Colorado Business Group on Health
Working Together to Improve Health Care Value

March 6th, 2019

Good afternoon Madam Chair and Members of the House Health and Insurance Committee:

As the Executive Director of the Colorado Business Group on Health, I would like to submit my support for HB19-1174, "Concerning Consumer Protections for Out-of-Network Charges" being sponsored by Representatives Esgar and Catlin and Senators Gardner and Pettersen.

The Colorado Business Group on Health is a 501c3 non-profit coalition of public and private health care purchasers including the State of Colorado, Colorado PERA, the City of Colorado Springs, Larimer County, numerous school districts along the Front Range, and various employers working together to improve healthcare value – both quality and price - in Colorado. We work closely with and support the efforts of other non-profit organizations such as the *Center for Improving Value in Health Care* and the *Colorado Consumer Health Initiative* as well as with government departments such as the *Department of Health Care Policy and Financing* and with employers across the State.

CBGH endorses the proposed bill's provisions for the prohibition of balance billing for the non-discretionary use of out-of-network providers, for the prior notification to a consumer that an out-of-network provider may be involved in their care, for the notification to patients that they have certain consumer protections, for the use of Medicare to benchmark pricing against an empirically based and rational payment model, and for the establishment of a process to resolve billing disputes without putting consumers in the middle of fights over profitability. We support these provisions as being in the best interests of Colorado's consumers as well as Colorado's employers and our overall economic development.

The advantages of HB19-1174 for the consumer seem obvious enough for most of us to immediately grasp. Even the most ardent market advocates, including myself, understand that consumers - already facing special obstacles to rational decision-making when seeking care as patients - simply should not be blindsided by the providers of that care. So, this bill most obviously protects individuals and families when they are most vulnerable and least likely or empowered to function as a "consumer" – which is the fair and right thing to do on its own. But HB-1174 has broader benefits for us all – consumers and purchasers alike.

The well documented consolidation of both health systems and hospital-based physician groups, nationally and in Colorado, has radically reduced the number of independent providers selling health care in any given market. Recent work shows that providers in the overwhelming majority of markets (90%) are "highly" or "super" concentrated with health care economists from Harvard, Stanford, Carnegie-Mellon, Berkeley and other business schools citing that pricing has only gone up while quality oftentimes has suffered. Essentially, significant sectors of healthcare have become an oligopoly with one outcome and apparent intent: increased prices.

This kind of consolidation, combined with the facts that much of health care "demand" is non-discretionary and largely *determined by the provider* rather than the patient, represents a rather significant departure from what we think of as a "free market." This is particularly true in more rural areas with one hospital where options are limited and patients have no choice. Allowing for "out-of-network billing" under a presumed right to "price to what the market will bear" (as one senior health system argued to me his system had) for emergency and non-elective services encourages these often-times tax-exempt facilities to very purposefully raise prices to irrationally and unjustifiably high levels for

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the self-serving strategy of leveraging negotiations with insurers. As a result, it further distorts the way an effective market would work. We all live with the unsustainable, unaffordable results, but our middle and lower income workers, including teachers, police, firefighters and other public servants are most effected.

As a former senior executive of a regional health system who contracted with regional and national health plans, I can attest first hand that – absent reasoned legislative steps such as HB-1174 - the current market incentives will not address this serious problem, particularly with regards to the hospital-based physicians, emergency services, and non-elective services. This is because what we euphemistically refer to as a health delivery system is, in fact, a hodge-podge of many uncoordinated and disparate components that, in some cases, actually have conflicting financial, professional, and personal interests. While the average lay person might reasonably expect structures such as medical staff bylaws, hospital-physician contracts, or even just a plain ol' sense of responsibility on the part of a hospital CEO or Board to protect the rights of the trusting patients who seek care and comfort in their facility, the reality is that, by and large, *none of these have done so*. If they had, this legislation – which follows numerous other states - would not be needed.

From at least the time of the ancient Greeks, the primary rule of Western medicine has been: "First, do no harm." Given that healthcare is now the leading cause of bankruptcy in the US, we must recognize that *financial harm IS harm*.

HB19-1174 is a necessary step to relieving that harm – both to patients and purchasers – and to making a consolidated provider market more balanced and rational.

Respectfully Submitted,
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RESOURCES

- ***"When Hospitals Merge to Save Money, Patients Often Pay More,"*** The Commonwealth Fund www.commonwealthfund.org/publications/newsletter-article/2018/nov/when-hospitals-merge-save-money-patients-often-pay-more
- "***Provider Consolidation Drives Up Health Care Costs***" www.americanprogress.org/issues/healthcare/reports/2018/12/05/461780/provider-consolidation-drives-health-care-costs/
- ***MedPAC Report to Congress*** (Documenting the adequacy of Medicare payments for "efficient" hospitals and that Medicare losses are driven by high commercial payments) www.medpac.gov/-documents-/reports
- ***"Private-Payor Profits Can Induce Negative Margins,"*** www.healthaffairs.org/doi/10.1377/hlthaff.2009.0599
- ***Becker's Hospital CFO Report, "Average hospital expenses across 50 states,"*** www.beckershospitalreview.com/finance/average-hospital-expenses-per-inpatient-day-across-50-states.html
- ***"It's Still the Prices, Stupid: Why the United States Is So Different From Other Countries"*** https://www.healthaffairs.org/doi/full/10.1377/hlthaff.22.3.89

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Excerpts from two particularly relevant articles on Out-of-Network Surprise Billing (as time and/or interest allows)

Health Affairs Blog 2013

Hospital Charges And The Need For A Maximum Price Obligation Rule For Emergency Department & Out-Of-Network Care

- "Hospitals have marked up charges ever higher and higher: from 20 percent above costs in 1980 to 220 percent in 2011"
- "High and increasing hospital charges, combined with increasing proportions of cases admitted through the hospital Emergency Department (ED), are major factors behind the ever-declining negotiating leverage of private health insurers. This situation, coupled with the increased pricing power of the ever-more-concentrated provider industry, will be a major contributor to the almost certain rapid escalation in total U.S. health care costs in coming years."
- "Centers for Medicare and Medicaid (CMS) charge data reinforce the conclusion that hospital prices and payment levels nationally are not rational in the sense that they are not the prices that a truly competitive market would produce."

Brooking Institute Report – February 2019

State Approaches to Mitigate Surprise OON Billing

- Normal "contracted price vs volume" trade-off doesn't typically work for hospital-based physicians (ED, Anesthesiology, Pathology, Radiology, Intensivists, hospitalist, neonatologist, etc); *they know if the hospital is in-network, they'll get the volume proportionate to hospital*
- As a result, only real incentive – absent language in hospital agreements – is to avoid hassles of balance-billing.
- Nevertheless, this allow these practices to negotiate significantly higher rates. Whereas most physicians contract commercially, on average, at 128% of Medicare...
    - Radiologists average 204%
    - ED physicians average 306%
    - Anesthesiologist average 344%
- Some of these groups have so consolidated in certain markets that hospitals have little if any leverage to force them to participate in negotiations with insurers
- "Principles for Designing a State-based Solution"
    - Take the patient out of the middle.
    - Apply protections comprehensively. All services where patients lack meaningful choice.
    - Minimize reliance on notice and consent exceptions.
        - Opportunity to opt out must be real.
        - Shouldn't be necessary in emergent and select other situation
    - Include a means of enforcement.
    - Be mindful of ERISA preemption
- Approaches States are taking. Two broad approaches:
    - Billing Regulation: Setting OON caps on charges
    - Contracting Regulation: Makes it impossible for services within an in-network provider to be out-of-network. Either require contracts thru facility or require plans to contract