



**American Hospital
Association®**

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March 23, 2018

The Honorable Bill Cassidy, M.D.
United States Senate
520 Hart Senate Office Building
Washington, DC 20510

The Honorable Michael Bennet
United States Senate
261 Russell Senate Office Building
Washington, DC 20510

The Honorable Charles Grassley
United States Senate
135 Hart Senate Office Building
Washington, DC 20510

The Honorable Tom Carper
United States Senate
513 Hart Senate Office Building Washington
Washington, DC 20510

The Honorable Todd Young
United States Senate
400 Russell Senate Office Building
Washington, DC 20510

The Honorable Claire McCaskill
United States Senate
503 Hart Senate Office Building
Washington, DC 20510

Dear Senators Cassidy, Senator Bennet, Senator Grassley, Senator Carper, Senator Young and Senator McCaskill:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our clinical 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) appreciates the opportunity to discuss the current state of health care costs, and efforts to increase transparency in the pricing of health care services and the quality of care.

Hospitals work within a fragmented health care system and complex billing structure that all parties – hospital leaders, regulators, insurers and patients – agree needs to be updated. Meanwhile, hospitals' mission remains constant: to advance the health of individuals and communities.

THE COST OF HEALTH CARE

Determining the cost of a health care service is complex and based on a number of factors. Several “inputs” form the basis for the cost of a service. These include the costs of wages/labor (nurses, technicians, etc.); pharmaceuticals; medical instruments and other supplies; and utilities,



among other factors. Costs for delivering a specific service may then vary by local wage rates and whether the provider engages in teaching or research. Patient volume also affects the cost of care. Importantly, the amount of care needed to treat a certain condition is not the same for every patient. For example, a total hip replacement may be relatively straightforward for an otherwise healthy individual. However, other patients undergoing such surgery may be managing multiple chronic conditions that require additional services to ensure the safety and quality of care.

Regulatory requirements also contribute to the cost of care: on average, complying with federal regulations accounts for \$1,200 of the cost for every hospital admission.¹ In other words, before accounting for any direct patient care, a hospital spends \$1,200 complying with government regulations. The most burdensome regulations relate to billing, coverage verification and compliance with the Medicare Conditions of Participation.

The cost of care delivered in hospitals and health systems also takes into account the “social goods” that only hospitals provide. These are the shared costs of maintaining stand-by capacity for rare, traumatic events, as well as the cost of caring for the uninsured and the underinsured, including Medicare and Medicaid beneficiaries. Both programs reimburse hospitals below the cost of delivering care. Hospitals provide these social goods in a unique manner: our members’ doors are open 24 hours a day, 7 days a week. Hospitals are where patients come with a feverish child in the middle of the night or when the flu turns life threatening. Hospitals are where ambulances bring the victim of a house fire and where we treat the mother and newborn addicted to opioids. The cost of hospital care, therefore, reflects more than just the direct care a patient receives.

Moreover, hospitals often have little control over changes in input costs, which may rise unexpectedly over the course of a year. For example, this year’s flu season has strained health system capacity and required many hospitals and health systems to hire additional physicians and nurses on a temporary basis to care for those infected by the virus. Recently, a small hospital system in West Virginia spent \$4 million on additional staff to meet increased demand during the flu season. Other input costs, such as prescription drugs, also may increase multiple times per year.

HEALTH CARE PRICING & BILLING

The price of a service – or what a patient or entity, such as an insurer, pays for this care – is largely dependent on the type of insurance coverage a patient has. The U.S. has made significant gains in coverage over the past several years, with approximately 90 percent of individuals enrolled in some form of coverage. For these more than 320 million individuals, insurers (including programs such as Medicare and Medicaid) are primarily responsible for determining

