

Legislative History for Connecticut Act

PA 14-145

HB5337

House	1760-1773	14
Senate	3456, 3474, 3480-3481	4
General Law	511-539, 542-549, 677- <u>693, 729-750, 767</u>	77
		95

H – 1186

**CONNECTICUT
GENERAL ASSEMBLY
HOUSE**

**PROCEEDINGS
2014**

**VOL.57
PART 6
1681 – 2023**

law/gbr
HOUSE OF REPRESENTATIVES

80
April 23, 2014

DEPUTY SPEAKER ORANGE:

Have all members voted? Have all members voted?
If all the members have voted please check the board
to determine if your vote has been properly cast. If
so the machine will be locked and the Clerk will take
a tally. And will the Clerk please announce the tally

THE CLERK:

House Bill 5380.	
Total Number Voting	145
Necessary for Passage	73
Those voting Yea	145
Those voting Nay	0
Those absent and not voting	5

DEPUTY SPEAKER ORANGE:

The bill passes. Will the Clerk please call
Calendar Number 177.

THE CLERK:

On page 43, Calendar -- House Calendar 177,
favorable report of the joint standing committee on
public health, substitute for House Bill 5337, AN ACT
CONCERNING FEES CHARGED FOR SERVICES PROVIDED AT
HOSPITAL BASED FACILITIES.

DEPUTY SPEAKER ORANGE:

Representative Baram.

REP. BARAM (15th):

Thank you, Madam Speaker. I move for acceptance of the joint committee's favorable report and passage of the bill.

DEPUTY SPEAKER ORANGE:

The question before the Chamber is acceptance of the joint committee's favorable report and passage of the bill. Representative David Baram.

REP. BARAM (15th):

Thank you, Madam Speaker. This is a major consumer bill for medical services that was negotiated by the Attorney General's Office with all stakeholders. It's an attempt to provide transparency and notice to consumers at a time when the medical industry is changing its landscape where hospitals are purchasing small doctor practices and other affiliated services like radiology services and lab services.

The attempt is to keep track of what is happening in the marketplace to allow consumers to select whether they want to go to a hospital based facility that charges a facility fee or go to another kind of medical service provider. It also allows the consumer to get an estimate of their fees and determine whether

-- what their liability will be as whether their insurer will cover it.

The notice that's provided is based upon uniform national coding selections and in an instance where there is what is called a CPTEM code that is either on or off a hospital medical facility the notice that has to be provided to the consumer is one where it indicates whether there is a separate facility fee that is separate from the professional fee and that is related to the operational expenses only of the hospital.

They have to give an estimate of what that fee would be. If the professional services are being performed by an affiliated provider what an estimate of the professional services would be, an explanation that the charges may be more at a hospital based facility than a nonhospital based facility and an explanation that they should contact their insurer to determine what charges will be covered.

In the second form of coding which is called CPT and this is where services are usually not provided directly to the patient such as a laboratory or a radiologist where they're just evaluating the medical services. There is no EM code and in that case for

off campus services only they would provide the same notice except there is no notice of the amount being charged because it is not in the coding practice.

All notices must be provided to a consumer where your appointment is ten or more days by mail or if it's less than ten days they have to give you the notice upon your arrival for your service. And in an emergency case they would give it to you as soon as reasonably possible or to your representative. There are some exemptions to this bill like Medicare which has its own rules and Medicaid and worker's comp where facility fees are not charged or paid for by the consumer.

There also has to be signage in all facilities that are hospital based indicating whether they are affiliated with a hospital base or healthcare system and there may be a charge and that they should consult their insurer. And also in all marketing materials the same notice has to be provided and the notice has to be provided to insurance companies so the insurance companies will now be aware whether a medical facility is part of a hospital based facility.

