



American Hospital
Association®

2019
ANNUAL
MEMBERSHIP
MEETING

Advocacy Messages

Your Mission on Capitol Hill

URGE CONGRESS TO:

1

Promote Better Care for America

by building upon and improving our existing system to increase access to coverage and comprehensive health benefits.

2

Protect Patients from “Surprise” Medical Bills

by enacting comprehensive federal legislation and supporting existing state laws that work.

3

Ensure Hospitals Have the Resources to Care

by rejecting proposals to reduce already stretched hospital and health system resources and supporting policies that would promote access.



Advancing Health in America

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1 Promote Better Care for America

THE AHA IS COMMITTED TO THE GOAL OF AFFORDABLE, comprehensive health insurance for every American. However, “Medicare for All” is not the solution:

- ➔ **RIGHT GOAL, WRONG PATH.** There are better and less disruptive ways to expand health coverage than by upending the employer-sponsored coverage market, which covers more than half of all Americans—180 million people—and replacing it with a new, government-run, one-size-fits-all plan. This would take away choice from millions of people who have no desire for such drastic change.
- ➔ **HEALTH CARE FUNDING SHOULDN'T BE SUBJECTED TO FURTHER POLITICIZATION.** Medicare is already subject to politicization and micromanagement including reducing provider payments to offset funding for other priorities that have no relation to health care. This instability, as well as the uncertainty wrought by repeated government shutdowns and political standoffs, could combine to jeopardize funding and access for everyone under Medicare for All.
- ➔ **INNOVATION COULD BE STIFLED.** Ramped up efforts to advance care, enhance quality and improve the patient experience would cease to be a priority if the federal government is controlling all payments to providers and can reduce costs simply through reducing rates. Further, funding cuts could hamper hospitals' ability to implement lifesaving new technologies, upgrade facilities and provide patients with the latest medical advances.
- ➔ **ACCESS COULD BE LIMITED.** Medicare does not reimburse hospitals for the real cost of the care they provide, paying only 87 cents for every dollar spent by hospitals caring for Medicare patients in 2017—a shortfall of \$53.9 billion. Chronic underpayment can lead to access issues for seniors as some providers, especially physicians, may limit the number of Medicare patients they take or stop seeing them altogether. A recent study

found that one proposal to create a government-run, Medicare-like health plan on the individual exchange could create the largest ever cut to hospitals — nearly \$800 billion — and be disruptive to the employer-sponsored and non-group health insurance markets, while resulting in only a modest drop in the number of uninsured compared to the 9 million Americans who would gain insurance by taking advantage of the existing public/private coverage framework.

The better path supporting access to health coverage for all Americans lies in continuing to build on the progress we've made in increasing coverage over the past decade.

The number of people with health insurance has increased significantly over the past 5 years, with more than 20 million individuals newly insured. Most of these individuals were able to enroll in coverage offered through the Medicaid program, their employer or the individual market as a result of improved and expanded coverage programs and insurance market reforms.

To make further coverage gains, we support:

- ➔ **CONTINUED EFFORTS TO EXPAND MEDICAID IN NON-EXPANSION STATES**, including providing 100% of the federal matching rate for the first 3 years that a state expands its program.
- ➔ **STRENGTHENING THE MARKETPLACES** to improve their stability and the affordability of coverage by reinstating cost-sharing subsidies and reinsurance mechanisms. Increasing subsidies to expand the number of people obtaining insurance through the health care exchanges should also be considered.
- ➔ **ROBUST ENROLLMENT EFFORTS** to connect individuals to coverage. The majority of the uninsured are anticipated to be eligible for Medicaid, or subsidized coverage in the marketplace or through their employer. We need an enrollment strategy that connects them to — and keeps them enrolled in — coverage. This requires adequate funding for enrollment efforts and navigators to assist consumers.

We must also ensure the long-term sustainability of Medicare, Medicaid and other programs that so many Americans depend on for coverage.

While we can all agree that there is more work to be done, we should come together and protect and improve our current system.



2 Protect Patients from “Surprise” Medical Bills

THE LAST THING A PATIENT SHOULD WORRY ABOUT in a health crisis is an unanticipated medical bill that may impact their out-of-pocket costs, and undermine the trust and confidence that patients have in their caregivers. America’s hospitals and health systems are committed to protecting patients from “surprise bills” that patients may incur as a result of unexpected gaps in insurance coverage or medical emergencies. As Congress debates a legislative solution, we believe it is critical to:

- ➔ **PROTECT THE PATIENT.** Any public policy solution should protect patients and remove them from payment negotiations between insurers and providers. Patients, regardless of the type of health care coverage they have, should be protected from gaps in insurance coverage that result in surprise bills. Patients should have certainty regarding their cost-sharing obligations, which should be based on an in-network amount. Patients should not be “balance billed,” meaning they should not receive a bill from the provider beyond their cost-sharing obligations. Patients should not have to bear the burden of serving as an intermediary between health plans and providers, rather health plans should be responsible for paying providers directly.
- ➔ **ENSURE PATIENTS HAVE ACCESS TO EMERGENCY CARE.** Any public policy solution should ensure that patients have access to and coverage of emergency care. This requires that health plans adhere to the “prudent layperson standard” and not deny payment for emergency care that, in retrospect, the health plan determined was not an emergency. Recent actions by some health plans to deny coverage of emergency services puts patients’ physical, mental and financial health at risk.
- ➔ **PRESERVE THE ROLE OF PRIVATE NEGOTIATION.** Any public policy solution should ensure providers are able to negotiate appropriate payment rates with health plans. The government should not establish a fixed payment amount for out-of-network services. Health

plans and providers take into account a number of factors when negotiating rates. Any rate or methodology sufficiently simple for national use would not be able to capture these factors. In addition, a fixed payment rate could undermine patients’ ability to access in-network clinicians by giving health plans less of an incentive to enlist physicians and facilities to join their networks because they can rely on a default out-of-network payment rate. Providers and health plans should be able to develop networks that meet consumers’ needs, and not be compelled to enter into contracts that could thwart the development of more affordable coverage options that support coordinated care.

