

February 4, 2022

The Honorable Kevin Hern
U.S. House of Representatives
1019 Longworth House Office Building
Washington, DC 20515

The Honorable Rick Allen
U.S. House of Representatives
570 Cannon House Office Building
Washington, DC 20515

The Honorable Victoria Spartz
U.S. House of Representatives
1523 Longworth House Office Building
Washington, DC 20515

Dear Representatives Hern, Allen and Spartz:

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) appreciates the opportunity to provide comments to the Affordability Subcommittee of the Healthy Future Task Force.

Hospitals, health systems and post-acute care providers – along with our doctors, nurses and other team members – have been on the front lines of the COVID-19 pandemic, working tirelessly to provide the best care for patients, families and communities. They have done this – and continue to do this – while facing daunting challenges. These difficulties have persisted into this year, with continued surges due to new variants that have led to increases in infections and hospitalizations.

Our shared focus with Congress is on providing relief from the pandemic, ensuring a smooth recovery and rebuilding a better health care system for the future, all while continuing to support efforts to promote greater affordability and value to patients and the health care system.

I. Improving Healthcare for America's Workers and Small Business Owners

We urge Congress to take additional steps to make health care coverage more affordable and easier to use for patients. Health insurance is meant to share large and unanticipated costs



across a pool of people. Coverage is essential for making health care affordable for individuals and families in the same way car insurance enables individual drivers to deal with an unexpected crash. While the country made substantial gains in health coverage over the past decade, we are just beginning to fully understand the crisis of under-insurance that is primarily being driven by high deductible health plans.

The AHA supports bolstering our current public/private framework for coverage to close the remaining coverage gaps and taking immediate steps to ensure that patients do not face financial barriers to using their coverage. We encourage policymakers to preserve and build on the strong foundation of employer-sponsored coverage and further strengthen the individual market while ensuring that Medicare and Medicaid are available to those who rely on these programs.

Association Health Plans

The AHA on March 6, 2018 submitted [comments](#) on the proposed rule modifying the definition of “employer” under the Employee Retirement Income Security Act (ERISA) in order to expand access to association health plans (AHPs). We expressed concern that the proposed rule failed to protect against discriminatory insurance practices and could contribute to instability in the individual and small group market, ultimately decreasing access to affordable coverage. We recommended that the Department of Labor (DOL) not finalize this proposed rule and instead work with stakeholders on ways to reduce costs and improve health plan choices for individuals and small businesses. Once the rule was finalized, we expressed concern that while the expansion of AHPs may reduce costs for some by focusing on healthier individuals, it comes at the expense of the millions who will continue to rely on the health insurance marketplaces, many of whom will bear the impact of price increases. We also expressed disappointment that the rule preempted states from fully regulating these types of plans, preventing states from ensuring appropriate consumer protections are in place. We would not support efforts by Congress to expand upon this rule to increase the number of entities eligible to form AHPs.

Individual Coverage Health Reimbursement Arrangement (ICHRA)

The AHA on Dec. 18, 2018 provided [comments](#) on the proposed rule that would change how employers may use health reimbursement arrangements (HRAs) to help employees finance health care coverage. We expressed support for these changes as proposed, as health plans sold on the individual market that meet all consumer protections are a comparable alternative to employer-sponsored coverage. However, we urged the agencies to finalize these changes only if they also finalized the policies related to antidiscrimination and the comprehensiveness of coverage.

II. Promoting Employer Programs to Lower Costs and Improve Care

In addition to making the health care system more affordable, hospitals and health systems are committed to ensuring that each dollar brings value. We will achieve this by continuously striving to deliver the highest quality care most efficiently, and that will require rethinking how and where we deliver care. We also will look for opportunities for providers to collaborate with payers and employers to ensure aligned incentives to achieve value, including identifying effective models of risk where appropriate.

We believe that direct contracting could be used to align a payer and providers around common objectives for a specific population, especially given their local ties to their communities, versus many traditional health plans, which may be nationally based. The benefit of this type of arrangement would be the potential for more direct communication between the employer and provider. We would caution, however, that operating such plans requires sophisticated knowledge and technology, and therefore some of the administrative services that are provided by a health plan would still be essential for managing a direct contracting approach. For example, in order to operationalize contract negotiation and management, claims payment, issue resolution, outcomes tracking and case management/utilization management, small and mid-size employers would likely have to contract with a series of vendors. In addition, small and midsize employers may not be able or willing to manage full risk. The employers will have to consider “value” – which is the combination of total cost of care and performance on key access, quality, and health outcome metrics relevant to the employee population. This will require an examination of clinical, claims and other data.

