Attachment A

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March 14, 2016

Senator Ray Scott, Chair
Senate State, Veterans and Military Affairs Committee
Colorado General Assembly
Colorado State Capitol
200 East Colfax Ave.
Denver, CO 80203

Dear Senator Scott:

I write in reply to your invitation that I offer commentary to the Committee on the provisions of Senate Bill 16-152.

For five months in late 2015 and early 2016 I served as the facilitator of an informal interim study which addressed health plan networks, out-of-network providers, and related issues in consumer protection under the existing C.R.S. §10-16-704. Organizations representing health plans (CAHP) and providers (CMS) were the principal participants in that initiative, which also included contributions from healthcare consumers, hospitals, representatives from DORA, and other interested organizations.

That work provided me with a deepened understanding of the out-of-network provider circumstance, one aspect of which would be addressed by SB 16-152. The following comments, however, are entirely my own. They do not represent the views of any agency, organization, or person who participated in that initiative. (The letterhead too is solely for purposes of identification. The University of Denver does not take positions on pending legislation that does not directly affect it.)

By way of brief summary, in my opinion the Bill: (i) creates a remedy that is disproportionate to the problem it would address yet may not achieve the bill's own objectives; (ii) is not sufficiently sensitive to its potential effects on Colorado healthcare and, ultimately, the welfare of Colorado healthcare consumers; and (iii) would create a system less likely to achieve its own goals than would an alternative process already contemplated by Colorado law.

In short, and with the great respect that is due to its sponsors, in my view SB 16-152 should be neither approved by Committee nor enacted.

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Specifically:

(i) The problem the bill addresses occurs when a provider who is "in-network" with a particular health plan causes a covered patient to be admitted to a facility – usually a hospital – which is also in-network for that health plan. During the hospital stay the consumer may, however, receive services from other providers working in that facility who are "out-of-network" with respect to that health plan.

Existing law, at C.R.S. §10-16-704(3)(b) and (5.5)(a), protects patients in that circumstance. Consumers are not required to pay provider's billed charges beyond what they would have been required to pay if the provider were in-network. Substantively, therefore, consumers are already fully protected against "balance bills." No changes to the law seem necessary in that regard.

There apparently have been instances in which covered consumers received balance bills from out-of-network providers, though whether inadvertently or otherwise is not known. Some consumers might then pay the balances despite not being obligated to do so, due to their lack of understanding of their rights and remedies under the existing law. I understand that the number of reported instances like this is very small; though the number unreported is also unknown.

SB16-152 would require that *in-network physicians* who admit patients to in-network facilities must provide to those patients comprehensive notices conveying information which such physicians today may or may not even have; that out-of-network providers must append notices of consumer rights to their bills, based on coverage distinctions of which they may or may not be aware; and that health plans must provide similar notices with every preauthorization for admission.

Any failure to live up to these provisions would be a *per se* deceptive trade practice in violation of the Colorado Consumer Protection Act. Under §6-1-112 of that Act a physician could be held liable for civil penalties of $2,000 per patient per transaction or a total of $500,000; or where the patient is elderly, as many hospital patients are, then for civil penalties of $10,000 per patient per transaction. In addition the provider would be liable to the patient themselves for at least $500 per event, and in some cases as much as three times the amount of the billed charges.

These consequences are not just excessive on their face, though they are that. Any penalty might be excessive given the notices that the bill would require. Admitting physicians cannot know all of the services their patient may encounter during an admission, nor which of them might be rendered by out-of-network providers. [As drafted the bill is unclear whether the facility itself also has the duty to provide such notices.] Any notice complying with these provisions would therefore have to be voluminous, generic, and unhelpful in the preadmission context. The notice would have to address both ERISA and non-ERISA health plans, with very different provisions as to each. Neither the provider nor the consumer may know which of

the notified provisions would apply to them. It all risks becoming another "sign here" page in a bewildering pile of paper set in front of a sick and usually frightened consumer.

