

**American Hospital Association  
Comments  
to  
the Senate Finance Committee  
on  
Expanding Health Care Coverage:  
Proposals to Provide Affordable Coverage to All Americans**

On behalf of our more than 5,000 member hospitals, health systems and other health care organizations, and our 40,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on your May 11 policy options paper on expanding affordable health care coverage.

Hospitals support the enactment of comprehensive, meaningful health care reform legislation this year. Over the past several years, the AHA Board of Trustees has worked to develop a framework for health reform. During that time, the board spoke with hundreds of hospital leaders, held public listening sessions and convened more than 100 organizations representing consumers, health advocacy groups, business, insurers, providers, unions and others to identify those changes in law and regulation necessary to improve health and health care in America. The result – *Health for Life: Better Health. Better Health Care.* – identifies five essential elements of reform:

- 1) Health coverage for all, paid for by all;
- 2) A focus on wellness;
- 3) The most efficient, affordable care;
- 4) The highest quality care; and
- 5) The best information.

The AHA believes that everyone deserves health care coverage that provides the right care, at the right time, in the right place. Health coverage for all, paid for by all is an essential element of health reform supported by the AHA. The economic recession gripping the nation has brought into sharp focus the need for health care reform as many Americans join the millions who are already uninsured with limited access to health services.



Expanding coverage also is key to cost control, as health care costs are higher when patients do not receive care at the right time or in the right setting. Many uninsured people delay needed care until it is an emergency. And the costs of the uninsured are reflected in higher health insurance premiums for those purchasing insurance. Providing coverage to all will help mitigate the “cost shift” that moves the financial burden of non-coverage from public to private payers.

The Senate Finance Committee’s (SFC) options paper presents a complex array of approaches to expanding affordable health care coverage – insurance reform, a national insurance exchange, a public plan, subsidies for low-income individuals and families, Medicaid expansion and coverage mandates for individuals and employers. This vast array of options also presents analytical challenges because many of the options are interconnected and, depending on which variation of the options is chosen, the final outcome could be very different. But despite these challenges, the AHA commends the committee for examining the balance between public- and private-sector solutions, and for affording the public the opportunity to engage on these issues.

We also would like to commend the committee for including options to promote prevention and wellness, as well as addressing health disparities. We look forward to working with the SFC and other policymakers to develop the best policy changes possible to achieve better health and health care in America. Our detailed comments on the key provisions affecting hospitals follow.

## **INSURANCE REFORM**

The AHA supports enhanced access to affordable private health insurance and believes that the insurance market reforms put forward by the SFC are the first critical steps toward expanding access to private insurance. The AHA supports the SFC paper’s recommendations on guarantee issue and renewability, as well as the elimination of pre-existing condition exclusions. We also support the federal rating band reforms. However, we have concerns that the rating reforms would not apply immediately to the small group market and could take up to 10 years to apply to this sector of the market depending on when a respective state adopts the federal rating band reforms.

In addition, the AHA is encouraged to see the establishment of a National Health Insurance Exchange as an option in the SFC paper. A national exchange holds the promise of organizing the insurance market to facilitate the purchase of coverage. It also can serve as the conduit for government subsidies that support the purchase of health care coverage for low-income individuals. But we are concerned that the exchange as described in the options paper might be too limited in scope, particularly in its authority to oversee health plans, risk adjustment and rating areas to ensure affordable private insurance. We also are concerned that the SFC paper does not include the participation of non-commercial health plans in the exchange. We would strongly recommend that the committee consider including in the exchange provider-based health plans, such as health maintenance organizations operated by hospitals and hospital systems.

### **MAKING COVERAGE AFFORDABLE**

The AHA strongly supports subsidies for low-income individuals and families to purchase affordable and meaningful private health coverage. We support the option to make the premium subsidy/tax credit refundable and advanceable. However, we are concerned that the tax credit might not be sufficient to purchase meaningful coverage and look forward to the committee's work in this area. We also support tax credits for small businesses and tying the credit to the size of the firm with respect to employees and average wages.

### **PUBLIC PLAN OPTION**

While the AHA has not taken a public position on the establishment of a public plan option to improve access to health care coverage, our members have expressed resounding concern that implementing another public program could exacerbate the underpayment of providers by paying rates at Medicare or Medicaid levels.