While some employers will consider using initiatives such as direct contracting, high performance networks and centers for excellence, it will be essential to ensure that their employees – the patients we serve in our communities – continue to have access to the full range of health care services offered through their employers’ insurance benefits. Instead, we are seeing an erosion of coverage in all types of health plans, as some health insurers restrict access to health care services by abusing utilization management programs and changing health plan rules in the middle of a contract year. For example, prior authorization, one of the most widely used utilization management tools, is designed to help patients obtain the right care in the right care setting. Insurers use prior authorization to ensure that providers order care that is consistent with clinical guidelines and protocols, as well as to confirm that such care is covered by the patient’s plan. However, some plans are now applying prior authorization to a wide range of services, including those for which the treatment protocol has remained the same for decades and there is no evidence of inappropriate use.

Unjustified use of utilization management tools such as prior authorization has a number of negative implications for patients and the health care system. As a result, patients are often blindsided by denials and can face unexpected medical bills. The extensive approval process that doctors and nurses must go through results in billions of wasted dollars to the health care system and contributes to clinician burnout. The AHA supports the Improving Seniors’ Timely

Access to Care Act of 2021 (H.R. 3173/S. 3018) that would establish requirements for the use of prior authorization under Medicare Advantage plans.

Other restrictions that impact patient access to providers include inadequate provider networks and site of service exclusions. Our hospitals report significant challenges accessing certain services, most notably inpatient mental health/substance use disorder recovery services, medication assisted therapy, long-term acute care hospital services and home health services. In many cases, patients wait in emergency departments or acute care inpatient beds for days awaiting authorization and placement. Patients may also find they have limited access to certain services or select specialties, such as oncology and orthopedics. Many health plans increasingly are only covering certain services when provided in limited sites of care. These policies are most often applied to specialty pharmacy, diagnostic tests, and surgical procedures; however, they also have been applied in the emergency setting. Specifically, health plans have questioned a patient's use of the emergency department without considering why the individual sought emergency services and thus have subsequently denied the claim. These decisions risk dis-incentivizing patients from seeking emergency treatment, which could result in serious harm to or death of a patient.

More information on commercial health plan restrictions and their impact on health care coverage is available [here](#).

III. Increasing Transparency and Marketplace Innovation

The AHA supports price transparency efforts that ensure patients have access to the information they seek when preparing for care, including cost estimates when appropriate. Hospitals and health systems are working to comply with the hospital price transparency rule and the relevant provisions of the No Surprises Act (i.e., Good Faith Estimates). The AHA has equipped hospitals with resources to prepare for the enactment of both policies, including advisories, webinars, podcasts and regular "office hours" to answer questions about how to implement the rules. However, it is critical that the government ensure alignment across the various federal price transparency requirements in order to avoid patient confusion that could harm, not help, patients' ability to use cost information to inform decisions about their care.

The hospital price transparency rule requires hospitals to publicly post "standard charges" in five different ways: gross charges, payer-specific negotiated rates, de-identified minimum and maximum negotiated rates, and discounted cash price. The rule also requires hospitals to publish machine-readable files with the gross charges and all payer-specific rates for all items and services. It also requires that hospitals provide patients with an out-of-pocket cost estimator tool or payer-specific negotiated rates for at least 300 shoppable services.

As you may know, many factors contribute to the negotiation of rates between health plans and providers. These could include: the scope of the contract (e.g., is it a limited scope contract for a subset of services, like emergency or quaternary care services only); anticipated

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patient volume associated with the contract; whether or not the rate is adjusted after the fact based on provider performance; and the characteristics of the patients enrolled in a particular health plans. The rates now posted on a hospital's website often do not reflect what is actually paid, as they too may be subject to a number of different adjustments as laid out in the contract.

As we have [documented](#), complying with the hospital price transparency rule takes extensive human and financial resources; and these same resources also have been needed to address COVID-19. For example, the personnel required to comply with the rule are the same staff responsible for bringing hospital surge capacity online and assisting with the monitoring and tracking of vaccine distribution. This likely led to some noncompliance with the rule at the beginning of 2021, though we know anecdotally from our members that compliance has continued to improve throughout the last year. It is important to note that there is no public record of hospital compliance at this point, as the Centers for Medicare & Medicaid Services (CMS) has not yet issued any civil monetary penalties (CMPs) for noncompliance. Due to a lack of understanding around the complicated nature of these files, we have seen a number of studies that have misrepresented hospital compliance by assessing the files in a manner that does not align with the requirements in the final rule. We urge you to not rely on such sources to estimate compliance with these requirements and instead base your assessment on CMS oversight.

