Statement of The Hospital & Healthsystem Association of Pennsylvania

For the

House Health Committee

Submitted by

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Harrisburg, Pennsylvania
December 18, 2013

Introduction: Chairman Baker, Chairman Fabrizio, and members of the committee, HAP represents and advocates for the nearly 240 acute and specialty care hospitals and health systems across the state and the patients they serve. We appreciate the opportunity to present the views of hospitals and health systems across the state on House Bills 1621 and 1622.

Background: The Hospital & Healthsystem Association of Pennsylvania (HAP) consistently has stated that there is a compelling public policy interest for the state to ensure a competitive insurance market. Indeed, market competition is essential to ensuring the broadest access to affordable insurance coverage. In addition, a balanced, competitive market leads to competitive premiums for employers and employees and competitive payments to health care providers. As a result, HAP believes that the stimulation of health insurance market competition should be a top priority for state government.

However, HAP has always opposed legislation that would result in a regulatory framework that either prevents health care providers from being able to effectively structure contractual relationships with health plans or unduly interferes with insurance market competition that seeks to offer innovative approaches. This is why HAP opposes House Bills 1621 and 1622.

Hospital Community Concerns: As introduced, House Bill 1621 would force hospitals that are operating as part of an integrated delivery network to contract with any health insurance carrier willing to enter into a contract. Similarly, House Bill 1622 would require a hospital-owned physician practice plan to do the same. Both bills take a unilateral approach to contracting.

While the concept of "any willing payer" legislation may seem to be an avenue to increase access for patients, the highly negative impact it will have on the competitive market will have the exact opposite effect. Specifically, House Bills 1621 and 1622 would create a disincentive for providers and insurers to strongly compete to create benefit packages that maximize the resources of both sides and result in patients having a clear choice about what insurance product and/or provider network is best for them. This has

always been the case with "any willing provider" legislation, and it will continue to be true if these bills, which incorporate "any willing payer," were to pass.

Major changes in health care—either as a result of the recent enactment of the Affordable Care Act or more long-term evolving trends—raise legitimate questions about whether or not Pennsylvania's current regulatory framework for health care providers and health insurers is sufficient. HAP is supportive of engaging in a public dialogue that seeks to shed light on key issues related to the changing insurance and health care delivery marketplaces. We think it is appropriate to ask:

- What changes to current law and regulations will help ensure there is a competitive insurance market that enables broad access to coverage?
- How do health provider and insurance practices need to change to foster the most efficient utilization and stewardship of limited resources?
- What health provider and health insurance practices provide the greatest barriers to access to high quality health care?
- What can the commonwealth do to enable innovation by health care providers and health insurers in responding to purchaser and subscriber needs?

HAP understands that there are likely more questions worthy of a vigorous public conversation and welcomes discussion on opportunities to advance care integration that effectively serves the health care needs of individuals and communities. However, imposing a unilateral "any willing payer" mandate on hospitals and hospital-owned physician plans is not an acceptable way to address these issues.

While HAP does not disagree that integrated delivery systems (IDS) have unique aspects that, in part, are generating the kinds of questions discussed above, House Bills 1621 and 1622 would create a very uneven playing field when it comes to the broader hospital and insurance communities. For example, while the legislation prohibits an IDS subsidizing an insurance plan, it is silent about the insurance plan subsidizing a hospital or health system. The legislation also prohibits IDS and physician practice plans from limiting practitioners in providing care related to their scope of practice. This could preclude facilities' medical staffs, which oversee practitioner quality, from establishing effective quality of care criteria that needed to be met for purposes of practicing within that facility. These unintended consequences could create further issues related to effective care delivery and access to quality care.

In addition, HAP opposes House Bill 1621 because the legislation would amend the Health Care Facilities Act—the law that provides state oversight of the quality of care provided by licensed health care facilities—by imposing contracting restrictions on hospitals. As such, it would require the state Department of Health to enforce the provisions of contracting law on licensed health care facilities. The oversight of patient safety and quality is the appropriate responsibility of the department in fulfilling its important obligation to protect quality and safety. They are not the right agency to oversee highly complex contracting issues between hospitals and insurers. This is

currently the purview of the Pennsylvania Insurance Department, and it should remain that way.