The provisions of SB16-152 with regard to *out-of-network* providers have similar flaws: providers must avoid, at their substantial peril, making errors about the insurance coverage of the patients whom they treat; or, to be assured of complying with the new requirements, providing notices that are too generic to be of use to the patients who receive them.

It is difficult to say how much these new administrative burdens would add to the costs of healthcare. It is equally difficult to say how the persons and entities that would be subject to them would behave so as to avoid the fines and penalties. One can only imagine the result being notifications either so generic as to be unhelpful or so detailed as to be impossible under the real circumstances of private healthcare.

(ii) The bill is not sufficiently sensitive to the complex realities of contemporary health insurance and health care. In addition to the points already mentioned, the allocation of responsibility and potential liability for in-network and out-of-network providers may have implications for providers and insurers that go beyond the apparent scope of the bill.

Insurers and physicians are in theory free to negotiate the terms on which any provider will, or will not, become a member of any given network. Many, on both sides of that aisle, feel that freedom is absolutely key to the economic structure of modern healthcare. Laws which add advantages, disadvantages, or risks to being in-network or out-of-network therefore have implications for those negotiations. A law, for example, which creates burdens and risks for out-of-network providers increases the bargaining leverage that health plans have in those negotiations. A law that creates burdens and risks for in-network providers may have the opposite effect, creating disadvantages and disincentives for being included in a network.

SB16-152 would do both. The economics are too complex to be able to say precisely how much and in which net direction the effects would happen. But I have little doubt that these new requirements risk confounding what is already a very complex balance. It is not hard to foresee the possibility of effects on network breadth vs network narrowness, on the viability of independent practices, on the concentration in both sides of the industry, and eventually on the quality and cost of healthcare.

It might be defensible to take on these much wider risks if the bill were otherwise well designed to achieve other goals, such as assuring more effective consumer knowledge and choice. But I think its advantages are likely to be very small, while the perturbations it may cause in the healthcare marketplace could be untoward.

(iii) Health plans, hospitals (and similar facilities), and providers (both in-network and out-) together comprise the healthcare system faced by patients who are the

intended beneficiaries of this bill. In the complex world of American healthcare these actors are sometimes independent, sometimes affiliated, sometimes coordinated and sometimes none of those. But from a patient's point of view, it is a "system" even when, legally, it isn't.

Informing the patient, and protecting the patient, is therefore a problem that calls for a *system* response. SB16-152 does not do that. It creates independent responsibilities for facilities, for in-network providers, for out-of-network providers, and for health plans. All of them are directed at the same goal but with no requirement of coordination, or uniformity. The result for consumers may be a cacophony of overlapping and incommensurable dense forms drafted more to protect the drafter from liability than to protect the reader from the lack of knowledge and choice.

In addition, SB16-152 would be applicable to fewer than half of all Colorado healthcare consumers. Those covered by ERISA plans alone comprise the majority of all those with employment-based insurance. The Colorado legislature has little power to address that problem by legislative fiat.

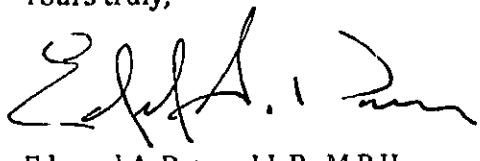
There are better ways to achieve patient protections. Recognizing at least one aspect of this problem, the ERISA problem, Colorado Law provides at C.R.S. §704(3)(a)(iii) a hint of a better mechanism to achieve these goals:

> "the general assembly encourages health care facilities, carriers, and providers to provide consumers disclosure about the potential impact of receiving services from an out-of-network provider."

There is wisdom in that provision. What it needs, to become effective, is an impetus for the participating parties to come together – or under the aegis of a regulatory agency to be brought together – in a "stakeholder" process with the directive to produce the protections thought necessary to further implement what §704 already provides. From that collection of knowledgeable participants there would almost surely come systemic solutions that offer coordination, efficient administration, comprehensibility for consumers, and lowered risk of upsetting other important apple carts in the process. The present bill would not achieve those objectives.

I thank you for your kind attention.

Yours truly,



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