Despite the fact that no hospital has yet been deemed noncompliant, CMS included modifications to the hospital price transparency requirements in its (CY) 2022 outpatient prospective payment system (OPPS) final rule. The agency included significant increases to the CMP for hospital noncompliance. Previously, the CMP was set at a maximum amount of \$300/day. Beginning Jan. 1, 2022, CMS will scale up the CMP based on a hospital's bed count. The maximum penalty will remain at \$300/day for small hospitals (30 or fewer beds), but will be set at \$10/bed/day for larger hospitals, with a daily cap of \$5,500. In addition, CMS prohibited those barriers that might prevent access to the machine-readable files, including through automated searches and direct downloads. Given these recent changes made by CMS, we do not believe it is necessary for Congress to make additional changes to the program.

Unlike the requirements in the hospital price transparency rule, which mandates the broad public disclosure of information that is confusing and of little practical value for patients planning for care, the price transparency policies in the No Surprises Act focus on providing tailored cost information to patients. We commend Congress for passing this legislation and are already working with CMS to ensure these policies are appropriately implemented. While we support these policies and believe they will better inform patients of their financial obligation, implementation will not be easy. As you note, new standards are needed for the implementation of the advanced explanation of benefit, with industry-wide buy-in and adoption. In addition, the No Surprises Act approach is duplicative of efforts already underway by providers, separate and apart from policy requirements, to respond to patients' needs.

Hospitals and health systems have historically relied on patient financial advisors to help with inquiries about what patients may pay for their care. Over the last few years, many hospitals and health systems also have embraced new technologies that enable patients to obtain tailored out-of-pocket cost estimates through online tools. There has been a significant growth in adoption of these tools as the availability and effectiveness of such tools has grown. Implementing and maintaining these tools requires significant organizational effort across many different departments and can take over a year to establish; these efforts are worthwhile, though, to ensure patients have clear information about every aspect of their health care decisions, including their expected out-of-pocket costs. We shared our detailed operational concerns and recommended solutions with CMS as part of the process to move forward on implementing these important policies and would welcome the opportunity to work with the Subcommittee on this issue.

IV. Increasing Competition and Identifying Anticompetitive Consolidation

- **Site Neutral Payment**

The AHA continues to strongly oppose current site-neutral cuts, which have dealt a significant blow to hospital financial stability, particularly during the COVID-19 pandemic, and would discourage Congress from imposing additional reductions. Hospitals have been on the front lines for almost two years, enduring historic financial challenges from forced shutdowns and a slow resurgence of non-emergent care, as well as increased costs associated with preparing for the pandemic and treating COVID-19 patients.

The RFI references the OPPS final rule for CY 2019, and its decrease in payments for excepted (“grandfathered”) clinic visit services at 40% of the OPPS payment amount. This cut is on top of the onerous site-neutral payment cuts that Congress enacted in 2015 that reduced payment for most services in non-excepted (“non-grandfathered”) off-campus provider based departments (PBDs). For CY 2022, CMS is continuing to pay for clinic visit services in grandfathered off-campus PBDs at this lower rate. The agency justifies the payment cut due to what it terms “unnecessary” increases in the volume of outpatient clinic visits. AHA is not aware of any evidence to support this policy rationale, and CMS is ignoring the many factors outside of hospitals’ control that also result in increases in OPPS volume and expenditures. This includes such things as: changes in patient demographics and clinical needs; technological advances; the impact of other Medicare policies that are intended to increase the volume of services in PBDs; drug price inflation; and physicians often refer Medicare beneficiaries to hospital outpatient departments (HOPDs) for services they do not provide in their offices.

HOPDs play a critical role in their communities, including providing convenient access to care for the most vulnerable and medically complex beneficiaries.

