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Colorado Hospital Association

UPDATED 4/8 with Proposed Amendments for Committee 4/13

Included in this document is the text of our original letter to sponsors outlining CHA's chief concerns, as well as suggested amendments (in blue, starting p. 2) in anticipation of the bills Hearing in House Health Insurance & Environment on Weds. 4/13.

ORIGINAL 3/30 LETTER TO SPONSORS:

Thank you for meeting with us recently on HB 22-1285, Prohibit Collection Hospital Not Disclosing Prices. CHA has a standing position in support of meaningful transparency for consumers, and we appreciate your desire to ensure hospitals are compliant with current federal transparency laws. At a threshold level:

- **Colorado hospitals acknowledge their obligations under the law and are actively working to ensure and maintain compliance.** While results of nongovernmental compliance analyses differ (and for good reason) Colorado hospitals are diligently working to comply with the federal law. CHA's own member survey found that a vast majority of Colorado hospitals are compliant, and small and rural facilities with fewer resources have struggled most to come into compliance. All hospitals also reported significant barriers to implementation since the law took effect, including:
  - Understanding requirements of the federal law,
  - Limited resources to implement or invest in technology, and
  - Matching federal requirements with existing state requirements.

- **Now in full effect, federal penalties are sufficient to ensure compliance and additional penalties are unnecessary.** Federal penalties for noncompliance with 45 CFR 180 are significant, reaching up to $2 million annually for mid-size and large hospitals. For context, imposition of full federal penalties across Colorado's largest health systems would result in penalties exceeding $20 million per system per year – a clear deterrent to noncompliance.

  In addition to civil monetary penalties (CMPs), the federal Centers for Medicare and Medicaid Services (CMS) may investigate noncompliance complaints, provide a written warning/notice of violation, require corrective action plans (CAPs) for material violations, monitor compliance with a CAP, impose CMPs for failure to submit/adhere to CAPs, and publicize CMPs.

  Further, as part of its health facility licensing, survey, and certification authorities, the Colorado Department of Public Health and Environment (CDPHE) currently has the authority to investigate and impose penalties for noncompliance with applicable state and federal law.

Below are our concerns with the bill as introduced. Collectively, these provisions will encourage frivolous legal claims against hospitals that will result in costly litigation and **increase health care costs** without improving transparency for consumers. They will also disproportionately impact small and rural facilities who have identified resources and other challenges impacting their ability to fully comply. In the spirit of being productive and collaborative, CHA requests consideration of the following clarifications and amendments to address our key concerns.

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CHA Guiding Principles

- Any penalties must be proportionate to the level of noncompliance and sufficiently tailored to promote compliance.
- Since compliance with the law for the benefit of consumers is the ultimate goal, hospitals should be given the opportunity to demonstrate compliance in lieu of penalties.

Associated Problems & Solutions

1. **The bill fails to specify any threshold for noncompliance that will trigger liability, such that even technical and immaterial violations will result in considerable penalties.**
    - **Clarify specific standards and definitions for what constitutes noncompliance.**
    - **Protect good faith efforts to comply:** Specify that only substantial and intentional violations may trigger liability, and better define noncompliance.
    - **Include an opportunity to cure:** Provide a reasonable time after a hospital is notified by CMS that a violation has been identified to come into compliance before facing penalties.

2. **The bill fails to identify an entity or standard by which compliance should be assessed.**
    - **Specify that only CMS can determine noncompliance with certainty:** As the enforcement entity under federal law, CMS has the authority and resources to sufficiently interpret compliance. State penalties should only be triggered if federal penalties have been imposed, as the federal enforcement scheme should be determinative.

Suggested Resolution 4/8:

Provide additional guidance for judicial review consistent with CMS enforcement authority.

Insert (p. 6, l. 7):

> For purposes of this section, a hospital shall be considered not in compliance if:
> a) The Centers for Medicare and Medicaid Services has found a hospital to be out of compliance, mandated a Corrective Action Plan, and has provided written notice to the hospital that they are noncompliant with such a plan or issued Civil Monetary Penalties, unless subsequent to the issuance of a written notice of noncompliance with a Corrective Action Plan or issuance of Civil Monetary penalties the hospital has cured the breach and attests to that fact; or
> b) The hospital is found by a court of competent jurisdiction, after considering compliance standards regarding hospital price transparency laws issued by the Centers for Medicare and Medicaid Services, to be substantially and materially out of compliance with hospital price transparency laws such that the patient-plaintiff could not access information relevant to their care and the hospital's noncompliance is found to be intentional or the result of bad faith.