Madam Speaker, this bill passed unanimously with the general law committee and the public health

law/gbr
HOUSE OF REPRESENTATIVES

84
April 23, 2014

committee. It's affective October 1, 2014. There is no fiscal note. This is a great bill for consumers who need medical services. I want to thank the Attorney General's Office for their hard work and I would urge my colleagues to pass this great consumer protection bill.

DEPUTY SPEAKER ORANGE:

Thank you, Representative Baram. Will you care to remark further? Representative Dan Carter.

REP. CARTER (2nd):

Thank you very much, Madam Speaker. One question to -- or a few questions through you to the proponent of the bill please.

DEPUTY SPEAKER ORANGE:

Please proceed, Sir.

REP. CARTER (2nd):

Thank you. Through you, Madam Speaker, there was some talk about the facility fees in that they were different than some of the private practices. I know there was some talk about the way that Medicare billed as a result -- or the reason we had these facility fees.

Through you, Madam Speaker, if I go to a practice that was purchased by a hospital and it was a regular

law/gbr
HOUSE OF REPRESENTATIVES

85
April 23, 2014

doctor's office is it my understand that this now --
this facility is a separate fee that's put out on top
of what their normal fee would be? Through you, Madam
Speaker.

DEPUTY SPEAKER ORANGE:

Representative Baram.

REP. BARAM (15th):

Through you, Madam Speaker, if a practice was
purchased by a hospital based system or health system
and they did charge a facility fee they have to give
notice to the consumer patient. It's not necessarily
presumed that they will charge a facility fee but if
they do that notice has to be given to the consumer.

DEPUTY SPEAKER ORANGE:

Representative Carter.

REP. CARTER (2nd):

And through you, Madam Speaker, why is it now
then some of these places that are purchased by
hospitals are even allowed to charge a separate
facility fee? Through you, Madam Speaker.

DEPUTY SPEAKER ORANGE:

Representative Baram.

REP. BARAM (15th):

Through you, Madam Speaker. The marketplace as I understand it is just forcing a consolidation of medical practices and a lot of individual practices are affiliating with hospitals as part of their adjustment to the more competitive marketplace.

In terms of the facility fee, oftentimes hospitals do have facility fees but they're integrated in the patient bill so that if you're an inpatient you're not necessarily seeing a separate facility fee but as hospitals acquire more practices they are passing these facility fees on through those individual practices and they are issuing separate bills identified as a facility fee that the consumer has to pick up unless the insurer decides that it's a covered expense.

DEPUTY SPEAKER ORANGE:

Representative Carter.

REP. CARTER (2nd):

Thank you very much, Madam Speaker. And thank you to the good Chairman of general law. I've also heard that with the way Medicare is billed, Medicare mandates in some instances have hospitals separate out these fees. So if you go to a hospital owned doctor's office, if a patients going to show up there and all

law/gbr
HOUSE OF REPRESENTATIVES

87
April 23, 2014

of a sudden find out that they have two fees. They have the fee that they're paying the physician and then they're paying the facility fee. Again mandate is separated by Medicare but they'll also have two copays.

So I think everything I've read about this bill and I've heard about this bill in committee makes this sound like a really good bill. It's something that's going to protect consumers by notifying them when there's going to be a separate fee and then they're able to at least have an idea of they're going to have a separate copay or what that's going to cost to them. So I urge its passage by my colleagues. Thank you, Madam Speaker.

DEPUTY SPEAKER ORANGE:

Thank you, Sir. Will you care to remark further or was that a question to you, David?

REP. BARAM (15th):

I think that was not a question.

DEPUTY SPEAKER ORANGE:

Okay. Fine. Will you care to remark further on the bill before us? Representative Srinivasan of the 31st, you have the floor, Sir.

REP. SRINIVASAN (31st):

law/gbr
HOUSE OF REPRESENTATIVES

88
April 23, 2014

Thank you, Madam Speaker. Good afternoon, Madam Speaker. I too rise here in strong support of this bill. And to go into a facility expecting especially in a doctor's offices where you've been going there for years and have been getting one bill and now that the hospital -- the office has been acquired by the hospital and the parameters have changed but the patient is clueless, is absolutely unaware unless -- until I mean, not unless -- until he or she receives the bill in the mail and then surprised at what is this fee.

