The Alliance to Fight for Health Care
Advancing employer-provided coverage

April 26, 2023

The Honorable Bob Good
Chair
Committee on Education and the Workforce
Subcommittee on Health, Employment, Labor, and Pensions
United States House of Representatives
Washington, DC 20515

The Honorable Mark DeSaulnier
Ranking member
Committee on Education and the Workforce
Subcommittee on Health, Employment, Labor, and Pensions
United States House of Representatives
Washington, DC 20515

Dear Chair Good and Ranking Member DeSaulnier,

Thank you for the opportunity to submit the following comments for the hearing record in connection with the April 26, 2023, hearing, "Reducing Health Care Costs for Working Americans and their Families." We applaud the committee for working to address health care costs and improve coverage in the employer market for working Americans and their families

The **Alliance to Fight for Health Care** is a diverse coalition comprised of businesses, patient advocates, employer organizations, unions, health care companies, consumer groups, and other stakeholders that support employer-provided health coverage. Together, we are working to ensure that employer-provided coverage remains an available and affordable option for working Americans and their families. The Alliance is dedicated to pursuing policies that increase transparency and competition to bring meaningful change — and cost savings — to our health care system and patients everywhere.

Employer-provided health care coverage is the backbone of the U.S. health care system — covering more than 178 million people. More people receive health insurance through an employer than all other sources of coverage combined—Medicare, Medicaid, Marketplace, Tricare, and the Department of Veterans Affairs. Employer-provided coverage has always been efficient, effective, and stable, and through the COVID-19 pandemic, it has also proven to be resilient — with employers quickly stepping up to meet the health care needs of employees during the crisis.

Employer-provided coverage produces substantial return on the federal government's investment in it — both economically and when it comes to our health. Research finds that employer-provided coverage provides significant economic, social, and public health benefits. According to a National Bureau of Economic Research working paper, employer-provided coverage delivers significant value — at least $1.5 trillion in social value annually beyond the cost of insurance borne by businesses, workers, and government tax exemptions, at nearly $10,000 per person.

Despite economic uncertainty in 2022, more than 70% of large employers prioritized adding or expanding benefits or resources to meet employee needs. This included access to virtual care resources, expanded behavioral health, and alternative care arrangements, such as accountable care organizations and centers of excellence, that drive employees to high-value care.

Despite efforts, rising health care costs continue to be a top concern for both employers and employees. Health spending is increasing across all payers, and now exceeds 18% of the U.S. gross

domestic product. From 2016 to 2020, the 9.3% per person spending growth in the employer market was caused primarily by a 16% increase in average medical prices.

Health care costs continued to be a significant barrier to care for patients. A recent Morning Consult poll on health care issues conducted on behalf of the Alliance found **health care costs are the No. 1 concern among insured Americans**. What's more, 57% of insured adults said **reducing health care costs should be Congress' top priority**. But insured adults do not want to start over. Nearly 70% of insured adults, across the political spectrum, prefer to **strengthen the existing system.** Further, a majority of adults want Congress to work to lower the cost of health care for ALL Americans, not just those who receive coverage on the exchanges or in federal health care programs like Medicare and Medicaid.

The Alliance to Fight for Health care agrees. We want to work with the Committee on Education and the Workforce and Congress to improve the U.S. health care system and reduce health care costs for ALL Americans by advancing policies to reduce health insurance premiums and increase affordability. And we come to the table with bipartisan ideas, including some of the those being raised before the committee today, like expanding access to employer-provided telehealth, preserving ERISA preemption and preventing unfair hospital billing practices. Legislation to prevent unfair hospital billing practices would require hospitals to indicate the location where care is provided when they bill patients for payments. This is important because it will help expose instances where patients are being billed high prices as if they are receiving hospital level care, when in reality they are in a doctor's office. These small steps will benefit patients and improve transparency and accountability.