¹ American Hospital Association, “Regulatory Overload: Assessing the Regulatory Burden on Health Systems, Hospitals and Post-acute Care Providers;” Oct. 2017. Accessed at: <https://www.aha.org/guidesreports/2017-11-03-regulatory-overload-report>

what consumers pay for care, including any premiums, deductibles and other cost sharing.² Nationally, hospitals contract with more than 1,300 insurers, each having different plans, all with multiple and often unique cost-sharing structures. For the approximately 10 percent of individuals who are uninsured, and for those who are within their deductible amounts, prices are set by providers and may vary based on a patient's ability to pay. In many instances, uninsured and underinsured patients pay little to nothing for their care. Hospitals provided more than \$38 billion in charity care and other uncompensated care in 2016, and, since 2000, have provided more than \$576 billion in uncompensated care.³

THE CHALLENGE OF ENGAGING CONSUMERS THROUGH TRANSPARENCY EFFORTS

Policymakers and health care leaders have been optimistic that better cost and quality information would help engage patients in their care and positively impact health outcomes and health care spending. However, efforts to date have not shown much success. Patients have not used much of the data that already is available – whether it is through public-payer initiatives, like the *Compare* tools available through the Centers for Medicare & Medicaid Services (CMS), or private-sector initiatives, such as Castlight Health.^{4,5}

Part of the challenge is that consumer shopping does not work well for the vast majority of health care services. In fact, some experts suggest that as little as 7 percent of health care is “shoppable” by consumers.⁶ This is in part because treatment for the same condition will vary based upon the severity of the case, any compounding co-morbidities, and a patient's genetic makeup. In addition, the need for health care often arises suddenly, and patients do not have time to compare price and quality information before seeking care. In many cases, an emergency services system decides where the patient will obtain care.

A nationally representative survey conducted by Public Agenda found that only half of Americans tried to find price information before getting care.⁷ It also found variation across states in how consumers access pricing information. While the study noted that patients view

² US Census Bureau, Health Insurance Coverage in the United States: 2016, Current Population Reports issued Sept. 2017. Accessed at: <https://www.census.gov/content/dam/Census/library/publications/2017/demo/p60-260.pdf>

³ American Hospital Association Uncompensated Hospital Care Cost Fact Sheet, Dec. 2017. Accessed at: <https://www.aha.org/system/files/2018-03/340b-community-benefit-analysis.pdf>

⁴ Dolan, R. “From The Archives: Prices And Consumer Shopping,” Health Affairs Blog, Jul. 19, 2017. Accessed at: <https://www.healthaffairs.org/doi/10.1377/hblog20170719.061105/full/>

⁵ Advisory Board, “NYT: Why price transparency tools have fallen short of expectations,” Jun. 20, 2016. Accessed at: <https://www.advisory.com/daily-briefing/2016/06/20/price-transparency-tools>

⁶ Frost, A., et. al, “Health Care Consumerism: Can The Tail Wag The Dog?,” Health Affairs Blog, Mar. 2, 2016. Accessed at: <https://www.healthaffairs.org/doi/10.1377/hblog20160302.053566/full/>

⁷ Public Agenda, Still Searching: How People Use Health Care Price Information in the United States, New York State, Florida, Texas and New Hampshire, April 2017. Accessed at: www.publicagenda.org/files/PublicAgenda_StillSearching_2017.pdf

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physicians, pharmacists, insurance companies and hospitals as trusted sources of information, over half of the survey respondents said they get their price information from a relative, friend or colleague. Of health care professionals, consumers identified the following as their sources for pricing information: insurance companies (48 percent), physicians (46 percent) and hospitals (31 percent).

Consumers need different types of pricing information depending on whether and how they are insured. A patient with traditional insurance may want to know what the co-pay or co-insurance amount is for a given service and have less need for the specific or total price the insurance company pays for their care. Uninsured individuals or individuals within their deductible amount may be interested in the price billed for a service at different facilities, as well as what financial assistance may be available. More research is needed to understand what type of pricing patients want and would find useful in their health care decision-making.

