Chair Monnes Anderson,
I just wanted to include this additional testimony for carried over session for SB 419.

Should this bill lead to a task force, I hope that the mission of this task force will address waste that occurs in hospitals.

What Hospitals Waste," by Marshall Allen, ProPublica, March 9, 2017.
Ten years ago, McLellan, a registered nurse, shocked to see what hospitals were tossing out, began asking them to give her their castoffs instead. In 2009 she launched Partners for World Health, a nonprofit that now has four warehouses throughout Maine... In 2012 the National Academy of Medicine estimated the U.S. health care system squandered $765 billion a year, more than the entire budget of the Defense Department. Dr. Mark Smith, who chaired the committee that authored the report, said the waste is "crowding out" spending on critical infrastructure needs, like better roads and public transportation. The annual waste, the report estimated, could have paid for the insurance coverage of 150 million American workers — both the employer and employee contributions... McLellan estimates the goods her group has right now are worth $20 million. Sure, that's a rounding error in the overall waste tab, but it starts being real money if you add up the discards of all the nation's medical facilities... Health care finance experts say while patients might not see the cost in their bills, the wasted supplies boost a hospital's overhead, which in turn makes everyone's costs higher... **Slabach said more than 600 rural hospitals are so strapped financially they risk closure and according to the data, some may be uncomfortably similar to facilities in Algeria and Bangladesh. Wealthier hospitals' waste could help them stay afloat.**

Kris Alman

On Thu, Mar 9, 2017 at 9:43 AM, kris alman <kris.alman@gmail.com> wrote:
Chair Monnes Anderson and members of the Senate Health Care Committee,

Two years ago, Senator Beyer sponsored SB 665. This committee held a hearing for that bill but it died in committee—without having had a work session. That was wrong. It's time to make amends. **This year, support your colleague and make SB 419 law.**

On the day in 2015 this committee held the hearing for SB 665, you also heard SB 900.[1] SB 900 became law. This law does nothing to curb the price of health care or to give patients any "consumer friendly" information to allow them to be better "consumers" in this so-called marketplace. That's how big business stakeholders are mollified.

What about individual stakeholders, who are digging more into their pocket even when they are insured? “Surprise bills” are a trick of the trade. Big players in the healthcare industry hoard and leverage pricing data as trade secrets, lobbying to maintain profits over people. Insurance companies create "psychotic complexity,”[2] cruelly shifting costs to patients with surprise medical bills.

In mid-February this year, the House Health Care Committee held a hearing to address “surprise bills.” HB 2339 would prohibit health care providers or participating health care facilities from balance billing a patient. As I pointed out in testimony[3] on HB 2339, Oregon’s APAC may be able to provide “statistically credible information” about “customary” prices, but what is a “reasonable” when what-the-market-will-bear prices prevail?

Oregon neither sets rates for all payers nor imposes healthcare spending caps in hospitals. Q-Corp boasts a first-in-nation regional cost comparison.[4] Oregon ranked highest when it came to the overall *price* index in the 5 regions studied.

TABLE 3: COMPONENTS OF MEDICAL COST COMMERCIAL POPULATION 2014 COMBINED ATTRIBUTED AND UNATTRIBUTED

Measure	HEALTH INSIGHT Utah	MHCC Maryland	MHI St. Louis, MO	MNCM Minnesota	Q CORP Oregon
TCI					
Overall	1.07	0.86	0.89	1.13	1.09
Inpatient	1.45	0.62	0.82	1.12	1.08
Outpatient	1.15	0.67	0.97	1.09	1.17
Professional	0.94	0.90	0.76	1.26	1.16
Pharmacy	0.91	1.16	1.09	0.95	0.86
RUI					
Overall	1.08	0.88	1.08	1.05	0.93
Inpatient	1.57	0.63	1.03	1.01	0.85
Outpatient	1.21	0.52	1.25	1.07	0.99
Professional	0.93	1.05	0.96	1.07	0.97
Pharmacy	0.93	1.14	0.96	1.06	0.88
PRICE INDEX					
Overall	0.99	0.97	0.82	1.08	1.17
Inpatient	0.93	0.98	0.79	1.11	1.27
Outpatient	0.95	1.28	0.77	1.02	1.18
Professional	1.01	0.86	0.79	1.18	1.19
Pharmacy	0.98	1.02	1.13	0.89	0.98
MEDICAL COST BALANCE*					
Inpatient	26%	16%	19%	19%	18%
Outpatient	32%	27%	36%	29%	32%
Professional	42%	58%	45%	53%	50%