We also encourage Congress to continue the work of this committee to reduce cost and improve health outcomes for millions of American workers and their families by enacting polices to:

- **Remove restrictions preventing pro-patient competition in health care markets**
- **Protect patients from paying hospital prices for doctors' office visits**
- **Align value-based care incentives to benefit patients across all health care markets**
- **Give employers the flexibility to design programs to address chronic conditions and improve health outcomes**

Policy goal: Remove restrictions preventing pro-patient competition in health care markets

Employers want to create health plan designs that provide extra help to people with chronic or costly health conditions to improve health outcomes. Currently, "anti-tiering" and "anti-steering" clauses in contracts between providers and health plans restrict plans from creating innovative, high-value programs such as high-performance networks. Passing legislation like the Healthy Competition for Better Care Act (117th S.3139) would enable more group health plans and health insurance issuers to enter into agreements with providers that guide enrollees to high-value providers and provide incentives to encourage enrollees to seek higher-quality, lower cost care. There is significant support for such proposals. Recent polling by the Alliance indicates that 85% of insured adults feel employers should be able to give employees who have enrolled in their company's health plan a discount for seeing a high-quality provider.

Policy goal: Protect patients from paying hospital prices for doctors' office visits

The Alliance supports lowering the cost of health care services through policy proposals such as site-neutral payment reform. Current Medicare and private health insurance payment policies pay more for services provided in hospital outpatient departments (HOPDs) – in other words, provider offices owned by but not located in the hospital. According to the Medicare Payment Advisory Commission (MedPAC), this disparity is incentivizing health care consolidation and higher-health care costs. As shown in an AMA survey, currently fewer than half of physicians now work in physician-owned practices, a trend that has sharply risen since 2012.

MedPAC discussed the payment disparity in their June 2022 report to Congress, "[I]n 2022, Medicare pays 141 percent more in a hospital outpatient department than in a freestanding office for the first hour of chemotherapy infusion." As noted by MedPAC, "partly in response to these incentives, in recent years hospitals have acquired more physician practices, and hospital employment of physicians has increased." MedPAC also notes that the resulting increased reimbursements are not linked to clear benefits, such as improved quality of care for beneficiaries, but they are linked to increased costs for patients.

Congress can build on site-neutral payment reform by requiring Medicare to align payment rates for certain services across the three main sites where patients receive outpatient care—HOPDs, ambulatory surgical centers (ASCs), and freestanding physician offices. MedPAC, in its June 2022 report, estimated expanding site-neutral payment policies in Medicare could generate $6.6 billion in annual savings for Medicare and taxpayers and lower cost-sharing for Medicare beneficiaries by $1.7 billion.

The savings if voluntarily adopted by the commercial market are likely even greater. New research by University of Minnesota economist Steve Parente conducted on behalf of the Alliance estimates that expanding site-neutral payment reform in Medicare and encouraging adoption in the commercial market could result in nearly $60 billion in savings annually in the commercial market.

Requiring transparency in reporting where care is provided (i.e., a hospital or a physician's office) is another commonsense step that can help improve clarity for all consumers. Congress should consider legislation such as The Transparency of Hospital Billing Act.

These policies can all be designed to protect vulnerable rural or safety net hospitals, while protecting patients from climbing costs and consolidation. There is significant support for site-neutral payment reform. The Alliance's recent Morning Consult poll found 86% of insured adults, across political parties, believe health care costs should remain the same regardless of where the service is received.

Policy goal: Align value-based care incentives to benefit patients across all health care markets

The Alliance believes that federal cost reduction and quality improvement efforts should seek to improve the health care market for *all* beneficiaries. Encouraging collaboration between public and private providers and payors could accelerate beneficial changes for all participants. Creating pathways to engage the group health market in CMS Innovation Center (CMMI) models more meaningfully will promote multi-payer collaboration and encourage public-private partnerships that improve quality, reduce costs, and advance the system as a whole.

All patients should have a seat at the table in advance of future model development and be part of an open dialogue to promote coordination and learning to help improve the system together.

Policy goal: Give employers the flexibility to design programs to address chronic conditions and improve health outcomes

The Alliance also supports policies that reduce barriers to high value care, including enabling plans and employers to offer more high-value care pre-deductible. Laws and rules limiting pre-deductible coverage for chronic disease prevention, onsite medical clinics and telehealth inhibit employers' ability to offer high-value and potentially life-saving care to their employees on an equitable basis. Because of this, the Alliance supports legislation, including:

- The Chronic Disease Management Act (117th H.R. 3563/S. 1424), which allows greater flexibility to offer pre-deductible coverage for chronic disease prevention.
- The Telehealth Expansion Act (117th S. 1704), which makes permanent the flexibility for plans to offer telehealth pre-deductible.
- Legislation that allows employers to provide more robust services (like chronic disease management and primary care) at onsite medical clinics pre-deductible without charging cost-sharing.
- Legislation that permits plans below a specified actuarial value to make and plan participants to receive contributions to Health Savings Accounts (117th S. 2099).