With respect to quality information, in 2014, CMS launched *Hospital Compare*, a website with quality data on 10 evidence-based measures for heart attack, heart failure and pneumonia patients. These measures became the foundation for CMS's public reporting and value-based purchasing programs for hospitals. However, since then, hospitals and consumers alike have become overwhelmed by the sheer number of measures on *Hospital Compare* specifically, and CMS's quality programs generally. CMS has added many, many measures to these programs without achieving its goal of substantially engaging consumers in the use of this information. Furthermore, many of the measures are not relevant to the care patients are seeking and do not focus on the most important opportunities to improve patient outcomes. In short, the current approach to quality measurement diverts time and resources away from what matters most – improving care.

The AHA believes we could greatly advance quality transparency by streamlining and focusing public reporting and pay-for-performance programs on “measures that matter.” Federal agencies should come together with providers and private payers to agree on a manageable list of high-priority aspects of care. Then, providers could use a small and critically important set of measures linked to these topics to track and report on progress toward improving the care delivered and the outcomes for patients. By focusing on “measures that matter,” providers would have a consistent framework to invest their quality improvement resources wisely and ensure that consumers are equipped with the most important and relevant information on how hospitals perform.

The AHA also has urged CMS to suspend its hospital star ratings from *Hospital Compare*, and to work with the hospital field, consumers and others to develop a more sound approach to reporting quality information. The flawed approach taken in the CMS hospital star ratings effort undermines the goal of transparency by providing an inaccurate, misleading picture of hospital quality. While the December 2017 update of star ratings corrected some important calculation errors, we continue to have significant concerns about the conceptual underpinnings of the star ratings. The measures included in the ratings were never intended to create a single,

representative score of hospital quality. Furthermore, the star ratings often do not reflect the aspects of care most relevant to a particular patient's needs. Unsurprisingly, there is significant variation between *Hospital Compare* and other quality rating programs.⁸

HELPING PATIENTS UNDERSTAND HEALTH CARE PRICING

Today's complex billing system did not develop overnight and will require thoughtful examination involving all stakeholders to find the right solutions that will benefit patients. In November 2003, the AHA Board of Trustees approved a Statement of Principles and Guidelines on practices hospitals are embracing for patient billing and collection. We updated the guidance in May 2012 to reflect advancements in the field and changes made by the Affordable Care Act (ACA) applicable to tax-exempt hospitals. The guidelines reflect the AHA's commitment to addressing this issue and demonstrate the shared partnership/responsibility between hospitals and patients to resolve billing issues in a timely, transparent and forthright manner.

America's hospitals are united in providing care based on the following:

- **Communicating effectively with patients** – Hospitals work to provide financial counseling to patients about their bills and make the availability of such counseling widely known. Hospitals strive to respond promptly to patients' questions about their bills and to requests for financial assistance and use a billing process that is clear, concise, correct and patient friendly. Hospitals are making available for review by the public specific information in a meaningful format about what they charge for items and services.
- **Helping patients qualify for financial assistance** – For many years, hospitals have worked with patients to help them with their bills as part of our mission of caring. Under the ACA, non-profit hospitals must have a written financial assistance policy that includes eligibility criteria, the basis for calculating charges and the method for applying financial assistance. Hospitals work to communicate this information to patients in a way that is easy to understand, culturally appropriate and in the most prevalent languages used in their communities, and have understandable, written policies to help patients determine if they qualify for public or hospital-based assistance programs. The ACA also requires that non-profit hospitals widely publicize (e.g., post on the premises and on their website and/or distribute directly to patients) these policies and share them with appropriate community health and human services agencies and other organizations that assist people in need.

⁸ Austin, M., et.al, "National Hospital Ratings Systems Share Few Common Scores And May Generate Confusion Instead Of Clarity," Health Affairs, Mar. 2015. Accessed at: <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2014.0201>

- **Ensuring hospital policies are applied accurately and consistently** – Hospitals work to ensure that all financial assistance policies are applied consistently and that staff members who work closely with patients (including those working in patient registration and admitting, financial assistance, customer service, and billing and collections, as well as nurses, social workers, hospital receptionists and others) are educated about hospital billing, financial assistance, and collection policies and practices.
- **Making care more affordable for patients who qualify for financial assistance** – Hospitals strive to review all current charges and ensure that charges for services and procedures are reasonably related to both the cost of the service and to meeting all of the community’s health care needs, including providing the necessary subsidies to maintain essential public services. Under the ACA, non-profit hospitals also have policies to limit charges for emergency and other medically necessary care for those who qualify for financial assistance to no more than the amounts generally billed to individuals who have insurance covering such care.