These changes address our concerns about CMS being the sole arbiter of determining noncompliance, and address concerns raised by Rep. Neville (and subsequently by the Attorney General's office in discussions with CHA) that under the current bill language, it is unclear which entities can determine compliance and under what standards or conditions. Among the AGO's concerns was that under FDCPA and the current bill language, collections agencies would be held strictly liable based on their determination of a hospital's strict compliance with federal law, an evaluation for which neither the AGO nor collections agencies (nor anyone other than CMS, from our perspective) is qualified.

3. **The bill fails to draw a clear line between commonplace billing practices and "collection actions."**
    - "Collection Action" is defined broadly ("attempting to collect a debt," p. 4, l. 26) and includes basic billing practices, such that under the definition, hospitals would be prohibited from even billing for patient care provided – potentially in violation of other laws/contracts specifying billing timelines. However, in the bill, billing is also expressly permitted (p. 6, l. 20-22), resulting in an unclear definition of "collection action."
    - Similarly, the bill seems to incorporate hospital "collection actions" into the Fair Debt Collection Practices Act (FDCPA, C.R.S. 5-16-101, et seq.). However, the FDCPA does not cover efforts of a service provider to collect its own debts, so its application to hospitals in this context is also unclear.
    - **Increase the threshold of prohibited activity.** We request clarification specifying a significantly higher threshold than "attempting to collect a debt" for activities considered "collection actions" if they are to be prohibited and subject to penalties.

Suggested Resolution 4/8:

Further clarify the definition of "collection action" to distinguish impermissible activity from routine billing:

> Page 4, l. 21: Change "collection action" to "extraordinary collection actions" and include modifications to clarify that extraordinary collection actions only apply to ***defaulted*** debt, such that 25-3-802(1) and (1)(a) reads as follows, and include conforming amendments throughout the bill.[1]
>
> (1) "Extraordinary collection actions" means any of the following actions taken with respect to a debt for items and services that were purchased from or provided to a patient by a hospital on a date during which the hospital was not substantially and materially in compliance with hospital price transparency laws:
>
> (a) Attempting to collect a defaulted debt from a patient or patient guarantor, whether by the hospital, an independent billing office, a debt collector as defined in section 5-16-103(9), or a collection agency as defined in section 5-16-103(3)

These changes are essential because **federal law requires hospitals to pursue routine collection activity.** Under 42 C.F.R. 413.89(e)(i)(A), collection efforts for Medicare patients must (1) be similar to the collection effort for comparable amounts from non-Medicare patients, (2) involve issuance of a bill, and (3) include other action such as subsequent billings, collection letters, and telephone calls, emails, text messages, or personal contacts with the party.

[1] Changing "collection action" into "extraordinary collection actions": Bill title (non-essential); bill summary; p. 4, l. 11, 15, 21; p. 6, l 25;

Additionally, the bill should further specify which debt collection practices are not permitted while a specific claim of noncompliance is being adjudicated.

> Page 5, l. 27, strike (1) and replace with:
> "The hospital, an independent billing office, a debt collector as defined in section 5-16-103(9), or a collection agency as defined in section 5-16-103(3) shall not, **while a valid claim by a patient-plaintiff against the hospital for failure to comply with hospital price transparency laws is pending in a court of competent jurisdiction:**
> (a) pursue debt collection against the patient-plaintiff,
> (b) sue the patient-plaintiff for debt owed, or enforce an arbitration or mediation clause in any hospital documents including contracts, agreements, statements or bills; or
> (c) directly or indirectly cause a report to be made to a consumer reporting agency regarding the patient-plaintiff's debt, as defined in section 5-16-103(6)

With this change, the patient/plaintiff would have to demonstrate by a preponderance of evidence that on the date they received their hospital services, the hospital was noncompliant with the federal hospital price transparency laws.