The Alliance supports meaningful steps toward introducing the necessary transparency, accountability, and consumer protections into our health care system to meaningfully reduce costs, improve outcomes, and drive towards value.

You can find a longer list of our recommended policies – including the barriers they aim to address – on our website at www.fightforhealthcare.com.

We look forward to working together on a bipartisan basis to increase transparency and competition that makes health care more affordable, supports continued innovation, improves job-based coverage, and advances the health care system for all patients.

Respectfully,

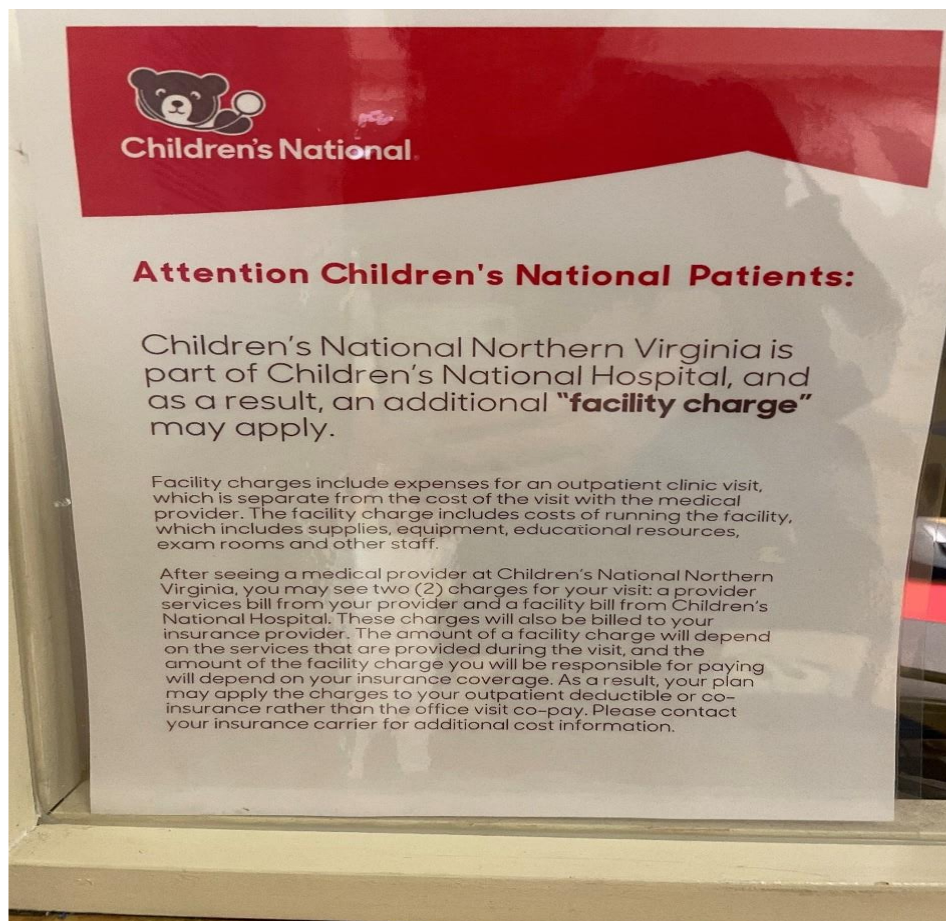
The Alliance to Fight for Health Care

APPENDIX

Same doctor. Same office. Should baby April pay more when they change the sign on the door?

When a physician's practice is bought by a larger hospital and the sign on the door changes, patients should not be forced to pay more. While the **Alliance to Fight for Health Care** appreciates the critical work hospitals do to care for patients and recognizes the challenges all sectors are facing given record-level inflation, patients should not be forced to pay hospital prices and hospital add-on fees for care that can be safely provided in doctors' offices. Site-neutral payment policies would reduce the incentives for hospitals to buy up physician practices, which will lower costs for patients.

