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

April 26, 2023

The Honorable Brett Guthrie
Committee on Energy and Commerce
Subcommittee on Health
2123 Rayburn House Office Building
Washington, D.C. 20510

The Honorable Anna Eshoo
Committee on Energy and Commerce
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Dear Chairman Guthrie and Ranking Member Eshoo,

Thank you for your continued focus on reducing health care costs for American families and for the opportunity to share ways in which the subcommittee can build on existing policy to lower health care costs for workers, employers, and the federal government.

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 by **lowering the cost of health care services and increasing transparency and innovation.**

Employers want to address policies that, first and foremost, are driving up costs for patients. Between 2015-2019, prices for individuals with employer-sponsored insurance grew close to 18.3% while utilization grew just 3.6%. Growth in health care prices, and particularly in inpatient hospital prices – which grew 24.6% – remains a persistent challenge to access and affordability. If we're going to help patients, we have to look at the problem and the bills being considered by the subcommittee to advance site-neutral payments do just that.

Further, the Alliance believes any business that is truly providing the highest quality care at the best prices should welcome additional transparency. Increased access to pricing and quality data will enable the market to work more effectively and efficiently, and support employer efforts to innovate, ultimately leading to better costs and quality outcomes for patients.

Employers' overarching mission is to drive better patient care. Employers prioritize investing in our employees' health care to support a healthy workforce. Employers and employees want the best outcomes and also to make sure that we are good stewards of their health care dollar. To do that, we need a strong and functioning health care system that places the patient at the center of care.

For those reasons, the Alliance supports several of the bills being considered by the Subcommittee, including:

- **H.R. ___**, To amend title XVIII of the Social Security Act to provide for parity in Medicare payments for hospital outpatient department services furnished off-campus
- **H.R. ___**, To amend titles XI and XVIII of the Social Security Act to require each outpatient department of a provider to include a unique identification number on claims for services,
- **H.R. ___**, To amend title XVIII of the Social Security Act to require payment for all hospital-owned physician offices located off-campus be paid in accordance with the applicable payment system for the items and services furnished
- **H.R. ___**, To amend XVIII of the Social Security Act to provide for site neutral payments under the Medicare program for certain services furnished in ambulatory settings
- **H.R. 2665**, the Supporting Safety Net Hospitals Act

Why "site-neutrality" is important

At a high level, site-neutral payment is the concept of aligning payment rates for certain services across the three main sites where patients receive outpatient care – hospital outpatient departments (HOPDs), ambulatory surgical centers (ASCs), and freestanding physician offices. Current Medicare and private health insurance payment policies pay more for services provided in hospital outpatient departments.

National polling sponsored by the **Alliance to Fight for Health Care** found insured Americans oppose current policy: 72% of insured Americans say the price of health care services should be the same no matter where that service is received.

Further, according to the Medicare Payment Advisory Commission (MedPAC), which advises Congress on Medicare payment policy, this disparity is incentivizing health care consolidation and higher-health care costs. For example, as MedPAC recently noted in their June 2022 report to Congress, "in 2022, Medicare pays 141 percent more in an HOPD than in a freestanding office for the first hour of chemotherapy infusion."

These payment rate differences incentivize hospitals to shift sites of care from physician offices to HOPDs – and, 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 the resulting increased reimbursements are not linked to improved quality of care for beneficiaries, but they are linked to increased costs for patients. Further, MedPAC notes that these policies can be adopted in a way that protects safety net and rural hospitals that serve as critical access points for low-income patients. For example, MedPAC evaluated a stop-loss policy as an alternative to a budget neutral proposal and concluded such an approach could "ensure access to care among low-income beneficiaries who rely on safety-net hospitals."

MedPAC's 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. New research by University of Minnesota economist Steve Parente conducted on behalf of the Alliance shows the effects for the commercial market are likely even greater. The research estimates that expanding site-neutral payment reform could result in nearly $60 billion in savings annually in the commercial market.