Both the Medicare and Medicaid programs already pay providers less than the cost of furnishing services to the programs' beneficiaries. According to AHA annual survey data, 58 percent, or 2,840 hospitals, were not paid their cost for serving Medicare patients in 2007. The Medicare Payment Advisory Commission (MedPAC) projects that hospitals will have a *negative* 6.9 percent Medicare margin in 2009 – down from a *positive* 6.2 percent Medicare margin in 1999 – the lowest level in more than a decade. In addition, the federal fiscal year (FY) 2010 inpatient prospective payment system (IPPS) proposed rule would further reduce hospital payment by \$22 billion over the next 10 years. Hospitals also experience severe payment shortfalls when treating Medicaid patients. On a national level, the Medicaid payment shortfall amounted to \$10.4 billion in 2007. What that means is that Medicaid paid only 88 cents for every dollar spent treating Medicaid patients. The perpetuation of underpayment for hospital services in a health care reform environment may regrettably lead to a reduction in access to needed services for communities, as hospitals will be forced to reduce services. We urge the committee to carefully consider the impact of reforms that could unintentionally result in reducing access to care.

### **SHARED RESPONSIBILITY**

One of the key elements for health care reform, as determined by AHA's multi-year *Health for Life* effort, is *health coverage for all, paid for by all*. In many discussions with our members, we found that they firmly believe that shared responsibility for individuals and employers is critical to achieving coverage for all. To ensure that an individual coverage mandate is meaningful, it will be important that insurance market reforms are not only thorough but also implemented rapidly. Such a mandate would be greatly enhanced by a robust national health insurance exchange that has a broad scope of authority that includes regulating health plans. Subsidies for low-income individuals, as well as expansions in Medicaid eligibility, are critical to ensure those low-income populations, long ill-served by the current insurance market, will have access to affordable coverage.

Employers have served as the backbone of our health care insurance system – voluntarily providing health insurance to U.S. workers and their families for more than half a century – and they should continue to bear responsibility for advancing health care coverage reform. One of the overall goals in moving toward universal coverage should be to support some aspect of the voluntary role that employers have long played. However, employers who do not participate in providing coverage should be assessed a penalty, which would be used to support the programs through which their employees obtain health care coverage. The AHA urges the committee to make certain it balances a mandate for individuals to obtain coverage with a strong requirement that employers continue to participate in the provision of health care coverage for their employees.

## **ROLE OF PUBLIC PROGRAMS**

### **Medicaid**

The SFC proposes significant reforms to the Medicaid program ranging from eligibility expansions to federalizing the Medicaid disproportionate share hospital (DSH) program. In this section of the options paper, the challenges of sorting through the interconnectedness between Medicaid, the insurance exchange, subsidies for the low-income, and the various public plan options have proven to be daunting. The Medicaid program has long served as the nation's health care safety net, providing access to health services for millions who cannot afford private insurance in a dynamic and changing economy. Changing the overall financing structure of the program and the way it supports providers serving vulnerable populations needs to be thoughtfully and carefully deliberated.

### **Medicaid Expansion and Program Payments**

The AHA supports expanding Medicaid eligibility with federal financing for the new populations covered through expanding eligibility for children, parents and pregnant women up to 150 percent of the federal poverty level. The SFC paper proposes phasing down the additional federal financial support to the states over a five-year period of time. However, given the current economic climate in many states as they work to recover from the current recession, federal support for this period of time may not be sufficient. In addition, the AHA applauds the committee's inclusion of the concept of provider payment protections. The AHA has long supported Medicaid provider payment protections including during the recent debate on the economic stimulus legislation. We would, however, urge some caution tying Medicaid payment protections to Medicare since the programs serve very different populations.

### **Medicaid DSH Program**

The AHA has grave concerns over the SFC's proposals to federalize the operation of the Medicaid DSH program. The program is our nation's primary source of support for safety-net hospitals that serve the most vulnerable populations – Medicaid beneficiaries, the uninsured and the underinsured. Many hospitals rely on Medicaid DSH payments to be able to keep their doors open. These funds go toward supporting a broad range of services for uninsured or underinsured children and adults – such as chronic disease

management, preventive care, dental care and child abuse screening. And Medicaid DSH funds help support essential community services such as trauma and burn care, pediatric intensive care, high-risk neonatal care and emergency psychiatric services. Such resources also help fund hospital readiness for natural and man-made disasters.