Specifically, among all Medicare beneficiaries, relative to patients seen in physician offices, patients seen in HOPDs:

- Are more likely to have severe chronic conditions and more chronic conditions;
- Are more likely to have a prior hospitalization and have higher prior emergency department use;
- Are more likely to live in communities with lower incomes;
- Are 73% more likely to be dually eligible for Medicare and Medicaid;
- Are 52% more likely to be enrolled in Medicare through disability or end-stage renal disease (ESRD);
- Are 31% more likely to be non-white;
- Are 62% more likely to be under age 65 and, therefore, eligible for Medicare based on disability, ESRD or amyotrophic lateral sclerosis; and
- Are 11% more likely to be over 85 years old.ⁱ

Furthermore, a recent analysis of Medicare fee-for-service claims data highlights that, during the pandemic, HOPDs were even more likely to treat more medically complex individuals than physician offices.

We are concerned that continued Medicare site-neutral payment reductions, together with the devastating impacts of COVID-19, will threaten beneficiary access to critical hospital-based services and undermine the ability of hospitals to adequately fund their 24/7 emergency capacity. A hospital's emergency stand-by role is funded through the provision of outpatient services. If CMS continues to erode this funding, so too will these critical services be eroded.

In fact, this wearing away is already occurring, due in no small part to CMS' policies. As spurred by the steady decline in Medicare margins over the past two decades, and as documented by the North Carolina Rural Health Research Program, 138 rural hospitals have closed since 2010, 19 of them in 2020. While the Medicare Payment Advisory Commission and others dismiss these closures by noting that the hospitals were "small" or "near other facilities," the concern remains that these very vulnerable rural hospitals are the "canaries in the coal mine." They serve as the initial indicators that we are beginning to reach a tipping point where private payers are no longer willing to fund, and hospitals can no longer sustain, operations on the cost-shift that such considerable Medicare underpayments, particularly those under OPPS, necessitate.

Expanding site-neutral cuts, on top of the financial impacts U.S. hospitals and health systems face due to COVID-19, would endanger the critical role that HOPDs play in their communities, as well as access to care for beneficiaries, including the most medically complex. The AHA urges Congress to not pursue additional site neutral payment policies.

- **Hospital Consolidation**

The challenges hospitals and health systems met, and continue to meet, as a result of a pandemic spanning now over two years in duration, is tangible proof of the benefits that communities derive from hospital mergers and acquisitions. They include: greater access to care, particularly in hard hit rural communities; redoubled efforts to improve quality; a greater ability to access capital to reconfigure facilities and services to meet changing consumer needs; and an ability to deploy staff where needed – either physically or virtually – and to move patients to facilities with the equipment and staff best able to care for them.

Mergers Help the Field Respond to Financial Pressures

There are many reasons for mergers and acquisitions in the hospital field. Often they are prompted by financial pressures that can limit a hospital's ability to arrange the resources needed to effectively care for its community. The numbers alone tell the story: 138 rural hospitals have closed since 2010,ⁱⁱ inpatient admissions have been declining for years, and Medicaid and Medicare rates are perpetually below the cost of providing care. Those combined underpayments amounted to \$100.4 billion in 2020, according to the AHA.

At the same time, hospitals' expenses continue to grow. Prescription drug spending per hospital admission increased 18.5% between fiscal years 2015 and 2017.ⁱⁱⁱ Private staffing firms and agencies are exploiting the workforce shortages attributable to the pandemic to greatly increase their profits by driving up labor costs to two, three or more times the amounts charged prior to the pandemic. The AHA and a number of members of Congress have requested the Federal Trade Commission investigate reports of collusive conduct and price gouging by these agencies, to no avail.^{iv, v, vi, vii}

Commercial health insurer consolidation contributes substantially to increasing providers' costs in ways that do not benefit consumers. 73% of metropolitan statistical area (MSA)-level markets were highly concentrated in 2020, up from 71% in 2014.^{viii} In fact, in nearly half of all markets (46%), one insurer's share is at least 50%. And peer-reviewed studies have found that when an insurance market is highly concentrated, insurers reduce provider payments and do not pass savings along to the consumer.^{ix} In addition, some of the insurers are using the leverage gained by acquisitions that went unchallenged by the federal antitrust agencies to increase costs for hospitals and health systems with myriad rules and policies (e.g., preauthorization, reduced access to lifesaving prescription drugs) that create serious hurdles to patient care and insidiously increase hospital costs.^x

