Statement for the Record
by the
Association of American Medical Colleges
before the
Education and Workforce Committee
U.S. House of Representatives

September 11, 2024

The Association of American Medical Colleges (AAMC) appreciates the opportunity to submit this statement for the record on the legislative proposals before the House Education and Workforce Committee on September 11, 2024. Specifically, the AAMC is providing feedback on the Health Competition for Better Care Act (H.R. 3120) and the Transparent Telehealth Bills Act of 2024 (H.R. 9457).

The AAMC is a nonprofit association dedicated to improving the health of people everywhere through medical education, health care, medical research, and community collaborations. Its members are all 158 U.S. medical schools accredited by the Liaison Committee on Medical Education; 13 accredited Canadian medical schools; approximately 400 academic health systems and teaching hospitals, including Department of Veterans Affairs medical centers; and more than 70 academic societies. Through these institutions and organizations, the AAMC leads and serves America's medical schools, academic health systems and teaching hospitals, and the millions of individuals across academic medicine, including more than 193,000 full-time faculty members, 96,000 medical students, 153,000 resident physicians, and 60,000 graduate students and postdoctoral researchers in the biomedical sciences. Following a 2022 merger, the Alliance of Academic Health Centers and the Alliance of Academic Health Centers International broadened participation in the AAMC by U.S. and international academic health centers.

Health Competition for Better Care Act of 2024 (H.R. 3120)
The AAMC opposes imposing unnecessary federal interference in contract negotiations between teaching health systems and hospitals and insurers like those proposed in the Health Competition for Better Care Act of 2024 (H.R. 3120). Contract negotiations are complex discussions that involve nuanced considerations related to compromises, payment amounts, patient types, volume, services, and many other variables – each of which is connected to a dollar amount and subject to negotiation. Both providers and insurers use specific contractual language to modify these variables to reach an agreement that is mutually acceptable to all parties.

Eliminating the ability of providers to use the contracting tools outlined in the legislation would give insurers an unfair advantage in these negotiations. As you know, insurers continue to consolidate and wield historically high market power, at times being the sole, or one of the only insurers in a particular area. This threatens to diminish hospitals' ability to fairly structure

contracts, stands to intensify health care consolidation, and would continue to inflate insurer margins while harming the very entities that are delivering patient care. Even more concerning, a recent study published by the AAMC's Research and Action Institute indicates that although the largest health systems have, on average, "a combined 43.1% of the market share (as measured by total inpatient hospital discharges) in each state, the top three large-group insurers hold an average of 82.2% of the market share in each state." Eliminating or limiting providers' ability to negotiate fair contracts will only increase this disparity.[1]

Anti-tiering, anti-steering, and all-or-nothing clauses, at their core, protect patient access to care by ensuring a more level negotiating environment between providers and insurers. While the Affordable Care Act did contain several network adequacy provisions, insurers consistently manipulate and devise narrower networks in the name of lower costs. Under these circumstances, where premiums continue to rise and provider networks shrink, patients pay the ultimate price, as they incur higher costs for reduced health care access. The contracting tools outlined in H.R. 3120 help prevent insurers from creating networks that exclude teaching hospitals and health systems and their faculty physicians, thus helping to ensure heightened patient access to the high-quality and comprehensive care that our members provide. Narrow networks put the health of patients at risk and increase costs to the patient should they seek or require out-of-network care at teaching hospitals.

Teaching health systems and hospitals have focused more on delivering care in the community. These care settings are critical to meeting patients' needs beyond the walls of a traditional inpatient hospital. However, this also means that teaching hospital and physician care settings are more decentralized and must absorb the costs of operating these additional facilities. Allowing insurers to pick and choose which parts of a hospital system to include in the network gives them significant contracting leverage as they will be able to cherry-pick facilities. An insurer may deem certain individual sites to be "cheaper" with no consideration to the quality of care, or accessibility of services to a particular community.

Teaching health systems and hospitals know best the distinct characteristics of the patient populations they serve and how best to treat their communities. Consequently, they must retain flexibility to negotiate the contractual terms that best meet the needs of those patient populations.

Transparent Telehealth Bills Act of 2024 (H.R. 9457)

Congress and stakeholders have acknowledged the importance of expanding access to telehealth care. As a result of critical COVID-19 pandemic policies, patients nationwide benefited from increased access to care via telehealth services. Congress' work to expand telehealth services to more people in rural, urban, and other underserved communities would effectively be undermined by eliminating critical financial support. Payment for telehealth services must account for practice-related expenses. Similar to physician office-based settings, provider-based entities (e.g. hospitals) will incur technology costs and continue to employ nurses, medical

[1] Grover, A., Orgera, K., Pincus, L., Senn, S., & Redford, G. (2024, May 1). *Data snapshot: Why market power matters for patients, insurers, and hospitals*. AAMC Research and Action Institute. https://www.aamcresearchinstitute.org/our-work/data-snapshot/why-market-power-matters

assistants, and other staff to engage patients during telehealth visits or to coordinate pre-or-post visit care. These expenses support the billing of an originating site fee, as is currently covered under Medicare, where the patient is present in a hospital outpatient department receiving telehealth services from a distant site provider. Additionally, to recognize costs incurred by hospitals, we recommend that a similar originating site fee be allowed when a practitioner in the hospital outpatient department is providing telehealth services to a patient who is at home.

Specifically, the AAMC is deeply concerned with the payment cuts to teaching health systems and hospitals proposed in the Transparent Telehealth Bills Act of 2024 (H.R. 9457). This bill would bar health care facilities from charging a facility fee for telehealth services billed by certain plans. This provision ignores the importance of facility fees to help offset the costs of providing care and the very real and increasing costs of maintaining facilities, retaining staff, and investing in technology.

The AAMC recommends amending the language of this legislation to allow for an originating site fee for distant site providers.

The AAMC remains committed to working with the Committee to improve access to quality health care. If you have any further questions, please contact AAMC Director of Government Relations, Ally Perleoni at aperleoni@aamc.org.