- ➔ **EDUCATE PATIENTS.** Any public policy solution should include an educational component to help patients understand the scope of their health care coverage and how to access their benefits. All stakeholders—health plans, employers, providers and others—should undertake efforts to improve patients’ health care literacy and support them in navigating their health coverage and the health care system.
- ➔ **ENSURE ADEQUATE PROVIDER NETWORKS AND GREATER HEALTH PLAN TRANSPARENCY.** Any public policy solution should include greater oversight of health plan provider networks and the role health plans play in helping patients access in-network care. Patients should have access to easily-understandable provider network information to ensure they can make informed health care decisions, including accurate listings for hospital-based physicians in health plan directories and websites. Patients also should have adequate access to in-network providers, including hospital-based specialists at in-network facilities, rather than simply a minimum number of physicians and hospitals. Federal and state regulators should ensure both the adequacy of health plan provider networks and the accuracy of provider directories. Health plans should be responsible for an efficient and timely credentialing process to minimize the amount of time a physician is “out-of-network.”
- ➔ **SUPPORT STATE LAWS THAT WORK.** Any public policy solution should take into account the interaction between federal and state laws. Many states have undertaken efforts to protect patients from surprise billing, but federal action is necessary to protect patients in self-insured employer-sponsored plans regulated under the Employee Retirement Income Security Act, which cover the majority of privately insured individuals. Any federal solution should provide a default to state laws that meet the federal minimum for consumer protections.



3 Ensure Hospitals Have the Resources to Care

PATIENTS SHOULD BE CONFIDENT IN KNOWING that their hospital is their lifeline to access care in their community. Additional reductions to payments for hospital services and other policy changes raise serious concerns about how hospitals and health systems can ensure they serve as the safety net for their patients. We urge Congress to:

- ➔ **DELAY THE MEDICAID DISPROPORTIONATE SHARE HOSPITAL CUTS.** The Affordable Care Act reduced payments to the Medicaid DSH program under the assumption that uncompensated care costs would decrease as health care coverage increased. Unfortunately, the coverage rates envisioned have not been fully realized. In addition, Medicaid underpayment continues to pose ongoing financial challenges for hospitals treating our nation's most vulnerable citizens. The cuts have been delayed by Congress—in a bipartisan manner—multiple times, but \$4 billion in reductions are scheduled to begin on Oct. 1, 2019. We urge Congress to delay the start of the Medicaid DSH cuts given the vital need for this program and reject additional cuts.
- ➔ **PRESERVE PAYMENTS FOR LEGITIMATE DIFFERENCES BETWEEN CARE SITES.** We urge Congress to reject so-called “site-neutral payment policies” under which proposed payments for services provided in hospital outpatient departments do not distinguish between the level of care provided in HOPDs versus other settings. HOPDs serve sicker and more vulnerable patients and are subject to stricter regulatory accountability compared to ambulatory surgery centers and physician offices, which simply do not meet those standards. We urge Congress to reject proposals like those contained in the administration's budget request that would pay HOPDs at lower rates.
- ➔ **REIN IN ESCALATING DRUG PRICES.** The high cost of prescription drugs is putting a strain on patients, Medicare, Medicaid, and the entire health care system.

AHA has recommended a number of policy solutions to restrain drug prices, from addressing anticompetitive actions by brand-name drug manufacturers to speeding up generic drug approvals and passing the CREATES Act. We urge Congress to act now.

- ➔ **SUPPORT PHYSICIAN TRAINING.** We face a critical shortage of physicians that threatens patients' access to care. Congress froze the number of Medicare-funded residency slots at 1996 levels in the Balanced Budget Act of 1997. We urge Congress to pass H.R. 1763/S. 348, which would add 15,000 new slots over five years. In addition, we urge Congress to reject cuts to existing underfunded graduate medical education programs, including the administration's proposal to consolidate GME funding now provided through Medicare, Medicaid and the Children's Hospitals GME program into a single grant program.
- ➔ **SUPPORT THE 340B DRUG PRICING PROGRAM.** For more than 25 years, the 340B program has been critical to expanding access to life-saving prescription drugs and comprehensive health care services, including to low-income and uninsured individuals. The AHA believes the 340B program is working as originally intended and opposes overly burdensome and unworkable reporting requirements on covered entities that would not improve access to care for communities. We urge Congress to reject efforts to cut the program.
- ➔ **SUPPORT ACCESS TO CARE IN RURAL COMMUNITIES.** Action is needed now to create new models of care to preserve access to health care in rural communities such as through a new Rural Emergency Hospital designation, experimentation with innovative payment models and extension/expansion of current demonstrations that work. It is important for new models of care to be flexible in their payment and delivery design to meet local needs. For example, an REH designation would allow existing facilities to meet a community's needs for emergency and outpatient services with payments that could sustain those services without providing inpatient care. We also urge Congress to make permanent the enforcement moratorium on CMS's "direct supervision" policy for outpatient therapeutic services provided in small, rural hospitals and to pass legislation to permanently remove the 96-hour physician certification requirement for critical access hospitals.