As health insurers have grown more dominant in every market, they have diversified vertically by adding products and services intended to circumvent medical loss ratio limits on profits. These include technology, analytics, pharmacy and care delivery. For example, UnitedHealth Group directs an enormous amount of premium dollars to itself through its growing network of employed, affiliated and managed providers – it currently has 53,000 providers and may

already have grown by at least 10,000 absent a challenge by the federal antitrust agencies to this blatant example of market power.^{xi} And insurers' acquisition of PBMs are contributing to the increase in hospital and health system drug spending. In fact, three of the largest PBMs are owned by health insurers: Caremark (CVS Health); Express Scripts (Cigna); and OptumRx (UnitedHealth Group).^{xii} Collectively, these three control 89% of the market and serve more than 238 million Americans.^{xiii}

The Benefits of Being Part of a Health System

Being a member of a health system brings measurable benefits to patients and health system employees including: lower health care costs; improved patient care; better access to health care providers; and increased investment in technology and equipment. A recent study published in JAMA confirmed once again that a full-integration approach to a hospital merger [is] associated with quality improvements, including improved mortality rates.^{xiv}

Lower Health Care Costs

Mergers with larger hospital systems can provide community hospitals the scale and resources needed to decrease costs.^{xv} Various studies confirm that increased administrative efficiencies and reduction of redundant or duplicative services contribute to merger-related cost reductions.^{xvi, xvii} For example, hospital mergers between 2009 and 2014 “were associated with a 2.5% reduction in operating expense per adjusted admission at the acquired hospitals.”^{xviii} Subsequent analyses found reductions in annual operating expenses per admission at acquired hospitals between 2.3% (extending analysis through 2017) and 3.3% (through 2019), and an approximately 1.5% to 3.5% reduction in total expenses through consolidation of administrative and supply chain operations.^{xix, xx} Another study of hospital transactions from 2000 and 2010 found “evidence of economically and statistically significant cost reductions at acquired hospitals” averaging between 4% and 7%.^{xxi}

Moreover, additional substantial savings come from improved information technology (IT) systems and advanced data analytics. Consolidated hospital systems can often better invest in IT infrastructure for both clinical and financial data that can then be used to identify best practices for more cost-effective, integrated and streamlined care.^{xxii} These data systems have substantial but largely fixed costs, making them effectively inaccessible to independent hospitals. Hospital systems can spread the costs over a larger patient population while also performing more sophisticated analyses given the larger patient database to identify patterns and improve care. In a survey of hospital executives involved in mergers, implementing or upgrading clinical information systems was the most common use of new capital received by the acquired hospital.^{xxiii}

In addition, hospitals realize the cost benefits of mergers quickly, with hospitals largely reporting reduced operating expenses one year after the merger.^{xxiv} And the benefits have a lasting impact, with studies finding cost savings still evident four years after consummation of

the merger and lower cost growth rates and lower price growth rates at merging hospitals compared to non-merging hospitals over an extended period.^{xxv}

But hospital cost savings do not always result in lower prices for consumers, because commercial insurance companies have historically been reluctant to pass lower costs on to them in the form of reduced premiums. This was demonstrated when the Department of Justice challenged the attempted merger of Cigna with Anthem.

Increased Ability to Make Needed Capital Investments and Effectively Deploy other Resources

Acquisitions of financially struggling hospitals can help preserve access to care. In one analysis, Kaufman Hall & Associates found that 20% of hospitals that experienced consolidation activity between 2015 and 2019 cited financial distress as a key driver for the transaction. More than a third of these hospitals had declared bankruptcy, a clear sign of imminent closure. More than 80% were saved from bankruptcy and remain operational today.^{xxvi}

Relative to their financially stable peers, financially distressed hospitals often cannot effectively recruit clinical staff, upgrade technology or offer specialty services. Acquiring-hospitals often provide capital infusions to address these issues, as evidenced by the almost 80% of respondents in one survey who reported significant capital investments in the acquired hospital after the transaction.^{xxvii} These investments result in improved services.

Mergers also can help hospitals “respond to marketplace needs and can help ameliorate resource constraints,” including physical space, capital and personnel.^{xxviii} With reduced patient volumes and financial difficulties, community hospitals often have excess capacity.^{xxix} Significant excess capacity can result in higher operating costs per patient, but reduction or elimination of excess capacity may be difficult to achieve absent mergers or consolidation.^{xxx}

Greater Ability to Participate in Payments Linked to Outcomes

Scale and capital investment also are key conditions that hospitals and health systems must meet in order to take on risk and participate in alternative payment models. Provider payment is moving away from volume-based systems in an effort to focus on improving patient outcomes while reducing costs. Realigning care around these incentives requires scale in order to assume financial risk. Moreover, these efforts would not be possible without analytics and key investments in health technology. Hospital and health system mergers will help increase participation in these models, which in turn will drive down the cost of care and improve health outcomes.

