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STATEMENT
of the
Federation of American Hospitals
to the
U.S. House of Representatives
Committee on Education & The Workforce

Re: Markup of 6 Bills on September 11, 2024

The Federation of American Hospitals (FAH) appreciates the opportunity to comment on the following three bills being considered by the Committee on Education and the Workforce: H.R. 3120, the Healthy Competition for Better Care Act; H.J. Res. 181, Congressional Review Act resolution to stop the Biden-Harris rule limiting access to Association Health Plans (AHPs); and H.R. 9457, the Transparent Telehealth Bills Act of 2024.

The FAH is the national representative of more than 1,000 leading tax-paying hospitals and health systems throughout the United States. FAH members provide patients and communities with access to high quality, affordable care in both urban and rural areas across 46 states, plus Washington, DC, and Puerto Rico. Our members include teaching, acute, inpatient rehabilitation, behavioral health, and long-term care hospitals and provide a wide range of inpatient, ambulatory, post-acute, emergency, children's, and cancer services.

H.R. 3120 – Healthy Competition for Better Care Act

The FAH supports efforts to expand access to affordable, high quality health care, including by fostering robust competition in health care and addressing the increasingly entrenched consolidation of the insurer and third-party administrator markets. Therefore, we **strongly oppose H.R. 3120**, which we are deeply concerned would raise costs and disrupt care, ultimately harming patients.

H.R. 3120 would broadly prohibit so-called anti-steering provisions and "all-or-nothing" provisions in managed care agreements, but these provisions are valuable tools to improving affordability, access, and coordination of care. The FAH opposes the imposition of such limitations on payer-provider contracting because of the significant risk that they would increase the cost of care, harm patients by fragmenting care, promote abuse by insurers and plans, and adversely impact the group and non-group markets.

With respect to provisions addressing steerage and enrollee incentives for using particular providers, at present, payers and providers are permitted to negotiate discounted rates that are contingent on the provider's inclusion in the payer's lowest cost-sharing tier for that provider type. These types of contractual provisions are thus often a key ingredient of volume-based discounts in payer-provider contracts, and they both promote competition among providers and allow payers to obtain price concessions that decrease health care costs for consumers. Limiting the ability of payers and providers to negotiate such terms would thus jeopardize the level of discounts that can be secured in negotiations, to the detriment of patients.

H.R. 3120 would also prohibit the negotiation of certain terms addressing affiliate participation in plans, which would diminish the value health systems offer to patients. Health systems play a critical role in coordinating patient care and promoting value-based care, and provider contracting at the health system level supports improved and integrated patient care across multiple provider types at lower cost to consumers.

Health systems have long been at the forefront of creating integrated delivery systems that minimize the duplication of services while improving patient outcomes and the experience of care. Hospital-based health systems have added and built lower cost sites of services for both pre- and post-acute care in an effort to better coordinate the entire continuum of care for patients and meet patient needs in their communities. For example, some health systems provide clinically based care navigation for high-risk obstetric, cardiology, orthopedic, behavioral health, and oncology patients, among others. These programs follow patients through the continuum of care in several settings, simultaneously improving quality of care and efficiency. Realizing the value of these initiatives depends on health systems contracting with payers on an integrated and coordinated basis. A federal statute that permits plans and insurers to cherry-pick amongst the components of a health system reduces integrated systems to fragmented, *à la carte* options that deteriorate patient quality of care and create risk—reversing course on other federal policies to drive accountable care.

Beyond the risk of eroding high-quality, integrated care, prohibiting health systems from contracting as integrated providers presents the risks of inefficiencies in care and increased consumer costs. Health systems are able to offer more significant discounts and better value when they contract on a system-wide basis across the continuum of care as opposed to entering into piecemeal contracts that are specific to particular services or locations. In addition, health systems appropriately use full-system contracts to facilitate investment in services needed in the community.

When a health system builds new locations or expands programs and service lines, it takes on significant financial risk in order to ensure access to needed services in the community. System-level contracting facilitates these investments in service lines and facilities—including in underserved rural communities, while also ensuring that the community can actually access new services and facilities on an in-network basis. System-level integration promotes market efficiencies and fosters competition for integrated delivery systems, and limitations on integrated contracting would reduce this critical dimension of competition to the detriment of consumers and force expensive, arduous, and unnecessary contracting processes on providers and payers.

These concerns are magnified as the line between payer and provider has blurred in recent years. A growing number of health insurance carriers acquire and operate a large number of provider sites. Insurers that are under common ownership or control with health care providers have a financial incentive to design plans for their own financial benefit, driving patient volume to their affiliated providers for profitable service lines while contracting with unaffiliated providers only to fill gaps. This strategy is often pursued even though the affiliated providers may have higher costs because driving patient volume to affiliates keeps a larger share of premium revenue with the insurer and its affiliates. A rule prohibiting integrated contracting by health systems would accelerate these trends, reducing consumer choice and price-based competition.

In short, volume-based discounts and integrated health system contracting have pro-competitive and pro-consumer benefits, and legislation that limits contracting around enrollee steerage and incentives or restricts contracting at the health system level risks unintended market harms. In circumstances where contracting strategies or other activities reduce payer or provider competition, Federal antitrust laws provide the appropriate framework for addressing anti-competitive conduct.