And so to inform them ahead of time is absolutely the right thing to do. And I too urge support from all my colleagues on both sides of the aisle. Through you, Madam Speaker, just one question to the proponent of the bill.

DEPUTY SPEAKER ORANGE:

Please proceed.

REP. SRINIVASAN (31st):

Thank you, Madam Speaker. Through you, Madam Speaker, when information is given to the patient that you will be charged a facility fee is that all that the information has to say or will there be an

law/gbr
HOUSE OF REPRESENTATIVES

89
April 23, 2014

indication as to what the amount will be? Through
you, Madam Speaker.

DEPUTY SPEAKER ORANGE:

Representative Baram.

REP. BARAM (15th):

Through you, Madam Speaker. If the billing code
is the CPTEM code they have to provide the amount of
the estimated facility fee and if the services are
provided by an affiliated provider they also have to
provide an estimate of the professional service fee.

DEPUTY SPEAKER ORANGE:

Representative Srinivasan.

REP. SRINIVASAN (31st):

Through you, Madam Speaker, so I understand it if
is a code that they are using it will be a standard
fee regardless of where the patient goes to. Through
you, Madam Speaker.

DEPUTY SPEAKER ORANGE:

Representative Baram.

REP. BARAM (15th):

Through you, Madam Speaker. Again the facility
fee would be determined by each individual hospital
based facility. There's no uniform fee that I've
heard of.

law/gbr
HOUSE OF REPRESENTATIVES

90
April 23, 2014

REP. SRINIVASAN (31st):

Okay.

REP. BARAM (15th):

And the professional fees by an affiliated provider could vary from hospital to hospital but if the EMT -- if the E -- EM code is used they have to provide an estimate of what that fee would be as well because the hospital is doing the billing for the medical provider at that point.

DEPUTY SPEAKER ORANGE:

Representative Srinivasan.

REP. SRINIVASAN (31st):

Through you, Madam Speaker, is it then the responsibility of the patient to see if their insurance will cover the facility fee also? Through you, Madam Speaker.

DEPUTY SPEAKER ORANGE:

Representative Baram.

REP. BARAM (15th):

Through you, Madam Speaker. One of the goals of this transparency bill is to allow the consumer time to determine whether their insurance company will in fact cover this and if not the consumer could then decide to go to a nonhospital based facility where

there is no facility fee and that's why we have the notice provisions if your appointment is scheduled ten or more days you have to receive it I think it's at least three days before your appointment.

DEPUTY SPEAKER ORANGE:

Representative Srinivasan.

REP. SRINIVASAN (31st):

Thank you, Madam Speaker. And I want to thank the good Chairman for his answers. And as I said earlier this is an extremely important piece of information that all patients should have going into getting their services. You know if they were going to -- to a new facility they may do the background check and check these things out but many of times as it happens here when practices are acquired the poor patient thinks they're going back to see the same doctor in the same environment and doesn't realize that there is component A and component B to the billing.

And for them not to be caught unawares and to be informed ahead of time is absolute transparency and I will definitely be supporting this bill. Thank you, Madam Speaker.

law/gbr
HOUSE OF REPRESENTATIVES

92
April 23, 2014

DEPUTY SPEAKER ORANGE:

Thank you, Sir. Will you care to remark further on the bill before us? Will you care to remark further on the bill before us? Will you care to remark? If not, staff and guests please come to the well of the House. Members take your seats. The machine will be opened.

THE CLERK:

The House of Representatives is voting by roll.

The House of Representatives is voting by roll. Will members please return to the Chamber immediately.

(Deputy Speaker Berger in the Chair.)

DEPUTY SPEAKER BERGER:

Have all the members voted? Will the members please check the board to determine if their vote is properly cast. If all the members have voted the machine will be locked and the Clerk will take a tally. Will the Clerk please announce the tally.

