social factors — including income, education, social connections, food security and housing — may account for up to 40% of what keeps individuals healthy.[6] Studies have found a relationship between social drivers of health and health care costs, suggesting that addressing the former helps to decrease the latter.

Improve Patient Safety, Equity and Quality of Care. While we have made enormous progress over the past few decades, preventable health care-associated infections and complications could result in unnecessary health care costs. Moreover, the pandemic has shed light on significant and historical health care inequities. Some studies have estimated that providing equitable care and achieving equitable outcomes would save the U.S. up to $1 trillion per year.[7]

Intervene Earlier for Those with Mental Illnesses. Mental health disorders frequently rank among the highest in direct medical spending for several reasons, including that

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[4] https://pubmed.ncbi.nlm.nih.gov/15010446/
[5] https://www.cdc.gov/chronicdisease/about/index.htm
[6] https://lambtonpublichealth.ca/health-info/social-factors/
[7] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5620509/pdf/ahdb-10-279.pdf

mental health patients are more likely to be hospitalized. Indeed, patients with high mental health costs incur 30% more costs than other high-cost patients.[8] Moreover, half of mental illnesses begin by age 14, with 75% beginning by age 25. Mental illnesses often precede other chronic conditions, like heart disease, which become more costly with age. Early intervention using low-cost strategies including frequent and early screenings as well as increased access to outpatient behavioral health services may not only reduce overall health spending, but also costs for patients.

4. **Recommendations to Reduce Improper Payments in Federal Health Care Programs**

Address Inappropriate Denials of Covered Services in Medicare Advantage. Hospitals and health systems are increasingly concerned about certain MA plan practices that may directly harm beneficiaries — such as through unnecessary delays in care or denial of covered services — and pose serious threats to the affordability of our health care system. These include:

- Abuse of utilization management programs;
- inappropriate denial of medically necessary services that Original Medicare would cover;
- requirements for unreasonable levels of documentation to demonstrate clinical appropriateness;
- inadequate provider networks to ensure patient access; and
- unilateral restrictions in health plan coverage in the middle of a contract year.

These behaviors add billions of wasted dollars to the health care system, are a major driver of health care worker burnout and ultimately harm the health of Medicare beneficiaries.

In recent years, a number of government oversight reports have raised concerns about beneficiary access to care and inappropriate MA plan denials. The Department of Health and Human Services Office of Inspector General (HHS-OIG) released an alarming report last year entitled, "Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically

[8] https://www.healthaffairs.org/content/forefront/reducing-health-care-costs-through-early-intervention-mental-illnesses

Necessary Care.”[9] The MA program is designed to cover the same services as Original Medicare, and by law, MA plans may not impose additional clinical criteria that are “more restrictive than Original Medicare’s national and local coverage policies.”[10] The HHS-OIG found that some of America’s largest MA plans have been violating this basic legal obligation. Specifically, the HHS-OIG found that 13% of prior authorization denials and 18% of payment denials met Medicare coverage rules and should have been granted. This means MA plans were paid by the government to provide coverage of certain services and failed to do so at an alarming rate.

In a program the size of MA, improper denials at this rate are unacceptable. Yet, as the report explained, because the government pays MA plans a per-beneficiary capitation rate, they have every incentive to deny services to patients or payments to providers to boost their own profits. As the HHS-OIG’s report shows, this is a tactic taken by certain MA plans. It is no surprise, therefore, that many insurers have found the MA program to be their most profitable line of business and have sought expansion into MA as part of their growth strategy.[11,12] Greater oversight and accountability is needed to ensure access and affordability to health care services in MA.

In 2021, the federal government paid MA plans $361 billion to cover benefits under Part A and Part B. This amount has tripled since 2011 when MA plans were paid $124 billion to cover these services, and these payments are further projected to increase to $943 billion by 2031.[13] As an increasing share of the federal budget, and with millions of new enrollees each year, it is more important than ever to have greater oversight and accountability of MA plans to ensure their payments are being used for their intended purpose of paying for care — and not extracted from the health care system as profit.