Site neutral reform advances patients' access to care

Expanding site-neutral payment reform would lower patient cost-sharing and lead to more consistent care. According to MedPAC, "beneficiary cost-sharing is much higher in HOPDs than in ASCs, as coinsurance is 20 percent of the payment rate for most services in both settings." So, if a service in a freestanding office visit is $100, the beneficiary's 20% coinsurance is $20. If that same service was provided in an HOPD (or in a freestanding office that was acquired by a hospital and is now billed as an HOPD), the same service would be $241, and the beneficiary's 20% coinsurance would be $28.20. These numbers can add up quickly if beneficiaries are receiving a series of cancer treatments – and can be especially problematic for seniors that operate on limited budgets.

Site-neutral payment reform aims to address this discrepancy and correct the distortion that is incentivizing consolidation.

Congress should act on site-neutral, transparency policies

While Congress and the Centers for Medicare and Medicaid Services have made progress toward right-sizing payments between health care settings, the **Alliance to Fight for Health Care believes there is more to be done to lower health care costs for patients and employers and generate savings for the Medicare program.**

That is why the **Alliance to Fight for Health Care supports congressional and regulatory consideration of MedPAC's balanced suggestion to align fee-for-service payment rates across ambulatory settings** and **encourage adoption of these policies in the commercial market, as well as policies to increase transparency.**

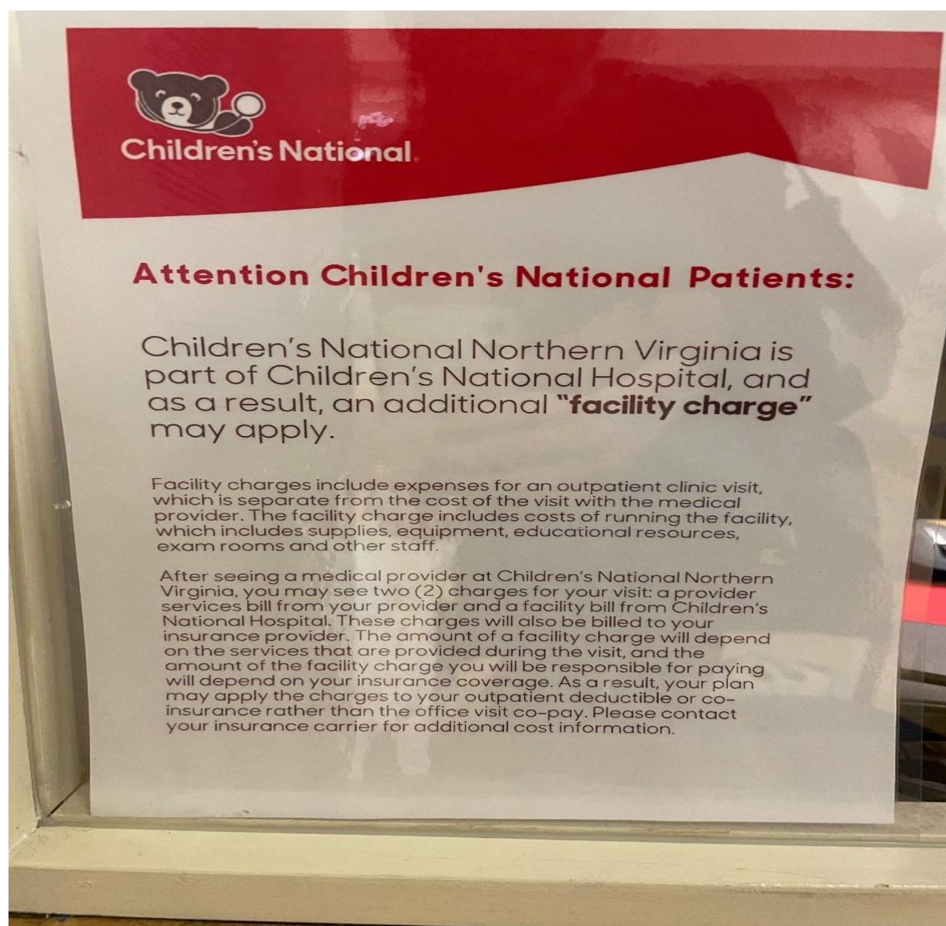
We look forward to working with the committee throughout this process to support policies that place patients at the center and incentivize the highest quality care at more affordable prices.

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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