More Stability and Opportunities for Hospital Workforce

Hospitals are often anchors for their communities and are also key economic contributors. Hospitals are jobs' creators and hire employees to serve in many roles at their facilities, both skilled and unskilled jobs. Hospitals are perpetually working to fill clinical positions, including physicians and nurses, where shortages are common and projected to become worse. This is especially true during the pandemic, when skilled nurses to treat COVID-19 patients are in short supply, and private staffing agencies are exploiting the scarcity to greatly increase their profits.

Mergers have great potential to create stability for employees in financially distressed hospitals. Those that were acquired between 2015 and 2019 (including some that are still pending completion) employed more than 60,000 full-time equivalent (FTE) positions.^{xxxix} Many of these jobs would have been at risk absent the merger.

Quality and Access Improvements Fueled by Mergers

Mergers can provide community hospitals with the necessary scale to use sophisticated data analytics, identify best practices and implement innovations such as telemedicine. Data-driven development of best practices can reduce the rates of readmission and mortality in merged hospitals. For example, one study found that acquisitions were associated with statistically significant improvements in quality measured as decreases in the overall outcome composite index (where a negative estimate indicates improved quality) and the 30-day readmission rate index.^{xxxix}

Moreover, a study of rural hospital mergers and acquisitions, published by JAMA Network Open in September 2021, found significant reductions in mortality for a number of common conditions — including acute myocardial infarction, heart failure, acute stroke, and pneumonia — among patients at rural hospitals that had merged or been acquired.^{xxxix} In a separate study, authors concluded a full-integration approach to hospital consolidation was associated with improvement in quality outcomes and patient experience.^{xxxix}

Acquired hospitals are often able to offer expanded services. One study found that nearly 4 in 10 (38%) of acquired hospitals added one or more services post-acquisition.^{xxxix} Patients at hospitals acquired by academic medical centers or large health systems also gain improved access to tertiary and quaternary services.

The Pandemic Confirmed the Value of Health Systems' Integration

The COVID-19 pandemic has highlighted many of the benefits of being part of a health system. Hospitals and health systems have been faced with multiple COVID-19 surges that pushed resources to capacity. Integrated health systems were well positioned to deploy their resources to procure equipment in short supply, utilize IT systems to triage equipment and

staff, reconfigure space to focus on infected patients and separate them from others and, perhaps most importantly, redeploy the workforce needed to meet these rapidly changing needs in multiple locations.

As COVID-19 case surges occurred throughout the country, health systems with multiple hospitals were able to transfer patients from one facility to another depending on their respective volume levels and available hospital and intensive care unit (ICU) beds. This was especially true for health systems with smaller, rural hospitals that had fewer ICU beds and staff trained to treat infected patients. Having the ability to look across a system and identify available capacity has been immensely important to ensuring patients received care and that resources were used efficiently.

This flexibility was not just limited to transfers of patients. Faced with unprecedented workforce challenges, health system leaders often were able to develop staffing strategies to address patient surges in emergency departments, ICUs and medical and surgical units. This adaptability extended beyond clinical staff. Health systems often were able to redeploy administrative staff to the front lines in roles such as unit clerks and vaccination processing teams.

Health systems also were able to deploy their resources and size to quickly mobilize dedicated supply chain teams responsible for locating personal protective equipment and other supplies and purchase them in bulk to avoid shortages. Often these efforts were on a global scale, as system staff looked for supplies outside their typical sources. In some cases, health systems were able to invest directly in domestic manufacturers to produce supplies.

In addition, health systems often were able to develop in-house testing capabilities, which allowed them to drastically expand and supplement strained local and state public health efforts. Many systems that established testing sites were later employing them as infusion centers and more recently as vaccination sites.