* Pharmacy data not applicable

Comparison data included that from the Maryland Health Care Commission (MHCC), in partnership with The Hilltop Institute. The report pointed out the following:

> *The low proportion of cost in facility claims for MHCC may be related to Maryland's longstanding efforts to regulate hospital payments, including global budgets for inpatient and outpatient revenues introduced in 2014. MHCC's low TCI (0.86) suggests that this approach may be associated with lower healthcare costs overall, an important finding which merits further investigation.*

Since 1977, the Maryland Health Services Cost Review Commission has set rates for all payers, from commercial insurers to Medicare and Medicaid. Now Maryland holds all hospitals to a growth rate of 3.58 percent, the state's per-capita rate of economic growth.[5]

The Governor's budget depends on bending the healthcare cost curve.

- Bending the Cost Curve – The Governor's Budget continues to build upon the coordinated care model and applies it to all major health care purchasing. The budget continues caps on annual health care spending for PEBB and OEBB at 3.4 percent per member. The budget also reflects flat inflationary expenses for CCOs starting in January 2018 and reduces the administrative allowance included in CCO rates, in reflection of shared responsibility across the health system to operate within a sustainable budget.

Bending the cost curve of public sector health care pricing cannot be accomplished if the commercial sector continues to extort employers (especially small businesses) and individuals.

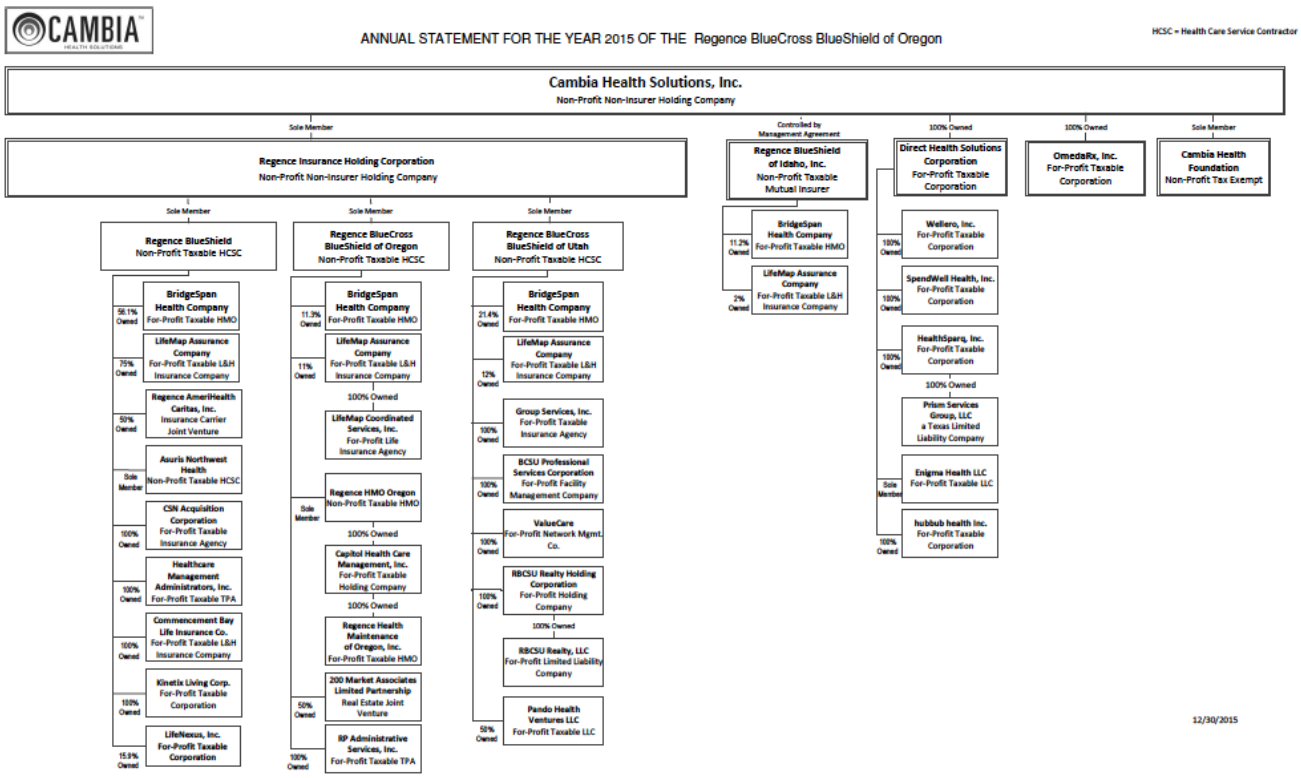
Cambia Health Solutions, Inc., the parent company of Regence BCBSO, is headquartered in Portland. Through subsidiaries in Oregon, Idaho, Utah and Washington, they sell health insurance as a member of the BlueCross BlueShield Association. Both Regence and Cambia are registered at the Secretary of State as nonprofits. Cambia is no ordinary nonprofit. Under Section 1012(b) of the Tax Reform Act of 1986 (TRA), a Blue Cross or Blue Shield organization is taxed as a stock insurance company, but is allowed a special federal tax deduction under section 833(a)(2) as a 501(m) "nonprofit." As such, Regence has no limits on lobbying or political contributions. National Association of Insurance Commissioners (NAIC) reports since 2010 show Regence BCBSO has paid cash distributions totaling $207 Million to Cambia Health Solutions Inc. What happens to those distributions? One cannot figure that out in reading through these reports.