Review Medical Loss Ratio (MLR) Standard. The MLR measures the amount of premium dollars that go toward health care services and quality improvement activities and caps the amount that insurers can spend on administrative activities or profits. The AHA believes the MLR standard is an important tool to ensure sufficient resources are dedicated to patients’ access to care and to hold health plans accountable for how premium dollars are spent. The MLR standard and its oversight help ensure the

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[9] https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf
[10] CMS, Medicare Managed Care Manual, ch. 4, sec. 10.16
[11] https://www.kff.org/report-section/financial-performance-of-medicare-advantage-individual-and-group-health-insurance-markets-issue-brief/
[12] https://www.forbes.com/sites/brucejapsen/2021/10/01/parade-of-health-insurers-expand-medicare-advantage-into-hundreds-of-new-counties/?sh=591ab1106b69
[13] https://www.kff.org/medicare/issue-brief/what-to-know-about-medicare-spending-and-financing/

affordability of health care services so that money spent in the health care system is actually used to pay for health care services. Given the vertical integration among large national organizations offering health insurance coverage through public programs, we encourage Congress to protect beneficiaries from improper manipulation of MLR by imposing additional scrutiny on plan expenditures so that patient premiums are being utilized appropriately and captured as intended in the required reporting.

We are greatly concerned about the ways in which vertical integration within some of the largest insurers can enable plans to channel health care dollars to their affiliated health care and data services providers at patients’ expense. Specifically, vertical integration may allow managed health plans to pay themselves or their subsidiaries for services in a way that counts as medical spending for the purpose of MLR, allowing them to extract greater profit from government programs. This practice circumvents the precise reason the MLR rules exists. MLR requirements — and oversight of those requirements — is key to ensuring appropriate spending by health plans. To be clear, we do not view all plan payments to affiliated entities as problematic, such as when an integrated system’s health plan pays affiliated clinicians an appropriate rate for patient care. What is problematic, however, is when a plan directs excessive dollars to its own affiliated vendors and service entities in ways that inappropriately increase health system costs while also increasing profit for the plan’s parent company, as well as when plans use their benefit design to steer patients to their affiliated providers in ways that may benefit the plan financially but may not consistently align with patient needs or choice.

Additionally, we are concerned about the categorization of funds spent on programs designed to limit coverage as “quality improvement” expenses. We understand that health plans may count some or all utilization management functions (e.g., programs like prior authorization that serve as gatekeepers to patient care) in the numerator of the MLR under the category of “quality improvement.” We are deeply concerned that many prior authorization and other utilization management programs have the opposite impact on quality by impeding patient access to necessary care. A 2022 American Medical Association physician survey found that 94% of physicians find prior authorization requirements delay patient access to timely care, with 80% reporting that the process can lead to treatment abandonment. Consider this blog post, “Leveraging Utilization Management to Reduce Medical Loss Ratio Rebates,” from Medecision, a care management company owned by a large commercial insurer.[14] The company touts that

[14] https://blog.medecision.com/leveraging-utilization-management-to-reduce-medical-loss-ratio-rebates/

if plans include an outcome or safety component in their utilization management programs, “then the money spent on UM will count toward a plan’s 80–85%. Patient care is improved and health plans hit their numbers, thus reducing the amount of rebates. Talk about a win-win.”

We believe that actively engaging in processes designed to shield expenses from potential patient rebates undermines the goals of the MLR standard. We urge Congress and the Centers for Medicare & Medicaid Services to review how insurers are categorizing their utilization management expenses and set clear guardrails around when, if ever, such activities can be categorized as quality improvement activities. Furthermore, we encourage the appropriate oversight agencies to ensure that MLR requirements disallow any form of manipulation, and that oversight of required reporting includes active monitoring for potential abuse.