THE CLERK:

House Bill 5337.

law/gbr
HOUSE OF REPRESENTATIVES

93
April 23, 2014

Total Number Voting	146
Necessary for Passage	74
Those voting Yea	146
Those voting Nay	0
Those absent and not voting	4

DEPUTY SPEAKER BERGER:

The bill passes. Are there any announcements or points or privilege? Are there any announcements or introductions? Representative Hennessy.

REP. HENNESSY (127th):

Thank you, Mr. Speaker, for the purpose of an announcement.

DEPUTY SPEAKER BERGER:

Please proceed, Sir.

REP. HENNESSY (127th):

Thank you, Mr. Speaker. Mr. Speaker, as Chair of the veterans committee it is with great pride and pleasure that I would like to announce that today is the 106 anniversary of the Army Reserve. And the legislature has presented a citation --

DEPUTY SPEAKER BERGER:

Sir, could you hold for one minute please. Will the Chamber please turn the volume down. We have a

**S - 679
CONNECTICUT
GENERAL ASSEMBLY
SENATE**

**PROCEEDINGS
2014**

**VETO
SESSION**

**VOL. 57
PART 11
3246 – 3508**

pat/gbr
SENATE

271
May 7, 2014

SENATOR LOONEY:

Calendar 456, House Bill 5440, move to place on the
Consent Calendar.

THE CHAIR:

So ordered, sir.

SENATOR LOONEY:

Calendar 459, House Bill 5321, move to place on the
Consent Calendar.

THE CHAIR:

So ordered, sir.

SENATOR LOONEY:

And Calendar 461, House Bill 5140, move to place on
the Consent Calendar.

THE CHAIR:

So ordered, sir.

SENATOR LOONEY:

Thank you, Madam President. Moving to Calendar Page
16, Calendar 474, House Bill 5337, move to place on
the Consent Calendar.

THE CHAIR:

So ordered, sir. Senator, is there also on Page 15
that you might have missed.

SENATOR LOONEY:

The matter on Page 15 we have already voted, Madam
President.

THE CHAIR:

pat/gbr
SENATE

289
May 7, 2014

Calendar 334, House Bill 5339.

Calendar 336, House Bill 5056.

On Page 7, Calendar 345, House Bill 5443.

On Page 9, Calendar 417, House Bill 5410.

On Page 10, Calendar 420, House Bill 5258.

Calendar 421, House Bill 5263.

Calendar 424, House Bill 5439.

On Page 11, Calendar 429, House Bill 5581.

On Page 12, Calendar 445, House Bill 5418.

Calendar 438, House Bill 5336.

On Page 13, Calendar 453, House Bill 5133.

Calendar 446, House Bill 5150.

Calendar 452, House Bill 5531.

On Page 14, Calendar 457, House Bill 5516.

Calendar 455, House Bill 5325.

Calendar 456, House Bill 5440.

Calendar 459, House Bill 5321.

Calendar 461, House Bill 5140.

On Page 15, Calendar 468, House Bill 5450.

Calendar 465, House Bill 5341.

On Page 16, Calendar 474, House Bill 5337.

Calendar 469, 5538.

Calendar 473, House Bill 5328.

On Page 17, Calendar 496, House Bill 5115.

pat/gbr
SENATE

295
May 7, 2014

SENATOR LOONEY:

If we might pause for just a moment to verify a couple of additional items.

Madam President, to verify an additional item, I believe it was placed on the Consent Calendar and Calendar Page 30, on Calendar Page 30, Calendar 592, Substitute for House Bill 5476.

THE CHAIR:

It is, sir.

SENATOR LOONEY:

It is on? Okay. Thank you. Thank you, Madam President. If the Clerk would now, finally, Agenda Number 4, Madam President, Agenda Number 4 one additional item ask for suspension to place up on Agenda Number 4 and that is, ask for suspension to place on the Consent Calendar an item from Agenda Number 4.

