Testimony of Jay Mullen, MD MBA FACEP

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Before the Vermont Senate Health & Welfare Committee
Regarding S.190 – An act relating to the Green Mountain Care Board, reference-based pricing, and hospital outsourcing of clinical care

Chair Lyons, Vice Chair Gulick, and members of the Senate Health & Welfare Committee, thank you for the opportunity to testify today.

My name is Jay Mullen, a practicing emergency physician at Brattleboro Memorial Hospital and President and CEO of BlueWater Health, an independent, physician-led emergency medicine group providing services throughout northern New England, including at Brattleboro Memorial Hospital. I also chair the Emergency Medicine Business Coalition (EMBC), a national organization representing independent physician owned democratic groups. (embusinesscoalition.org)

I am here today in opposition to S.190, because the bill—while well-intentioned—would unintentionally harm the very independent physician groups that enable Vermont's community hospitals to maintain high-quality, cost-effective, 24/7 clinical services.

1. Independent physician groups like BlueWater are essential partners—not cost drivers

Independent groups fill critical staffing needs for Vermont's community hospitals, particularly in specialties like emergency medicine, anesthesia, and radiology. Hospitals rely on these groups because they provide lower-cost, flexible, high-quality coverage that is often more affordable than hospital employment or national corporate contracting models.

National EMBC performance data demonstrates the strength of this model:

- EMBC member groups together represent 4,900 physicians across 31 states, collectively covering 7.5 million emergency visits per year.
- 62% of member groups have been in business more than 35 years, demonstrating long-term stability and deep community integration.

- More than 90% of EMBC practice groups report that at least 75% of their physicians live locally to the hospitals they serve—meaning these clinicians are embedded in the communities they treat.

This is not outsourcing in the traditional sense—this is local physicians serving local communities, supported by a national infrastructure of shared best practices.

S.190 assumes outsourcing is synonymous with cost inflation or lack of oversight. In reality, independent groups are often the lowest-cost and highest-performing option available to rural hospitals.

2. S.190 creates major disincentives for high-quality, lower-cost independent groups

By absorbing independent group revenue into hospital budgets and subjecting it to rate-setting, S.190 eliminates the fiscal stability and operational independence required for these groups to function.

A. Recruitment becomes significantly more difficult

Physicians choose independent practice because it offers:

- Local governance
- Clinical autonomy
- Predictable compensation
- A mission-driven, community-based environment

S.190 collapses this model, making Vermont far less competitive at a time when emergency physician vacancies are at historic highs.

B. Hospitals lose access to lower-cost, high-performance partners

Independent groups typically operate with:

- Lean administrative overhead
- Efficient staffing models
- Competitive but sustainable physician compensation

When these groups are forced into hospital budget structures, hospitals lose this cost advantage.

C. Risk of consolidation—and higher long-term costs

The likely outcome is predictable:
Independent groups exit → hospitals must employ physicians or hire national corporate groups → costs rise, flexibility declines, turnover increases.

This has already happened in states with similar regulatory barriers.

We have already seen what happens in states such as California, Massachusetts, New Mexico, Oregon, Washington, Connecticut, Rhode Island, and New York, where aggressive transaction review laws or strict corporate-practice rules have driven independent physician groups out of the market. Hospitals are then forced to employ physicians or contract with large national corporate groups—*a far more expensive model with less flexibility and higher turnover*. Those states now struggle with exactly the issues S.190 would create here.

3. The bill's assumptions about emergency billing are incorrect—patients are already fully protected under Federal and State law

The No Surprises Act, enacted by Congress in December 2020 and implemented on January 1, 2022, is one of the most significant patient-protection laws in modern healthcare. It was created to eliminate unexpected medical bills that patients previously received when treated by out-of-network clinicians—particularly in emergencies, when patients have no ability to choose their provider.

The law prohibits balance billing for all emergency services, requires insurers to treat emergency care as in-network regardless of physician contract status, and establishes a federal arbitration process for payment disputes *between insurers and providers*, keeping patients completely out of the middle.

This federal framework already provides comprehensive protection for every emergency patient in Vermont, making additional state-level regulation in S.190 unnecessary and duplicative.

To be clear:

Emergency patients cannot be balance-billed today—period.

Under the *No Surprises Act*:

- Emergency patients cannot receive out-of-network bills
- Emergency clinicians cannot balance-bill patients
- Patients always pay in-network cost sharing, no matter who is on-call

Vermont has its own version of the No Surprises Act with Act 137 of 2022. The state law covers all provisions of the federal No Surprises Act, except those relating to air ambulance providers.

These laws fully address the very issue S.190 is attempting to regulate.
There is no longer any risk of surprise bills in emergency care.

Thus, the bill's justification is based on a problem that has already been solved at the Federal and State levels.

4. Patient and physician choice will shrink under S.190

Independent groups allow physicians to choose practice environments that value:

- Community-based care
- Autonomy
- Collaborative governance
- Local quality improvement

If Vermont becomes inhospitable to independent practice models, these physicians will choose to work elsewhere—especially when neighboring states offer more favorable regulatory environments.

For patients, the loss of independent groups means:

- Less diversity of clinical expertise
- Less local involvement
- Less innovation
- Fewer options for hospitals seeking the right fit

Regulatory overreach reduces—not expands—patient choice and quality.

5. Oversight is appropriate, but S.190's approach is overly broad and counterproductive

Oversight, quality reporting, and financial transparency are important goals. However, S.190 attempts to achieve these aims through a framework that ultimately undermines the hospital system it seeks to protect.

The bill reclassifies independent, physician-led clinical groups in a way that does not recognize their specialized expertise or operational independence.

It folds their revenue into hospital budgets despite substantial evidence that these groups *lower* costs through efficient staffing and lean infrastructure.

And it attributes rising hospital expenses to contracted clinical services, even though the primary drivers of cost inflation are well-documented: workforce shortages, fixed overhead, capital requirements, and payer mix challenges—not the work of independent physician groups.

Moreover, EMBC performance data shows that independent groups significantly outperform national benchmarks:

- 30 minutes shorter median length of stay compared to industry averages.
- 50% fewer patients who leave without being seen (LWBS)—a metric directly tied to patient safety and hospital revenue preservation.

If Vermont's goal is improving throughput, reducing crowding, improving patient safety, and supporting hospital revenue, independent groups deliver those results today.

6. A better approach: regulate fairly while preserving independent practice

Vermont can achieve transparency and patient protection without dismantling a highly effective care delivery model. Alternatives include:

- Require disclosure of outsourced contracts—without folding independent group revenue into hospital budgets.

- Apply consistent financial assistance policies—without reclassifying independent physicians as hospital departments.
- Acknowledge federal surprise-billing protections and avoid duplicating regulation.
- Preserve the flexibility hospitals need to choose the staffing model that best fits their community.

Independent groups are not the problem—in many cases, they are the solution.

Conclusion

S.190 would unintentionally eliminate the very partners that Vermont hospitals rely on for 24/7 emergency coverage, quality performance, and cost-effective staffing—all while attempting to fix a billing issue that federal law already resolved.

The consequences would be:

- Fewer physicians choosing to practice in Vermont
- Fewer staffing options for hospitals
- Fewer choices for patients
- Higher long-term system costs

Independent, physician-led groups consistently outperform national benchmarks, maintain strong community ties, and offer financially sustainable staffing solutions. Vermont should protect—not undermine—this vital resource.

I respectfully urge the Committee to reconsider or substantially revise S.190.
Thank you for the opportunity to testify. I am happy to answer any questions.