HAP does not believe the mandatory arbitration process called for by either bill is feasible. As a matter of public policy, HAP has always opposed any effort by state government to force health care competitors—either providers or payers—into a contract. In addition to the likelihood that the initial payment rates of a default agreement will be completely unacceptable to one of the two sides, the requirement that the two parties must reach consensus on the selection of an arbitrator, will lead to a very long and arduous arbitration. Further, the process rules required by the legislation are not intended to facilitate agreement on contract negotiations between hospitals and insurers. Finally, the legislation only regulates hospitals and hospital-owned physician practices. There is no requirement that insurers be bound to arbitration or that providers could invoke this step in the event that an insurer is unreasonable in its development of contract provisions.

Recommendations: Imposing an "any willing insurer" mandate on hospitals and hospital-owned physician plans—regardless of the system type—goes well beyond any compelling interest by state government. In fact, House Bills 1621 and 1622 will result in unfair competition, and lessen opportunities for a competitive insurance market in the future.

Instead, HAP recommends that the General Assembly and the Pennsylvania Department of Insurance convene stakeholders to determine how current laws and regulations should be amended to better address the following key issues:

Accountability Across Delivery and Financing of Care—Hospitals and health systems believe that accountability and transparency are needed for both the delivery of care by facilities and health care practitioners, as well as the financing of care, including health insurance. Accountability includes recognition of the role that the delivery system and payers have for supporting medical and other health professional education, the needs of the uninsured and publicly supported patients (i.e. Medicaid, Medicare, and CHIP), and the need for communities to have access to needed, but less profitable services (e.g., obstetrics, trauma care, etc.). Accountability should also exist for all facilities and payers regardless of ownership status.

Equitable Standards—Pennsylvania hospitals and health systems call for broadening and strengthening licensure and delivery system accountability and to ensure that the same rules apply to all facilities providing same or similar health care. Current state health care facility licensure needs to be broadened to incorporate licensure of new types of facilities (such as imaging centers) providing the same or similar services that hospitals provide and which are currently under regulatory purview. Licensure standards should support a "level-playing field," again regardless of ownership. The same or similar standards of accountability should be addressed in licensure; reporting (e.g., transparency); reimbursement; and provision of care to uninsured, Medicaid, and other publicly supported patients.

Balance between Market Forces and Regulation—Hospitals and health systems recognize that achieving an appropriate balance between competitive market forces and regulatory requirements is important in maintaining an innovative and progressive system of delivering and financing health care. While state government has a compelling public policy interest in setting licensure standards as a means of assuring Pennsylvanians access to quality and safe health care services, market forces at the community level should continue to be the preferred method for determining community need for health care facilities and use of insurance products.

Public Reporting—Transparency is important to assuring that patients, the public, community leaders, and other stakeholders have access to information on quality and pricing of the delivery and financing or insurance of health care. Transparency, both in health care delivery and in health insurance, should enable better decision-making by patients, payers, and other stakeholders within communities. As an aside, HAP will be supporting reauthorization of the Pennsylvania Health Care Cost Containment Council in 2014, as the council's enabling legislation must be re-enacted. The council has played an important role in advancing transparency and must be continued.

Competition—Hospitals believe that fair competition is essential in health care delivery, just as it is in health care coverage. Competition that enables choice by consumers in accessing health care fosters innovation and improvement in health care and is essential in advancing medical practice and technology. Competition that enables employer/employee choice in obtaining health care coverage advances affordability of insurance and benefit design. Competition by health insurers enables fair and appropriate payments to providers delivering cost-effective, quality health care.

Conclusion: Updating the state regulatory framework for health care facilities and insurers is essential for patient protection. However, any changes proposed should be evidence-based, consistently applied, allow for flexibility in responding to a dynamic and rapidly changing health care environment, and enable the provision of quality care in a cost-effective and efficient manner. In addition, appropriately structured state oversight of health insurers is essential for financial protection of subscribers in accessing health care, fostering greater competition, ensuring that coverage is affordable, and enabling insurance plans to be responsive to employer and employee health benefit needs.

HAP remains open to discussing legislation that updates the regulatory framework for health care providers and insurers, so long as the focus remains on quality, safety, and access to care. Any changes to the oversight of facilities or insurance plans must result in patients having access to a continuum of services, must enable cost-effective and safe delivery of essential hospital services, must foster health care innovation, must advance the coordination of care for individuals with chronic medical conditions, and support continuous quality improvement. At the same time, oversight must carefully balance the need for public protection with the benefits of a competitive market—both in health care delivery and in health insurance.

Thank you for the opportunity to present the hospital community's views on House Bills 1621 and 1622. I would be pleased to answer any questions you may have.

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HAP 12/2013