A NAIC report (ending December 31, 2015), shows that Regence BCBSO does not pay Oregon income tax.

> Though Regence BlueCross BlueShield of Oregon is a nonprofit company, it is not exempt from paying taxes. As a taxable 501(m) nonprofit company, Regence BlueCross BlueShield of Oregon pays taxes and fees in the form of premium taxes, Affordable Health Care Act (ACA) fees, Oregon reinsurance pool assessments and federal income taxes.

It's shocking that, in the rate setting process, the Insurance Division does not address excessive surpluses as a cost driver of healthcare. The medical loss ratio has been a very imperfect tool for keeping rate increases in check. "Nonprofit" Regence BlueCross BlueShield has amassed huge surpluses—over five times industry requirements as of Dec. 31, 2014.[6] Year after year Regence BlueCross BlueShield of Oregon (BCBSO) earns profits—this year being no exception.[7] It was the *only* major Oregon insurance company to post a profit in 2015.

BridgeSpan is the only insurance product Cambia Health Solutions Inc. sold on the federally subsidized exchange. A for-profit HMO, BridgeSpan is partially owned by all 4 "nonprofit" state subsidiaries: Washington (56.1%), Oregon (11.3%), Utah (21.4%) and Idaho (11.2%). The Obamacare "marketplace" was doomed from the start.



The legislature should require insurance companies with a robust surplus to stabilize rates, provide community benefits, or invest in quality improvement or cost containment initiatives.

Big business stakeholders put profits over people. “Your money or your life” is not acceptable. Please support SB 419.

Respectfully,
Kris Alman MD

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[1] https://olis.leg.state.or.us/liz/2015R1/Downloads/MeasureDocument/SB900

[2] https://theweek.com/articles/666799/how-american-health-care-kills-people

[3]https://olis.leg.state.or.us/liz/2017R1/Downloads/CommitteeMeetingDocument/97572

[4] http://www.qcorp.org/sites/qcorp/files/RWJ_TCOC_PhaseII_BenchmarkBrief_Nov30_final_Web%20%281%29.pdf

[5] http://www.governing.com/topics/health-human-services/Maryland-Becomes-First-State-to-Cap-Hospital-Spending-.html

[6] https://consumersunion.org/wp-content/uploads/2016/05/consumers_union-nonprofit_insurer_surplus_update_report-2015_06.pdf

[7] http://www.bizjournals.com/portland/news/2017/03/02/heres-which-oregon-insurers-lost-moneyor-gained-in.html Regence BlueCross BlueShield of Oregon had net income of $30 million, up from $26 million the previous year, with underwriting gains $29 million.