In addition to these principles, the AHA has worked closely with the Healthcare Financial Management Association (HFMA) to promote greater price transparency in health care. We participated in an HFMA-led, multi-stakeholder task force in 2014 that resulted in guiding principles supported by patients, hospitals, insurers and physicians, among others. These principles seek to empower consumers to make meaningful comparisons, require stakeholders to communicate prices in ways patients can easily understand, pair prices with information on the value of a service, provide enough information that the consumer will understand the total price of care and require active commitment of all stakeholders.⁹ The final task force report also provides a framework for communicating price transparency based on different purchaser groups including: insured and uninsured patients, employers and referring clinicians. Moreover, the task force developed a consumer guide toward understanding health care prices. To further support the work of the taskforce, the AHA developed a toolkit for hospitals to achieve price transparency for consumers.¹⁰ The toolkit includes a self-assessment and recommended action items, such as staff training and community engagement. It also profiled hospital and hospital system best practices on price transparency.

The AHA also worked closely with the National Association of Insurance Commissioners (NAIC) and other stakeholders in the development of the NAIC’s Health Benefit Plan Network Access and Adequacy Model Act (Model Act). The Model Act provides language that state governments may use to establish standards for the creation and maintenance of provider networks by health carriers and assure the adequacy, accessibility, transparency and quality of health care services offered under a network plan. Of particular relevance to the issue of price transparency is the provision in the Model Act on “surprise bills” to protect consumers from

⁹ HFMA, “Price Transparency in Health Care: Report from the HFMA Price Transparency Task Force,” 2014.

¹⁰ AHA, “Community Connections, Achieving Price Transparency for Consumers: A Toolkit for Hospitals,” 2014. Accessed at: <http://www.ahacommunityconnections.org/tools-resources/transparency.shtml>

unexpected large bills and balance billing. The Model Act addresses balance billing for planned services provided at in-network health care facilities that may use health care professionals who are not in the same health plan's network. The Model Act would implement disclosure requirements and require that plans establish payment programs for out-of-network health care professionals. It also would require plans to adopt a structured mediation process to resolve any remaining payment disputes with out-of-network health care professionals. To support the efforts of the NAIC, the AHA developed a toolkit for our hospital and health systems members and state hospitals associations designed to facilitate their advocacy at the state level for the adoption of the NAIC Model Act, including the "surprise billing" provisions.¹¹

STATE-LEVEL TRANSPARENCY INITIATIVES

States have led a number of price transparency efforts, with more than 40 states now requiring or encouraging hospitals to report information on charges or payment rates and make that data available to the public.¹² These state efforts range from making information public on pricing for frequent hospital services to information on all inpatient services, such as publication of a hospital's chargemaster. In some cases, states have developed these price transparency initiatives in collaboration with the state hospital associations. For example, the Colorado Hospital Price Report is a joint project of the Colorado Hospital Association and the Colorado Department of Regulatory Agencies, Division of Insurance. Every year, the hospital association and the Colorado State Division of Insurance publish hospital prices and health insurer reimbursements on a public website. This website gives consumers and purchasers of health care services access to information about average hospital charges and average reimbursement rates paid by insurance companies or health maintenance organizations. The report includes the 25 most common inpatient medical conditions and surgical procedures performed by hospitals.¹³

In Oregon, the Oregon Association of Hospitals and Health Systems launched the consumer-friendly OregonHospitalGuide.org after working with the state. The association manages the website, which includes a section on cost estimates for each hospital, information on how consumers can contact hospital billing departments, as well as links to hospitals' financial assistance policies.¹⁴

Other state hospital associations have pursued voluntary efforts in which they work with their members to promote principles of price transparency. The Hospital & Healthsystem Association of Pennsylvania developed guidelines for consumer-focused hospital financial services to assist its members in designing administrative and communication processes around financial

¹¹ AHA NAIC Model Act Toolkit, 2016.