H.R. 9457 – Transparent Telehealth Bills Act of 2024

The FAH supports the reimbursement of telehealth services by Medicare, Medicaid, private insurance, and other payers at the same level as in-person services. Telehealth increases access to care, especially for those in remote or underserved areas, by providing timely, patient-centered services. The **FAH opposes H.R. 9457**, which aims to prohibit increased payments for telehealth services provided by facility-based providers under group health plans or group health insurance coverage. This bill would effectively remove the critical payments that are often charged for telehealth services when provided by a facility-based provider.

Telehealth enhances patient choice by allowing access to a broader range of health care providers and services. Additionally, telehealth can lead to cost savings by enabling early intervention, which helps prevent long-term, costly health events. It also improves health outcomes through better clinical care integration and continuous monitoring. Furthermore, telehealth offers flexibility and convenience, allowing patients to receive care from the comfort of their homes, reducing the need for travel. The FAH advocates for the reimbursement of telehealth services at the same level as in-person services and supports efforts to eliminate geographic and originating site restrictions.

H.R. 9457 fails to recognize and provide payment for the unique resource costs that hospitals face in furnishing telehealth evaluation and management (E/M) services. In providing these services, it is critical that hospitals receive adequate payment so that patients can maintain widespread access to these important services and avoid a return to the pre-pandemic infrastructure where many patients had limited access to many services or had to take hours or even days to travel to a provider to receive these services in person.

Hospitals incur substantial upfront investment and ongoing costs to establish and annually maintain their virtual infrastructure, including secure platforms, licenses, information technology

support, scheduling, patient education and clinician training. Typically, more preparation is required for hospital providers and staff to furnish a virtual visit than for an in-person visit.

The Centers for Medicare and Medicaid Services (CMS) is studying these telehealth infrastructure, practice, and labor resource costs, considering their intensity and complexity, to ensure payment for telehealth that accurately reflects the inputs for furnishing these critical services upon which beneficiaries have come to rely for purposes of increased access to healthcare. The FAH supports this research and urges members of the Committee to ensure that America's seniors continue to have access to high quality care in their homes via telehealth by rejecting this legislation.

H.J. Res. 181 – Congressional Review Act resolution to stop the Biden-Harris rule limiting access to Association Health Plans (AHPs)

The FAH supports healthy competition in the insurance marketplace, promoting affordability for all. Therefore, the **FAH strongly opposes H.J. Res. 181**, which would create different rules for AHPs, and in turn, destabilize insurance markets and increase the cost of coverage.

Under the 2018 rule that H.J. Res. 181 seeks to reinstate, the regulatory definition of "employer" under the *Employee Retirement Income Security Act of 1974* (ERISA) was expanded to include associations formed by employers with substantially loosened links to each other. The rule provided incentives for plans to reduce the generosity of health care benefits jeopardizing affordable access to meaningful coverage for those individuals who need health care the most. FAH opposed the 2018 AHP rule,[1] supported the recission of that same rule earlier this year,[2] earlier this year, and now strongly opposes its reinstitution. In short, this resolution would:

- Create different rules for AHPs, destabilize health insurance markets.
- Diminish access to comprehensive health coverage, thus harming consumers, particularly those in most need of health care services.
- Incentivize the growth of multiple employer welfare arrangements (MEWAs), of which AHPs are generally a type and which have a long history of past abuse and failure.[3]

Under federal law, coverage offered by large employers is exempt from a set of standards and consumer protections that insurance offered to small employers and individuals must otherwise meet. Specifically, by being considered a single large group, association-sponsored coverage could avoid important consumer protections including minimum benefit standards, annual and lifetime

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[1]FAH, "Re: Definition of Employer under Section 3(5) of ERISA-Association Health Plans [EBSA-2018- 0001; RIN 1210-AB85]," March 6, 2018, https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/rules- and-regulations/public-comments/1210-AB85/00457.pdf. and- regulations/public-comments/1210-AB85/00457.pdf.

[2]FAH: "Re: Proposed Rescission of AHP Final Rule (RIN 1210–AC16),", February 20, 2024. https://assets.fah.org/uploads/2024/02/FAH-letter-on-AHP-rule-rescission-20240217.pdf

[3]See, for example, FAH, "Re: Definition of Employer under Section 3(5) of ERISA-Association Health Plans [EBSA-2018-0001; RIN 1210-AB85]," March 6, 2018, p. 5. Since 2018, DOL has taken civil and criminal enforcement action against 21 MEWAs to protect participants and beneficiaries from fraud or mismanagement of such arrangements. In the last five years, the Department has civilly recovered over $95 million from mismanaged or fraudulent MEWAs (88 *Fed. Reg.* 87,973).

limits on cost sharing, rules that limit underwriting of premiums, single risk pool requirements, and participation in risk adjustment. Associations could further take advantage of the looser restrictions by underwriting premiums offered to certain small employers to discourage enrollment of less appealing groups.

For example, they could offer coverage only in geographic areas where they determine healthier individuals reside, and they could manipulate the health care benefits they offer in ways that make their coverage unappealing to individuals who need access to more comprehensive health care. This segmenting of risk would result in higher and increasing premiums for individuals left out of associations, which could spiral over time, ever worsening adverse selection that would destabilize the non-AHP products.

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We thank the Committee for their continued work in promoting innovation and affordability within health care; however, we urge Congress to oppose the three pieces of legislation detailed above. The FAH stands ready to collaborate with the Committee on improving our nation’s health care system by improving integrity and promoting access and we look forward to working together on these critical issues.