This is an example of what happens to patients when a hospital buys their doctor's office. It shows a recent notice that baby April and her mom saw posted while checking in for their usual office visit last month. The office is over 11 miles from the hospital.



In case you missed it!

The News & Observer: "The health care didn't change. The office hasn't moved. Why is UNC now charging more?"

Sneaky fees are driving up health care costs for patients. A recent News & Observer article, "The health care didn't change. The office hasn't moved. Why is UNC now charging more?" highlights a growing trend of hospitals purchasing independent physician practices and clinics and charging patients more by adding so-called "facility fees."

The article describes how some UNC patients received a letter informing them that their dermatology clinic would be converted into a hospital-based clinic: "Almost everything about the health care at those clinics would stay the same, the letter assured patients. The location of the clinics, the doctors working there and the care they provided would not change." In fact, the only clear change, according to the letter, was an "additional 'facility fee' from UNC hospitals."

The article explains, "Health policy experts say this is an increasingly popular way for hospitals to get more money for providing the same care. By declaring free-standing clinics to be part of the hospital, they are able to tack on a facility fee, boosting their revenue."

The article quotes Ge Bai, a health policy researcher at the Johns Hopkins Bloomberg School of Public Health, who said, "It squeezes dollars from the pockets of patients and payers and channels them to the hospital's bank account."

The ***Alliance to Fight for Health Care*** **opposes hospital tactics that increase the financial burden on the patient and encourages Congress to expand site-neutral payment policy, which aims to align payment rates for certain services that are commonly and safely provided in lower-cost care settings.**

- The News&Observer

The health care didn't change. The office hasn't moved. Why is UNC now charging more?

By Teddy Rosenbluth

Published online March 13, 2023

Last month, some UNC Health patients received a letter informing them that three outpatient dermatology clinics would be converted into "hospital-based clinics."

Almost everything about the health care at those clinics would stay the same, the letter assured patients. The location of the clinics, the doctors working there and the care they provided would not change.

What will change, the letter pointed out, is how patients are charged for that care.

Beginning on March 6, patients of the clinics have been charged an additional "facility fee" from UNC Hospitals.

This fee, which one health policy expert researcher called a "revenue-generating gimmick," will almost always result in a more expensive bill for the patient and their insurance provider, said several experts interviewed by the N&O.

Health policy experts say this is an increasingly popular way for hospitals to get more money for providing the same care. By declaring free-standing clinics to be part of the hospital, they are able to tack on a facility fee, boosting their revenue.

“It squeezes dollars from the pockets of patients and payers and channels them to the hospital’s bank account,” said Ge Bai, a health policy researcher at the Johns Hopkins Bloomberg School of Public Health.

A NATIONAL TREND

In North Carolina, hospital-based clinics are common.

UNC Health operates 75, Duke Health 35 and WakeMed 24, according to spokespeople from the health systems. All charge facility fees.

Hospitals argue that facility fees are necessary to afford running large medical facilities at all hours of the day and night.

But critics question whether that facility fee is necessary for some of these clinics, like UNC’s dermatology offices, that keep regular hours and are miles away from a hospital. They point out that the health systems have many clinics that are not “hospital-based” and are able to operate without an added facility fee.

Hospitals have been purchasing and re-labeling independent physician clinics to boost revenues for the last decade or so, said Matthew Fielder, a health policy researcher at the USC-Brookings Schaeffer Initiative for Health Policy.

There is no statewide or national data on how many clinics have been “converted” into hospital departments in recent years.

However, a recent report to Congress found that people are increasingly seen by their doctors at places billed as hospital outpatient departments. The percentage of appointments at that type of facility rose from 9.6% in 2012 to 13.1% in 2019, the analysis found. That’s a 27% increase.

For patients, the change can result in hundreds or thousands of dollars added to their bills. One Ohio woman saw her portion of the bill for her arthritis injections increase from $30 to $354 after the clinic providing the injections was converted into a hospital department, Kaiser Health News reported.

Facility fees create a strong incentive for hospitals to buy up independent clinics and flip them into hospital clinics, said Barak Richman, a researcher at the Duke-Margolis Center for Health Policy.