Even if universal coverage is achieved through health care reform, there will be populations that will remain uncovered, and hospitals will be asked to bear the burden of their health care and essential community services. The AHA recommends that the committee reject reductions in federal support for DSH programs before the following system reforms occur: coverage expansions are universal and fully implemented and Medicare and Medicaid payment shortfalls are addressed. These views were shared with Congress in an April 27 coalition letter signed by the AHA, Association of American Medical Colleges, Catholic Health Association of the United States, Federation of American Hospitals, National Association of Children's Hospitals and National Association of Public Hospitals and Health Systems.

#### **Transparency in Medicaid and CHIP Waivers and State Plan Amendments**

The AHA supports the SFC's proposal to impose new statutory requirements on states to increase transparency when developing and implementing Medicaid and Children's Health Insurance Program (CHIP) 1115 waivers. In addition, this proposal would mandate transparency-related requirements for states when proposing limiting benefits with regard to their Medicaid State Plan Amendments. The AHA has long advocated such transparency measures and believes they are important steps in guaranteeing the public a say in how policies affecting coverage are determined at the state level. The AHA recommends that these transparency-related requirements be extended to setting provider payments rates as well.

#### **Quality of Care in Medicaid and CHIP**

The AHA strongly supports the development of nationally standardized quality measures that are applicable to pediatric populations and other individuals who are covered under the Medicaid program. We support the development of national, standardized measures as proposed in the SFC coverage options paper. In the SFC options paper on delivery system reform, the committee thoughtfully included language directing the Secretary of the Department of Health and Human Services (HHS) to work with two different multi-stakeholder groups to both develop national health care quality measurement priorities and goals, and select applicable quality measures for public reporting that align with those priorities and goals. We suggest that the committee add similar language to the Medicaid quality measures proposal.

*The Children's Health Insurance Program Reauthorization Act of 2009* directs the implementation of the pediatric quality measures on a state-by-state basis. The AHA suggests that the committee make some modifications to this process in expanding the measures to the broader Medicaid population. In the current reporting environment, hospitals are required to report on quality data to many different entities at the federal and state level, as well as to private insurers, accrediting organizations and others. The

multiplicity of reporting requirements leads to duplication of efforts and an increased burden when various entities ask hospitals to report on different measures through different measurement systems that use different formats. It also leads to confusion because the different reporting systems often produce discordant results. A hospital can appear to be an excellent performer in one database and a lesser performer in another on exactly the same aspect of care. These conflicting results dilute hospitals' ability to identify and focus attention on those aspects of care that need substantial improvement. The AHA strongly believes that a more unified approach is needed.

Through the work of the Hospital Quality Alliance (HQA), a national set of quality measures has been developed and implemented through a common federal data reporting system, the *Hospital Compare* Web site. *Hospital Compare* should be the common data platform for quality reporting through all federal health care programs, including Medicaid. We agree that, under the Medicaid program, states should have the option to publicly portray data on the hospitals in their state. However, if they choose that option, only national standardized quality measures should be reported, and the data should flow through the *Hospital Compare* system. The development of a patchwork state-by-state quality reporting system would be to the detriment of consumers who would need to visit multiple Web sites to find quality information, and to providers who would have to pull quality improvement data from various sources. Further, should the committee look to use the *Hospital Compare* system as the national system for Medicaid data collection and reporting, as AHA recommends, Congress should provide the Secretary with additional resources to upgrade the system's capacity to ensure it can manage the inclusion of an increased amount of data.

## **OPTIONS TO IMPROVE ACCESS TO PREVENTIVE SERVICES AND ENCOURAGE HEALTHY LIFESTYLES**

### **Scoring Prevention and Wellness Initiatives**

The SFC's options paper places a strong emphasis on wellness, disease prevention and chronic care management in both the Medicaid and Medicare programs. The AHA applauds this effort. A focus on wellness is critical to improving the health of Americans, and to mitigating the rise in health care spending. Early investment in wellness will yield significant returns in terms of improved health outcomes, productivity and quality of life. We strongly recommend that the committee encourage the Congressional Budget Office as well as the Administration's economic analysts to be flexible in scoring health care legislation – especially provisions related to wellness – as an upfront investment in prevention will yield long term savings to our health care system.