THE CHAIR:

Seeing no objection, so ordered, sir.

SENATOR LOONEY:

Thank you, Madam President, and that item is Substitute House Bill Number 5566 from Senate Agenda Number 4.

Thank you, Madam President. If the Clerk would now, if we might call for a vote on the Consent Calendar.

THE CHAIR:

Mr. Clerk. Will you please call for a Roll Call Vote on the Consent Calendar. The machine will be opened.

THE CLERK:

An immediate Roll Call has been ordered in the Senate.

pat/gbr
SENATE

296
May 7, 2014

An immediate Roll Call on Consent Calendar Number 2 has been ordered in the Senate.

THE CHAIR:

If all members have voted, all members have voted, the machine will be closed. Mr. Clerk will you please call the tally.

THE CLERK:

Consent Calendar Number 2.

Total number voting	36
Necessary for adoption	19
Those voting Yea	36
Those voting Nay	0
Those absent and not voting	0

THE CHAIR:

The Consent Calendar passes. Senator Looney.

SENATOR LOONEY:

Thank you, Madam President. Two additional items to take up before the, our final vote on the implementer. If we might stand for just, for just a moment.

The first item to mark Go is, Calendar, to remove from the Consent Calendar, Calendar Page 22, Calendar 536, House Bill 5546. If that item might be marked Go.

And one additional item, Madam President, and that was from Calendar, or rather from Agenda Number 4, ask for suspension to take it up for purposes of marking it Go, that is House Bill, Substitute for House Bill 5417. Thank you, Madam President.

THE CHAIR:

Seeing no objection, so ordered, sir.

SENATOR LOONEY:

**JOINT
STANDING
COMMITTEE
HEARINGS**

**GENERAL
LAW
PART 2
506 – 1173**

2014

So, again, I appreciate people coming and that we will start -- so we start with the public officials. The first person we have signed up is our Attorney George Jepson -- Attorney General. Yes he is.

Good afternoon, Mr. Attorney General.

ATTORNEY GENERAL GEORGE JEPSON: Thank you, Senator.

It's my understanding that if we have to get out of here it's (inaudible) go first?

SENATOR DOYLE: Yeah. That's the rule, yes. You like that rule, right?

ATTORNEY GENERAL GEORGE JEPSON: Just checking.

I've been doing -- here with my special counsel, Bob Clark, from my office who has led the negotiations and discussions on this -- on this piece of legislation; House Bill Number 5337, which is AN ACT CONCERNING FEES CHARGED FOR SERVICES PROVIDED AT HOSPITAL-OWNED FACILITIES.

I'd like to start out by praising the Connecticut Hospital Association for their cooperation in -- in working through this legislation. We're not altogether on the same page, but we're a lot closer than one might have expected us to be three or four months ago.

And also especially like to thank Yale New Haven for their cooperation and working with Bob Clark on developing the bill that is before you.

Generally speaking, competition relies on transparency and consumer knowledge of the

costs and alternatives before them. This bill is about providing transparency into an area of commerce, a provision of medical services at hospitals and facilities, which is, I think, unfortunately, lacking under our current legal regime.

In 2009 changes were made in Connecticut's healthcare law so that have driven a great deal of integration and consolidation within the -- within the industry in ways in many respects positive, but in some respects need to be -- created issues that need to be addressed.

In particular, that legislation allows not-for-profit hospitals to acquire what have been independent physician groups and treat them essentially as employees of the hospital. This vertical integration has taken place at a very rapid pace and has, in fact, become the business model of a number of the hospitals in the state to grow through acquisition of these physician groups.

Yesterday I testified before the public health committee about one aspect of this consolidation and vertical integration which is the antitrust implications of this -- this rapid consolidation and -- and vertical integration. Today I am addressing legislation that deals with another aspect, an outcome that flows from this kind of vertical integration.

