WISCONSIN HOSPITAL ASSOCIATION

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September 19, 2023

The Honorable Tammy Baldwin
United States Senate
Washington, DC 20510

Dear Senator Baldwin,

On behalf of our more than 135 member hospitals and integrated health systems across the state, the Wisconsin Hospital Association (WHA) writes with serious concerns over provisions in the Bipartisan Primary Care and Health Workforce Act, legislation scheduled for a markup in the Senate HELP Committee on Thursday, September 21.

In particular, WHA requests you work to remove sections 301-303 which contain harmful site-neutral payment cuts and problematic contracting language that severely tilts health care provider and insurance contract negotiations in favor of insurance companies. A summary of WHA's concerns over each provision is listed below.

- **Section 301** – this section rewrites federal contract law to be tilted heavily in favor of insurance companies. It removes a health care provider's ability to attempt to negotiate provisions that keep health insurers honest and expand consumer choices.

  Rural health care providers in particular report that health insurers sometimes attempt to cherry-pick their lowest cost services while steering away consumers from their other services (sometimes keeping their other providers out-of-network entirely). If a hospital or health system does not have an adequate mix of services in an insurers' network, it can threaten the solvency of that provider in instances where they have too many services that they are losing money on.

  Insurers will often obfuscate this issue by suggesting they need the law changed in their favor to keep costs down for consumers. Unfortunately, their track record does not bear this out. We have seen a bevy of recent examples of insurers abusing their role in in a way that is actually driving up costs in the health care system (see recent examples of prior authorization denials by Cigna or delayed payments and delays in enrolling/credentialing providers by Anthem, for instance).

  WHA asks that you remove this problematic language to keep the playing field level.

- **Section 302** – this section requires each off-campus hospital outpatient department to obtain a new unique health identifier. It would create a new administrative burden on hospitals, while providing a questionable (if any) benefit to accomplishing a stated goal of transparency. This is because off-campus providers are already required to include the exact address and a modifier describing the type of site they are. This is essentially the same information that would be gathered from this requirement of obtaining a new modifier.

- **Section 303** – this section prohibits health care providers from billing facility fees for evaluation and management and telehealth services. Under long-standing Medicare policy, health care provider billing differs based on whether the physicians are practicing out of a physician clinic or hospitals. In a physician clinic, physicians typically bill on the physician fee schedule. This type of billing has a facility fee built into it. However, when billing under Medicare's hospital prospective payment system, physicians bill a lower rate that does not have a facility fee built into it. Hospitals then bill their facility fee which covers the higher costs hospital facilities support, such as:

  - Providing emergency room and inpatient care 24 hours a day and 7 days a week
  - Providing more specialized care for patients with higher-acuity needs
  - Serving patients regardless of their ability to pay, including a higher mix of Medicaid/Medicare patients.

Over the years, commercial insurers have followed Medicare's practice of negotiating rates with health care providers based on this facility fee arrangement developed by Medicare. It is important to note that they are not required to utilize such a contracting arrangement. Like section 301, this proposed policy would greatly tip the scales in favor of health insurers and likely lead to billions in losses for hospitals and health systems.

While hospitals are sympathetic to consumer concerns about unexpected facility fee charges, implementing this policy would short-circuit a larger debate about how to transition our health care system toward one that pays more based on the value of care provided. Additionally, the No Surprises Act passed by Congress in 2020 has led to hospitals sending estimates of the cost of care in advance of scheduled procedures that include the facility fee charges. Consumers now have the ability to decide to shop around for another provider in their network if they are dissatisfied with the up-front estimate.

Because hospitals use facility fees to fund the safety-net services they provide, it begs the question: how do the authors of this policy expect hospitals to maintain these safety net services if they no longer have the revenue to support them?

As you have heard from our hospital leaders in recent visits they have made to Washington, DC, the last few years have been extremely challenging for hospitals to navigate. While the strains of COVID are well behind us, its impact ripples on. Hospitals have continued to face supply chain shortages, high inflation, a sustained health care workforce shortage driving rising labor costs, severe challenges discharging patients due to nursing homes shuttering, and steep increases in drug costs, particularly given drugmakers' actions to deny 340b discounts at community pharmacies hospitals contract with.

We greatly appreciate your continued support of hospitals on these issues, and hope you will work to remove these troubling proposals in the Senate HELP markup so we can keep Wisconsin hospitals running strong.

Sincerely,

Eric Borgerding
President and CEO

Cc: Wisconsin Congressional Delegation