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Advancing Health in America

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Statement

of the

American Hospital Association

for the

Committee on Education and the Workforce

Subcommittee on Health, Employment, Labor, and Pensions

of the

U.S. House of Representatives

"ERISA's 50th Anniversary: The Path to Higher Quality, Lower Cost Health Care"

April 16, 2024

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 in response to the committee's efforts to build upon and strengthen the Employee Retirement Income Security Act (ERISA).

Below are the AHA's recommendations on how to strengthen ERISA. Please view our full response to Chairwoman Foxx's request for information for more details on each topic.

Vertical Integration and Consolidation

The AHA is deeply concerned that vertical consolidation in the commercial insurance industry harms Americans and their communities by reducing overall access to services and providers and undercutting smaller providers that are seeking to provide services to communities who need them most.

In the ERISA context, these kinds of mergers and acquisitions may result in prohibited transactions that create significant issues for plan beneficiaries. For example, the acquisition by insurers of providers or specialty pharmacies — or preferred vendor arrangements with industry players — has led to insurers employing practices that may improve their bottom line while hampering access to or quality of care. An insurer may direct patients to providers owned or operated by the plan and away from other providers, even if the patient prefers another option (called "patient steering"). An insurer may also require beneficiaries to obtain medically necessary drugs from specialty pharmacies unrelated to, and far from the oversight of, their health care providers because of a favorable arrangement for the health insurers (called "white bagging"). These practices reduce quality and delay access to medically necessary care for beneficiaries.

HOSPITAL PRICE TRANSPARENCY

Hospitals and health systems are dedicated to improving price transparency for patients. However, the numerous and sometimes conflicting requirements have created an overwhelming landscape of pricing information that is challenging to utilize. There are three primary federal price transparency policies, each at different stages of implementation and each with different reporting and formatting requirements. Below are the AHA's recommendations for each:

- Hospital Price Transparency Requirements: Hospitals are required to disclose a machine-readable file annually and provide consumer-friendly information to patients on shoppable service prices. **We urge Congress to avoid making further statutory changes to the Hospital Price Transparency requirements.**
- Transparency in Coverage Requirements: Insurers must publish monthly machine-readable files inclusive of all negotiated rates and out-of-network allowed amounts and provide personalized out-of-pocket cost estimates for all covered services. **To ensure a single source of reference for negotiated rates, we recommend Congress direct CMS to maintain the requirement that insurers post all negotiated rates with providers, while allowing hospitals to focus solely on posting chargemaster rates and cash prices.**
- No Surprises Act: Includes a process for patients to receive estimates based on their unique health care treatment plans. **To ensure patients can access the information they most need as they plan for their care, we urge Congress to allow price estimator tools to continue to be used to meet the hospital shoppable service requirements as part of the Hospital Price Transparency regulations.**

Before the new information available through the price transparency policies can be used effectively by the public, including plan sponsors, more needs to be done to align and streamline the various policies. We would therefore request that Congress refrain from advancing additional legislation that may further confuse or complicate providers' ability to provide meaningful price estimates and potentially add unnecessary costs to the health care system.

CYBERSECURITY

The cybersecurity threats facing health care are serious and affect every entity in the sector. Recent events related to the attack on Change Healthcare make that pellucidly clear. With respect to the Health Insurance Portability and Accountability Act (HIPAA), all covered entities (including health plans governed by ERISA) have responsibilities to ensure the security of patient data that is described in the HIPAA Security Rule (45 CFR Part 160 and Subparts A and C of Part 164).

The AHA believes that the current HIPAA rules generally offer an effective legal framework, and any fundamental revisions would create more challenges than benefits. Congress should neither make any major revisions to HIPAA nor introduce new privacy or cybersecurity principles directly into the ERISA statute as this would be unnecessarily confusing to the regulated community, which is already well-governed by HIPAA.

OVERSIGHT OF ERISA-REGULATED INSURERS

Inappropriate Denials of Care

Certain commercial insurers are erecting unfair barriers to care, including imposing unnecessary prior authorization requirements. These practices significantly increase administrative costs for the health care system, hindering access to care and contributing to clinician burnout. Among some insurers, most appealed prior authorization denials are ultimately overturned. Even if beneficiaries can ultimately receive the care they need, this appeal process comes with significant cost. Inappropriate payment delays and denials for appropriate care contribute to financial and emotional stress for enrollees, serious patient care delays, health care provider financial instability and compounding fiscal challenges plaguing our health care system.

Additionally, there is mounting evidence that these unfair practices are increasing. Government agencies, as well as courts and arbitrators, have also uncovered concerning findings with respect to certain commercial insurer conduct. We strongly support increased scrutiny of insurer conduct under ERISA-regulated plans, especially with respect to practices that may routinely or inappropriately deny claims for medically necessary services. We also encourage Congress to consider whether commercial insurers are adhering to their fiduciary duties set forth in the statute. Greater oversight is needed to protect patients and consumers from cases of insurer misconduct and to ensure appropriate access to health care services that employers have provided payment to cover.

Prompt Payment

In addition to challenges with inappropriate denials of care, hospitals and health systems are increasingly reporting significant financial impacts from insurers' failure to pay promptly. An AHA member survey found that 50% of hospitals and health systems

reported having more than $100 million in unpaid claims that were more than six months old. Among the 772 hospitals surveyed, these delays amounted to more than $6.4 billion in delayed or denied claims that are more than six months old.

These delays add unnecessary cost and burden to the health care system. Given these realities and the challenges health care providers face in securing prompt payment from insurers for covered services, it is troubling that there are no prompt payment requirements with which insurers must comply under ERISA-regulated health plans (except for limited provisions related to out-of-network claims subject to the No Surprises Act). Existing legal frameworks aimed at addressing claims procedures or prompt payment do not cover the ERISA-regulated space.

The AHA urges Congress to apply a federal prompt payment standard for ERISA-regulated insurance plans, either in the ERISA statute or separately, and to increase oversight and scrutiny of timely payments to health care providers for services delivered to enrollees under the contract.

MEDICAL LOSS RATIO REQUIREMENTS

The AHA is deeply concerned about the ways in which insurers' vertical integration practices enable plans to undermine the MLR requirements by channeling excessive health care dollars to their affiliated health care and data services providers at patients' expense. While the AHA supports arrangements in which an integrated system's health plan pays affiliated clinicians an appropriate rate for patient care, it is problematic when a plan directs excessive dollars to its own affiliated vendors and service entities in ways that inappropriately increase health system costs or steer patients to affiliated providers when it is not in the best clinical or financial interest of the patient to do so.

The use of vertical integration to circumvent the goals of the MLR requirements is concerning and potentially harmful for patients and consumers. We urge policymakers to pursue solutions to increase oversight of the MLR as it relates to vertically integrated insurer conglomerates and prevent inappropriate or excessive payments to aligned companies to ensure that the MLR continues to protect patients in the manner it was intended by Congress.

CONCLUSION

Thank you again for your interest in strengthening ERISA. We look forward to working with you to support and advance these important issues.