The result of being acquired -- of a previously independent physician group being acquired is that the hospital, in billing for the patient services, now can tack on what's called a facility fee in addition to the professional fee that -- that is being charged.

And we -- my office has received I think it's around 70 complaints about this where people --

patients go to the -- the doctor or the -- the dermatologist, the cardiologist that they've been seeing for years. They're accustomed to paying one professional fee. They show up for the next visit and they get their bill, and in addition to that professional fee, a facility fee has been charged on top of that to reflect in theory the cross-overhead to the hospital of -- of providing this -- this service.

We believe that if a -- if a patient learns of this facility fee when they show up let alone when they -- when they receive their bill, they're really not in a position to decide whether they want that service or do they want to shop elsewhere.

And the -- the thrust of this legislation we can get a little more into the details is to set the circumstances in -- of what a hospital must do to inform a consumer of what they can expect prior to the visit in terms of the professional fee and the -- and the facility fee.

And so I'll close my testimony with that.

SENATOR DOYLE: Thank you, Mr. Attorney General.

Any questions?

Senator Kissel.

SENATOR KISSEL: Thank you very much, Chairman Doyle.

Attorney General, it's great to see you again. Long time no see, Attorney Clark.

I've seen constructs similar to this. For example, past years when this committee's dealt with gas stations, you know, when we try to

sort of -- or try to disaggregate costs associated with the franchise from costs of gasoline and things like that, the answer always is that they're just going to then somehow build it into the overall single fee.

And so given that what these institutions are now doing is having sort of two fees, what is there to prevent them working out agreements, perhaps, with the provider themselves, to build these costs so that they -- they are somewhat masked in one charge?

ATTORNEY GENERAL GEORGE JEPSON: Bob should feel free to chime in on this one. It's an interesting question.

ROBERT CLARK: Yeah, and -- and to be clear, we're not through this legislation trying to prohibit anyone from -- from billing the way they currently do. In fact, they're permitted to do that under Medicare rules and that's really sort of what drives the manner in which they also bill under the private contracts with insurance carriers. And we -- we recognize that's a possibility.

The -- the purpose of this legislation, though, is to at least alert consumers to the fact that this particular practice is owned by or operated by a hospital in a way that permits them to charge two different bills. And the importance of that is not only that the consumer can then decide for him or herself whether they want to go visit a provider who isn't affiliated with a hospital and doesn't charge this other fee.

But the single bill, if -- if hospitals were, for whatever reason, able and willing to go from the -- the two-bill model that we're addressing here to a single-bill model, and --

and -- but the aggregate amount was the same, that would actually be better for consumers in many instances because right now, they're paying co-pays on both fees. So they're paying two co-pays and they may be reaching toward different rules on their deductibles under their policies.

One might be towards their hospital deductible and the other towards their physician deductible.

SENATOR KISSEL: Thank you very much. And I have just one follow-up, Mr. Chair.

Recently I went -- I -- I was referred to a -- a cardiologist and one of the things that took place was that as I arrived, they asked me to sign off that I would be responsible for any charges not covered by my insurance policy.

And so when I inquired further as to what this one -- essentially half hour to 45-minute visit, initial visit, would cost, the aggregate was \$900. And I said, can you give me a ballpark as to what my insurance would cover, and -- and they really couldn't.

So trying to be a good consumer and not feeling that their time was pressing, I said well, I really don't think it's fair for me to just sort of sign you a blank check up to \$900. Give me the -- the code so that I can circle back with my insurance provider and try to figure out what's covered, what's not and then perhaps shop around.

Which then -- the mindset of most folks with healthcare is we're not shoppers. We -- we just, you know, doctors are close to God and we entrust our lives in their hands and sometimes folks are on the hook for exorbitant fees. And

there's been any number of news accounts that depending on where you go, the same procedures can be dramatically different.

In the proposed legislation that you're advocating, what is the most important part that you believe that could help inform consumers to make informed decisions in seeking out healthcare treatments?