In short, hospital mergers and acquisitions provide numerous benefits for the communities they serve. Uncompensated care alone amounts to more than \$745 billion since 2000, and was more than \$42 billion in 2020, the most recent year for which data is available and the initial year for the pandemic. To suggest that hospital transactions put commercial health insurers at a disadvantage is preposterous. The insurers' market shares in every state contradict this contention and their conduct is reflected by their position as a dominant industry. Again and again during the pandemic, it required both private and government efforts to delay or halt some of the insurance industry's most egregious conduct, such as prematurely ending waivers for pandemic related illnesses and costs as early as April 2021, long before the pandemic subsided.^{xxxvi} This rollback accompanied reports that these same insurers had doubled their profits from the year before the pandemic.^{xxxvii} Similarly, the AHA protested one insurer's decision to retroactively deny emergency room claims in the middle of the pandemic warning, "[t]hreatening patients with a financial penalty for making the wrong decision could have a

chilling effect on seeking emergency care. This is dangerous for patients' health at any time, but is particularly unsafe in the midst of a public health emergency."^{xxxviii}

We encourage the Subcommittee to examine consolidation across the entire health care sector, as there is significant mergers and acquisitions activity occurring between and among health insurance plans, providers, retail pharmacies, PBMs, tech companies, device manufacturers and pharmaceutical companies.

- **340B Program**

The 340B Drug Pricing Program provides vital financial help to eligible health care entities serving vulnerable communities. The program requires pharmaceutical companies participating in Medicaid to sell certain outpatient drugs at discounted prices to health care organizations that care for high numbers of uninsured and low-income patients or care for specific populations, such as children or cancer patients. 340B hospitals use the savings they receive on the discounted drugs and reinvest them in programs that are critical for the communities and patients they serve, which can include enhancing patient services and access to care, as well as providing free or reduced priced prescription drugs to vulnerable patient populations. The 340B program is now more crucial than ever as 340B hospitals are on the front lines of the COVID-19 public health emergency, while incurring historic financial and operational challenges. Among these challenges is the high cost of pharmaceuticals. Despite the 340B program's proven track record of expanding access to critical patient services, pharmaceutical manufacturers have repeatedly attempted to scale back or significantly reduce its benefits to hospitals and the patients they serve.

The 340B Program is Working as Originally Intended

To qualify for the 340B program, hospitals must serve a disproportionate number of low-income and uninsured people, treat a specific population such as children or cancer patients or be a critical access hospital providing essential services to their rural communities. These hospitals also must provide services to low-income populations that do not qualify for Medicaid or Medicare. According to data that hospitals report in their Medicare Cost Reports, 340B hospitals accounted for roughly 68% of the nearly \$42 billion in uncompensated care provided by all hospitals in 2019. In addition, in 2018, 340B hospitals provided nearly \$68 billion in total community benefits. 340B hospitals provide these high levels of uncompensated care and community benefits to their community despite operating on thin margins, with approximately one out of every four 340B hospitals reporting a negative operating margin; this financial pressure has increased since the onset of the COVID-19 pandemic. For outpatient services, 340B hospitals had total and outpatient Medicare margins of negative 18.5% and negative 16.7%, respectively.

340B hospitals have continuously demonstrated their commitment to using their savings to provide important services and programs to vulnerable communities. Hospitals that participate

in the 340B program are subject to rigorous oversight and must meet numerous program integrity requirements, including: an annual recertification process to attest to meeting all program requirements; audits conducted by the Health Resources and Services Administration (HRSA), which oversees the program, and drug manufacturers; and maintaining auditable records and inventories of all 340B and non-340B prescription drug claims. Further, 340B hospitals regularly conduct self-audits to ensure they are maintaining their compliance with program rules and regulations. In addition, the AHA established 340B Good Steward Principles to demonstrate 340B hospitals' commitment to transparency in meeting the program's congressional objective: "to stretch scarce Federal resources as far as possible, reaching more eligible patients and providing more comprehensive services." Through their support of these principles, hospitals have proactively committed to communicating their annual 340B savings and how they use those savings to benefit their communities. 340B hospitals also report significant amounts of data on their annual Medicare cost reports, as well as the Internal Revenue Service Form 990, thereby demonstrating their ongoing financial investments in uncompensated care and community benefits.

Despite the immense need for the program, especially during the COVID-19 crisis, pharmaceutical manufacturers have continued their attacks on the 340B program in an attempt to deflect attention away from the issue of the skyrocketing drug prices that they alone dictate. They use their profits to pay for multiple studies portraying the pharmaceutical industry as a victim of an "out of control program that has veered away from Congress' original intent." However, nothing could be further from the truth. Their efforts to decrease the size and scope of the 340B program would undoubtedly shift away money from hospitals and the vulnerable patients and communities they serve to instead benefit their bottom lines. The value of the discount obtained by 340B covered entities is directly tied to the prices of the drugs that only the pharmaceutical manufacturers can determine. Therefore, the higher the pharmaceutical manufacturers decide to price their drugs and continuously increase those prices, the greater the 340B discount or margin will be. The statutory 340B discount amount has not changed significantly since the program was put into place in the early 1990s and any increases in the 340B margin are in large part due to pharmaceutical manufacturers' own actions, which include raising the prices of their products faster than the rate of inflation.