¹² AHA Toolkit for Hospitals, 2014.

¹³ Colorado Hospital Association, Colorado Hospital Price Report. Accessed at: <https://cha.com/colorado-hospitals/price-report/>

¹⁴ Oregon Association of Hospitals and Health Systems (OAHHS). June 28, 2016. Accessed at: www.oahhs.org/news-and-publications/press-releases/oahhs-highlighted-financial-communications-best-practices

assistance services.¹⁵ The California Hospital Association (CHA) adopted “a voluntary effort by its member hospitals to adjust their prices (i.e., charges) to a level that is explainable, understandable and reflects the unique cost structure of the hospital’s mission and patient population.”¹⁶ To support this voluntary effort, CHA developed a consumer guide clarifying hospital charges.

In addition to hospital price transparency, states also have taken a leadership role in driving more transparency around drug prices, which are a significant factor in the rising cost of health care. Examples of recent state activity include:¹⁷

- **Oregon:** Governor Kate Brown last week signed a bill that will require drug manufacturers to report the rationale behind any high drug price increases.
- **Louisiana:** The state requires each drug manufacturer or pharmaceutical marketer to provide to the Louisiana Board of Pharmacy the current wholesale acquisition cost for approved drugs marketed in the state four times a year.
- **Maryland:** The state imposes fines on generic drug manufacturers if they increase the wholesale acquisition cost (WAC) of their products by 50 percent or more in one year, if the WAC is more than \$80 or if the price increases while there are three or fewer drug manufacturers actively manufacturing and marketing the drug.
- **Nevada:** The state requires insulin manufacturers to disclose the prices they set and provide written explanations of price increases.
- **North Carolina:** The state bans a common Pharmacy Benefit Manager practice of prohibiting a pharmacist or pharmacy from providing an insured patient with information on the amount of the patient’s prescription drug cost sharing and the efficacy of a lower-priced alternative drug if one is available.
- **Vermont:** The state requires public reporting on drugs purchased by the state for which the wholesale acquisition price has increased by 50 percent or more over the past five years or by 15 percent or more over the past 12 months.

CONCLUSION

Hospitals and health systems are a critical component to the fabric and future of our communities. We recognize the challenge of health care affordability, and hospitals have worked hard to hold down costs. We have made progress, with recent data clearly showing that hospital costs and price growth have slowed. National spending for hospital care grew at just 1.9 percent

¹⁵ Hospital & Healthsystem Association of Pennsylvania, *Consumer-Focused Hospital Financial Resources*. Accessed at: www.haponline.org/Initiatives/Increasing-Transparency/White-Paper-on-Consumer-Focused-Hospital-Financial-Services

¹⁶ California Hospital Association, *Modern Pricing: Clarifying Hospital Charges for Consumers*, 2014. Accessed at: www.calhospital.org/modern-pricing-resources

¹⁷ <https://www.raps.org/news-and-articles/news-articles/2018/3/oregon-bill-on-drug-price-transparency-headed-to-g>

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between 2016 and 2017, the lowest rate since September 2011.¹⁸ Hospitals remain committed to helping bend the cost curve for their patients, communities and the nation.

We agree that consumers need useful information when making health care-related decisions for themselves and their families. Providing understandable and useful information about health care costs is just one way America's hospitals and health systems are working to improve the health of their communities. The AHA and its members stand ready to work with policymakers on innovative ways to build on efforts already occurring at the state level, and share information that helps consumers make better choices about their health care.

Thank you for this opportunity to submit comments on the issues of pricing of health care services and the quality of care. If you have questions, or would like further information, please contact Molly Smith, Vice President, Coverage and State Issues Forum, at mollysmith@aha.org or (202) 626-4639.

Sincerely,

/s/

Thomas P. Nickels
Executive Vice President

¹⁸Altarum Institute's Center for Sustainable Health Spending, https://altarum.org/sites/default/files/uploaded-related-files/CSHS-Spending-Brief_November_2017.pdf