4. **The bill allows for <u>five separate penalties</u> regardless of the level of noncompliance:**
    - Hospitals must cease all forms of debt collection during the noncompliance period (p. 6, l. 1-6),
    - Hospitals must refund any payments made (p. 6, l. 10),
    - Hospitals must pay an additional penalty on top of the refund (p. 6, l. 11),
    - Hospitals risk their health facility license or certification (p. 7, l. 8-13), and
    - Hospitals appear to face additional penalties under the Fair Debt Collection Practices Act, including actual damages, costs, attorney fees, and civil penalties up to $1,000 (or $500,000 for class actions) (p. 7, l. 1-5).
    - **Specify who may recover punitive damages.** In order to rationally tie penalties to an actual injury, only individuals who attempted to shop for specific hospital services and were thwarted by hospital noncompliance should be eligible to file a claim.
    - **Reduce potential penalties.** The five separate penalties outlined above are excessive, and sit on top of considerable federal penalties. State penalties should only be triggered if federal penalties have been imposed, as the federal enforcement scheme should be determinative.
        - Further, the following penalty language conflicts and should be clarified: Noncompliant hospitals "shall refund the payer... and shall pay a penalty to the patient or patient guarantor in an amount equal to the total amount of the debt" (p. 6, l. 10-12), except that "nothing in this part...requires a hospital to refund any payment made to the hospital for items or services provided" (p. 6, l. 23-25).

Suggested Resolution 4/8: Ensure penalties are proportionate to noncompliance.

Strike p. 6, l. 10-18 and p. 7, l. 8-13 and replace with:

p. 6, l. 7: (2)...

(a) Shall not be entitled to recoup payment for services provided to the patient-plaintiff and

(b) May be liable for additional penalties determined by the court in proportion to the violation which shall not exceed:

(i) Dismissing any pending court action with prejudice

(ii) Ordering the payment of attorney fees and costs

(iii) Removing from the patient-plaintiff's credit report relating to the debt

(iv) Filing a formal complaint with the Centers for Medicare and Medicaid Services regarding the noncompliance.

(3) A hospital-defendant that is found by the court to be substantially and materially compliant with the hospital price transparency laws is entitled to recoup attorney fees and costs and the greater of the following for health care services provided:

(i) Amount posted pursuant to the health care price transparency laws

(ii) The median in-network rate, as defined for the purposes of 10-16-107, C.R.S.

(iii) Negotiated rate for the patient-plaintiff

Other Requested Amendments:

1. Add definition: "Patient-plaintiff" means a patient who received health care services from a hospital and subsequently files an action against the hospital pursuant to this section, or that individual's guarantor or other financially responsible party.

2. Legislative declaration changes
   - Page 4, l. 4, remove reference to "and other state laws governing health-care price transparency" as irrelevant and unsubstantiated.
   - Page 3, l. 27 – p. 4, l. 1, strike "health-care prices in Colorado are among the highest in the nation." This lacks context and is not fully accurate. While we acknowledge that health care affordability continues to be a challenge, Colorado performs at or below the national average on a number of measures of health care cost. Several examples:
     - ***Colorado ranks 5th best*** of all US states in addressing affordability to curb excess healthcare prices, reducing low-value care; extending affordable coverage to all residents; and making out-of-pocket costs affordable from Altarum's Healthcare Affordability State Policy Scorecard.
     - In 2020, Coloradans had access to the ***6th lowest individual ACA premiums in the US*** resulting in an average of $1,260 less per year for Coloradans to spend on individual healthcare insurance.
     - ***Coloradans spend less on premium and deductible costs*** as a percentage of income than most states. Using US median household income of $67,521, that equates to each household spending $877 less per year on healthcare than the average US household.
     - ***Coloradans spend a lower share of personal expenditures*** on healthcare (14.9%) comparted to the that the US average (16.9%) or an average of $940 more to spend on other items instead of healthcare.
     - While recent reports (2018) have indicated that the average price of hospital services in Colorado is higher than most states in the US, in the context of higher inflation costs, population growth, and case mix, ***Colorado hospital costs are in line with national averages.***
     - Trends in hospital costs are improving: ***Colorado ranks 9th best*** in the U.S. in the year-over-year increase in expenses per adjusted discharges (a reflection of expense trends).
   - To balance out level of hospital criticism in the legislative declaration, suggest adding:
     - Colorado's health care delivery system is ranked among the best in the nation in comprehensive national reports on access, quality, and cost;
     - Hospitals are a critical resource to Colorado communities, providing life-saving care to millions each year;
     - To ensure sustainability, it is essential that health care providers receive adequate compensation for the care they provide
     - All parties benefit when consumers are provided sufficient information to make informed decisions about their medical care;

3. Remove Section 3 (p. 7, l. 6-13), as it is redundant with existing law. CCR 2.11.1(A) states "The Department [CDPHE] may deny an application for an initial or renewal license for reasons including but not limited to, the following:...(1) The applicant has not fully complied with all local, state, and federal laws and regulations applicable to that license category or classification..."