### **USPSTF Recommendations**

Hospitals believe in fostering evidence-based medicine and, thus, support the work and findings of the United States Preventive Services Task Force (USPSTF). The AHA is pleased that the SFC's options paper proposes to encourage the utilization of effective preventive services, those rated an "A" or "B" by the USPSTF, by removing or limiting

beneficiary cost-sharing. Studies have shown that cost is often a barrier to receipt of certain medical services. Given that these services have been identified as clinically effective interventions to improve health and wellness, we encourage the committee to eliminate all cost-sharing for these services under Medicare. Also, given limited health care resources, we support the committee's proposal for the Secretary not to cover services rated a "D" by the USPSTF. These services may not only be less effective but potentially harmful to certain patient populations.

The AHA supports increasing federal Medicaid match funds to support state efforts to establish effective preventive services and immunizations (those rated "A" or "B" by the USPSTF or those recommended by the Advisory Committee on Immunization Practice). We encourage the SFC to carefully evaluate whether a 1 percent increase in the federal match rate is sufficient to support these state efforts.

### **State Grants**

The AHA supports incentive-based programs to encourage individuals to lead healthier lifestyles. We support the SFC's proposal to provide grant funding to states. These grant programs include "RightChoices," which provides annual funding to states to improve patient access to certain evidence-based primary preventive services such as health screenings and immunizations, and the competitive "Prevention and Wellness Innovation" grants to provide funding to improve care coordination, access to preventive services and treatments, and better integrate the delivery of health care services.

### **Employer Wellness Credits**

The SFC's options paper proposes to provide employers with "qualified wellness programs" an annual tax credit for a maximum of five years for 50 percent of the costs they pay for providing the programs to their employees. The AHA supports this approach. Providing work-based incentives better targets such incentive funds and encourages employers to embrace initiatives that contribute to the health and wellness of their employees.

## **OPTIONS TO ADDRESS HEALTH DISPARITIES**

We commend the committee on addressing health disparities in the options paper. The AHA believes this is a critical priority as Congress seeks to implement health reform and supports the options discussed in the paper, with some suggested modifications, discussed below. At the same time, the SFC should expand the range of provisions needed to address disparities effectively. The AHA appointed a Special Advisory Group on Improving Hospital Care for Minorities about 18 months ago, with members from a broad cross-section of stakeholders, both within and outside of the health care field. Recently, the Special Advisory Group developed a set of legislative priorities they view as essential for eliminating the health disparity gap and improving hospital care for minority populations. We recommend these priorities for consideration in developing the draft reform legislation. The legislative priorities address three areas, which are detailed

in the group's letter to President Obama and are summarized below. The letter can be found at <http://www.aha.org/aha/letter/2009/090504-let-disparitiesgrp-obama.pdf>.

**Priority 1: Support improvements in health care delivery designed to eliminate disparities in health care for minority populations.** These specific recommendations speak to reforming health care delivery in underserved areas through the development of systems of care including care coordination and technological connections among safety-net and community-based providers; the collection and better use of race, ethnicity and primary language data and the integration of that data with demographic and public health data; and the careful development and testing of quality performance measures under traditional Medicare and Medicare Advantage.

**Priority 2: Develop and expand the health care workforce to improve the availability of needed practitioners in minority and underserved communities.** The specific recommendations under this priority address issues related to expanding the broad range of primary care professionals, increasing the diversity of the health care workforce, embedding cultural competency training in medical, health professions and health management training programs, and improving the National Health Service Corps.

**Priority 3: Eliminate other barriers to access for minorities.** These recommendations address coverage for all, the socioeconomic factors that contribute to disparities, cultural competency training for already-practicing health care providers and other health care workers, and coverage for language services for the rapidly growing number of patients who have limited English proficiency, are functionally illiterate, or are deaf or hard of hearing.