This is particularly problematic in North Carolina, which has one of the most consolidated health care markets in the country.

“It’s a widespread phenomenon,” Richman said. “It has fueled consolidation for nothing but bad reasons.”

Alan Wolf, a spokesperson for UNC Health, said the billing changes were necessary to keep up with wage and pharmaceutical inflation, which he said has “far exceeded reimbursement for dermatology services.”

He said the change will allow the clinics to hire more staff and cut appointment wait times.

Fielder said he’s unaware of any evidence that shows this type of reclassification meaningfully improves access to care.

“There is, on the other hand, abundant evidence showing that changes like these increase providers’ revenues,” he said. “UNC has delivered these services in a physician office setting until now, and many other providers are continuing to do so.”

On the federal level, insurance companies have pushed for “site-neutral” Medicare billing, which would make clinic reimbursement rates the same regardless of whether they are independent or hospital-affiliated.

A report published last month by the Blue Cross Blue Shield Association found that adopting these policies could save the federal government, private health insurance companies and consumers a combined $471 billion over 10 years.

Bai said the best way to avoid facility fees at outpatient clinics is to call ahead and ask the billing department whether there will be a facility fee. If there is, she said patients could potentially find another provider.

However, she said this advice comes with an important caveat:

“The billing department might not be able to give a clear answer and patients might not have the time and energy to check when under stress.”

Feb. 6, 2023

Dear Patient,

We are writing to let you know that UNC Dermatology and Skin Cancer Center's clinics will be converting to hospital-based clinics March 6, 2023.

We would like to let you know what this transition means for your future care. You will continue to see your same provider at the same location, and your provider will participate in the same insurance plans. You also will continue to have access to our highly skilled and compassionate care team. In addition, this transition allows our clinics to offer additional hospital-based resources and care that can only be obtained at an academic medical, teaching, and research facility such as UNC Hospitals. We look forward to providing our services to you and your family.

The names of our clinics will change to:
UNC Hospitals Dermatology & Skin Cancer Center at Southern Village
UNC Hospitals Dermatology & Skin Cancer Center at Raleigh
UNC Hospitals Dermatology & Skin Cancer Center at Hillsborough

Like our other hospital-based clinics, you (or your insurance provider) will be billed by both your provider and by the hospital. UNC Faculty Physicians will bill you for medical provider services such as those performed by a medical doctor, nurse practitioner or physician assistant. UNC Hospitals will bill you a facility fee, as well as for other services such as drugs or tests you receive during your visit. As a result of this change, your financial responsibility could differ from your copay amount/previous visits.

Your liabilities (charges) will be based on how your insurance processes claims based on the new hospital-based setting including deductibles, coinsurance and co-pays.

Our patient financial representatives at UNC Hospitals are available to assist you with understanding these billing changes. Please call our **Patient Accounts Department** at (984) 974-2222 or toll free at (800) 594-8624 if you need to speak with them.

Mohs surgery will now only be available at our Southern Village location. This service is not converting to a hospital-based clinic, and you will only be billed by UNC Faculty Physicians for Mohs surgical services. In addition, dermatopathology also is not converting to a hospital-based clinic, and you will only be billed by UNC Faculty Physicians for dermatopathology services.

Our providers and staff hope to make this transition as smooth as possible for you. You have a choice in medical providers, and we hope you will continue to rely on our practice for your healthcare needs. If you choose another healthcare provider, you will have full access to your medical records.

Thank you for trusting us with your care.

Teddy Rosenbluth covers science and health care for The News & Observer in a position funded by Duke Health and the Burroughs Wellcome Fund. The N&O maintains full editorial control of the work. This story was originally published March 13, 2023, 7:45 AM.

*The **Alliance to Fight for Health Care** is a diverse coalition comprised of businesses, patient advocates, employer organizations, unions, health care companies, consumer groups and other stakeholders that support employer-provided health coverage. Together, we are working to ensure that employer-provided coverage remains an effective and affordable option for working Americans and their families. The coalition (previously working as the **Alliance to Fight the 40**), led the successful effort to repeal the so-called 40% "Cadillac Tax" on health care coverage.*

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