BlueCross BlueShield of Vermont

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MEMORANDUM

TO: Senate Committee on Health and Welfare

FROM: Rebecca C. Heintz, BCBSVT General Counsel

DATE: February 27, 2020

RE: Testimony on S.290

This memo summarizes BCBSVT's testimony provided on S.290, some of which was provided directly to the Committee on February 26, 2020.

Overall Comments

- We strongly encourage the Committee to recall the overall healthcare reform objectives of reducing the cost of health care or, at least, reducing the rate of increase. To this end, we would advocate for legislation that empowers the GMCB to advance that goal without burdening the GMCB, or the system it oversees, with administrative tasks that may or may not add value or advance reform goals. We are concerned that some of the proposals in S.290 will continue to consume GMCB resources on tasks that do not meaningfully advance the goals of the ACO and the All Payer Model.
- BCBSVT supports the testimony from other stakeholders that encourage the Committee to ensure that the regulatory framework supports and encourages payment reform and does not inadvertently tether us to the fee for service payment system that currently encourages over-utilization and waste.

BCBSVT Comments on Section 7 - 9

- BCBSVT is opposed to GMCB review and approval of health plan contracts with providers. From a policy perspective, this would be an enormous undertaking and consume extensive state resources to become involved in a process that is, for the most part, without a need for such oversight. If the Legislature feels that some state oversight is needed, we would encourage an examination of whether having the GMCB or DFR serve as an arbiter of disputes when needed might be a more effective strategy.
- In looking at the proposed bill and related testimony, we do note there appears to be some confusion relating to the difference between a FFS rate paid to a provider for a service and the general contracts that exist between a payer and a provider. We encourage clarity of purpose and intent regarding this distinction in any legislation.
- VMS has proposed to make it explicit that health care providers should be allowed to band together to negotiate contracts with insurance companies as a collective bargaining unit. We are concerned such a process will increase the cost of contracting and may lead to increased health care costs without delivering higher quality. Provider consolidation is already creating enormous pressure for the health care system and this would appear to exacerbate that dynamic.
- It's unclear how additional regulatory oversight of provider payer contracts would advance reform goals, but it would most certainly add costs for both providers and payers. More fundamentally, it would dramatically slow down the ability of payers and providers to innovate relating to payment reform. It would create barriers instead of fostering creative approaches to outstanding issues.
- Additionally, the scope of the review is unclear. There are literally thousands of individual contracts. There are numerous different types of providers with complex industry dynamics. There are contracts that cover a single service with a single patient. There are contracts that are intended to support a single pilot program. Any review program should be explicit in scope.
- We also note that contracts are competitively sensitive and, as such, it would be vital that such contracts not be available to competitors.
- If contracts were to be reviewed, we would encourage the existence of meaningful standards that GMCB would be using to judge contracts against beyond those included in Section 9. We note that current Vermont law contains strong provider protections in payer contracting and we believe these standards are working well. We also note that current enforcement of chapter 221, subchapter 2, of title 18 lies with DFR, which has developed expertise in the application of these laws to specific situations. We would not support transitioning that responsibility from DFR to GMCB at this time. Not only

because DFR has developed some expertise in this area, but it further distracts the GMCB from focusing on meaningful reform.

- We note that the GMCB has proposed a study, however, it appears that study is focused on the challenges associated with provider rate setting. BCBSVT believes that it is likely to require a great deal of resources for GMCB to undertake rate setting and, as noted above, worry that it may be focusing too many resources on the FFS system at a time when such system should be mostly phased out.
- It is very important to BCBSVT that it not be the only payer subject to any new process. Although BCBSVT seems large to some, it is small compared to the payers it competes against. Saddling BCBSVT only with the administrative burden (and competitive disadvantage of not being able to negotiate freely with providers), puts the local payer at a significant disadvantage.
- We are concerned about the language in Section 9 that indicates a contract will not be effective until it is approved. What happens in the meantime?

<u>BCBSVT Comments on Section 10</u>

- BCBSVT is opposed to not allowing increases in administrative costs in excess of the consumer price index. We note that administrative costs are often driven by things outside of payers' control, such as taxes and mandates that require investments in new technology. This arbitrary limitation will simply continue to make the insured market more and more untenable, furthering limiting competition.

<u>BCBSVT Comments on Section 11</u>

- BCBSVT objects to the addition to 18 VSA § 9418c requiring at least 120 days for a provider's consideration of a proposed contract and for negotiation of contract terms. This is unduly long and fails to recognize that providers are often eager to get contracts renegotiated to the extent is involves increases to payment rates.
- Further, the 120 days does not align with the hospital budget approval process, which drives rate negotiations with hospitals.