Unlawful Contract Pharmacy Denials Must Stop

Some pharmaceutical manufacturers are taking unprecedented actions, beyond the scope of the statute, to limit the distribution of certain 340B drugs to hospitals and health systems through contract pharmacy arrangements. HRSA has long allowed 340B covered entities to contract with outside pharmacies to dispense drugs to eligible patients in order to expand the reach of the 340B program. Contract pharmacies serve as an extension of the 340B provider and offer patients access to prescription drugs outside of the hospital or community clinic. This programmatic flexibility was intentionally designed by Congress in order to ensure patients would have ready access to life-saving drugs. The use of outside pharmacies is especially important for hospitals that are located in and/or serve rural communities, as many of these hospitals do not operate in-house pharmacies, so they must rely on contracting with outside

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pharmacies to ensure their patients have access to their medications. More than 80% of rural 340B hospitals use contract pharmacies to ensure their patients receive outpatient drugs, as well as other essential services.

However, just as the COVID-19 pandemic hit in 2020, afflicting millions of people across the country and imposing historic challenges for many hospitals and health systems, some pharmaceutical manufacturers began an onslaught of unlawful actions ranging from limiting the distribution of certain 340B drugs to demanding superfluous, detailed reporting of 340B drug claims distributed through hospitals' contract pharmacies. Despite repeated calls from the Department of Health and Human Services to stop these unlawful practices, pharmaceutical manufacturers have continued to violate the statute by knowingly overcharging for 340B drugs.

The pharmaceutical manufacturers' tactics have negatively impacted 340B hospitals' ability to stretch their scarce resources to provide more affordable access to care and must be ended immediately. The 340B statute is clear – pharmaceutical manufacturers must provide 340B pricing to eligible hospitals for any drug, regardless of where or how that drug is dispensed.

Eligibility Flexibility Needed During the Public Health Emergency

The COVID-19 pandemic has ravaged the United States, with approximately 75 million people infected and more than 880,000 people dead through January 2022. Our nation's hospitals and health systems are on the front lines of dealing with this devastating virus. Mandatory shutdowns of non-emergent procedures to make way for increased demand for COVID-19 care resulted in strained financial and operational resources for hospitals across the U.S. These actions, while necessary, created an unfortunate consequence, in that they significantly reduced patient volumes and altered some hospitals' payer mixes. Those patients insured through Medicaid or Medicare supplemental security income (SSI), otherwise known as the "DSH Adjustment Percentage Threshold," determine whether or not a hospital qualifies for 340B program eligibility.

As patients avoided inpatient care and non-emergent procedures due to the pandemic, some hospitals experienced changes in the types of patients they served, causing their DSH percentage to fall below the 340B eligibility threshold. These hospitals have been forced out of the 340B program due to these temporary COVID-19-related modifications to their DSH adjustment percentage, putting many of these important programs and services that depend on savings from the 340B program at risk. Should hospitals lose their 340B eligibility, this will directly impact patients and their access to care.

Congress or the Administration should act to ensure that 340B hospitals that were participating in the program at the start of the COVID-19 public health emergency, and may have experienced changes to their DSH adjustment percentage due to the COVID-19 pandemic, retain their 340B eligibility. Legislation has been introduced in the Senate, S. 773, and the House, H.R. 3203, to provide 340B hospitals with certainty by allowing these hospitals to continue to access the 340B program during the public health emergency. In addition, the AHA

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continues to call on the Biden Administration to provide this same flexibility through the 1135 waiver process. If swift action is not taken to address this issue, it is very likely that some 340B hospitals may lose access to the program, thereby jeopardizing care for the patients and communities they serve.

Thank you again for this opportunity to provide comments regarding the January 10 request for information. We look forward to continuing discussions with the Subcommittee and other members of the Healthy Future Task Force in efforts to address the affordability of health care.

Sincerely,

/s/

Stacey Hughes
Executive Vice President

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