With respect to the options presented in the committee's coverage paper, we offer the following comments and suggestions.

- **Required Collection of Data:** We strongly support the upgrading of the Social Security Administration's (SSA) enrollment database, the inclusion of data useful for conducting research on disparities and development of interoperability between critical data systems.
- **Data Collection Methods:** The AHA supports the collection of race, ethnicity and primary language data by hospitals to improve their ability to identify and address disparities in care. To that end, our affiliated Health Research & Educational Trust developed a toolkit for hospitals on the collection of such data in a standardized way that, while sometimes more detailed, can be "rolled up" into the current Office of Management and Budget (OMB) categories. Not only does it include technical implementation information, but also staff training modules on how to collect such information in a culturally sensitive manner. The toolkit was recently endorsed by the National Quality Forum (NQF), which we hope will lead to more standardized and accurate reporting of this information. We urge that federal efforts to require collection of race, ethnicity

and primary language data be consistent with this approach. The toolkit can be found at [www.hretdisparities.org](http://www.hretdisparities.org).

- **Standardized Categories for Data:** The AHA supports movement to the standardized OMB categories, as indicated above. However, we recommend that the use of a “multiracial” category be allowed, rather than requiring patients to check “all that apply.”
- **Public Reporting, Transparency and Education:** We recognize the need to utilize race, ethnicity and gender data in examining quality and disparities issues. However, we are concerned that publishing quality measures broken down into these categories on the Hospital Compare Web site might not work for a variety of technical reasons. For example, breaking down the quality measures data into such small units may not yield statistically valid results. The National Priorities Partners, an NQF-based effort convened in 2008, is working to transform the nation’s health care system to ensure all Americans have access to safe and affordable health care. The 28 partners represent those who pay for, deliver and evaluate health care. The partners are developing an agenda to thoughtfully look at disparities. The AHA recommends that the SFC use the work of the partners as the foundation for having the Secretary measure and report on health disparities.
- **Language Access:** The AHA supports addressing the language service needs of patients and, to that end, has been working with the HHS Office for Civil Rights (OCR) for several years on a range of efforts to improve language access in hospitals. We also support the expansion of the 75 percent federal match under Medicaid for language services provided to all Medicaid enrollees. However, we have several issues with this proposed option. First, the proposal should be expanded to cover language services for Medicare beneficiaries as well. With the rapidly growing limited English proficient patient population and the fact that the vast majority of health plans (public and private) do not provide any support for language services, hospitals and other health care providers are struggling to meet this need.

The proposal also incorrectly states that the HHS Office of Minority Health’s national standards for the delivery of “culturally and linguistically appropriate health care services” (known as the CLAS standards) is the regulatory standard for federally funded health care programs regarding language access. That is not the case. The regulatory standards are the guidelines issued by the OCR, and it is the enforcement agency. Furthermore, the CLAS standards were developed outside the *Administrative Procedures Act* regulatory process and other requirements for impact and regulatory flexibility analyses. They were issued prior to the issuance of government-wide guidelines on language access issued by the Department of Justice (DOJ) and then interpreted by HHS in its own guidelines on how its agencies and programs should apply the DOJ guidelines.

The CLAS standards were never updated to comply with either the DOJ or HHS guidelines, while the OCR guidelines were updated. One of the critical aspects of the DOJ/HHS guidelines that the CLAS language standards do not comply with is the flexibility provisions to reflect the size and nature of a specific community's population and recognition of available local resources. We recommend that the proposal to extend the CLAS standards to all private health plans offered under the health insurance exchange be changed to requiring adherence to the OCR guidelines.

**Waiting Period and Maternal and Child Health Services Block Grant Funding**

The AHA strongly supports allowing state Medicaid programs to cover legal immigrant adults by waiving the current law five-year waiting period and sponsor income requirements. Also, we support the committee's proposal to increase funding for the Maternal and Child Health Services Block Grant program to develop and implement programs to reduce infant mortality and improve maternal health.

The AHA will continue to work with the SFC and its staff in strengthening the ideas presented in the coverage options paper. We are steadfast in our support of expanding affordable health care coverage and look forward to working with the committee and its staff as Congress moves forward with critical health reform legislation.