ATTORNEY GENERAL GEORGE JEPSON: That's a very good question and part of what the transition that needs to take place. I personally believe an - - an American in Connecticut is for consumers to become more cost conscious, especially in your higher and higher deductibles, about shopping for their -- their healthcare and take responsibility for that.

And this -- this legislation actually takes a big step in exactly that direction because the -- the hospital would be required in a case such as yours to provide that kind of information to you well in advance of your visit so you would have time to do that kind of comparison shopping should you so -- so desire.

Bob wants to add anything to that?

SENATOR KISSEL: That just leaves me to one last question. I'm sorry, Mr. Chair.

And as we embark on trying to shop for healthcare is there is a problem -- I sort of have this mindset. Maybe it's because of the way I was -- I just sort of grew in this country that you need that order or that directive from your primary care physician to - - to get the consultation from someone with more expertise depending on the field.

And I've always thought, and correct if I'm

wrong, that unless your primary care physician has the order to go consult; then your insurance wouldn't cover it.

And so my question is, typically the primary care physician says go see this practice or this practice as opposed to just go see a cardiologist. And am I wrong in that? Is the insurance constructs that we have now for medical care tied to what the primary care physician recommends as far as another physician or practice? Or is it just -- it -- it will be equally covered depending on what the procedures are that you're going -- you're referred to?

ATTORNEY GENERAL GEORGE JEPSON: Somebody can correct me if I'm wrong, but it -- it used to be the case that primary care physicians were used essentially as gatekeepers for -- for them to point you in a particular direction for -- for additional care and that is, as I understand that, really no longer the case.

SENATOR KISSEL: Thank you very much, Attorney General, Attorney Clark.

Thank you Mr. Chairman.

ROBERT CLARK: I would -- I would only add that it's -- it's really going to vary from plan to plan. I think as Attorney General Jepson noted, that used to be much more common that in order to get to a specialist you'd need to go see a primary care physician first. There may still be some plans where that's the case. I think it's less common now than it was under the old -- sort of the older HMO models that came out during the nineties.

But I don't think you are ever required to go see any particular physician as opposed to get

permission from your primary care provider to get a -- basically to see a specialist for a particular issue.

In fact, there are -- there are rules about whether or not doctors can steer referrals toward other providers under federal law that could, in some instances, prohibit that type of referral. But that's -- that's more than what this -- this bill is seeking to take on. This is what we think is really an important first step, albeit maybe even a small one toward a big, big, big issue in Connecticut on transparencies.

SENATOR KISSEL: Well, thank you very much. That -- that helps inform me that really we have to circle back and basically check what the terms of our own insurance policies are. Maybe the old style, maybe a new style, and for what it's worth for any of the physicians or any medical providers that I've been consulting recently, they all are fabulous in case they're watching on CT-N.

Thank you, Mr. Chair.

SENATOR DOYLE: Thank you.

Senator Witkos.

SENATOR WITKOS: Thank you, Mr. Chairman.

And good afternoon, gentlemen.

Because the world of health insurance is changing so rapidly, I got to kind of bring it back and dumb it down so I understand it a little bit better. Is this something that we're doing proactively or are we required to do it under, you know, federal legislation or state legislation that you're aware of?

ATTORNEY GENERAL GEORGE JEPSON: If I understand your question correctly, we would be requiring this -- actually the Connecticut Hospital Association to its credit became the first in the nation about six weeks ago or a month ago to take steps in -- in this direction of -- of notifying consumers in advance and they deserve credit for that.

But this is in reaction to the changes that have occurred since 2009 where the adoption of this statute that allows this kind of vertical integration take place.

SENATOR WITKOS: And -- and there's not necessarily an increased cost to the consumer. It's -- or there may be -- they're allowed to now charge a facility fee in addition to the professional fee or are we telling them if you itemize out the fees so the consumer can see which is which?

ATTORNEY GENERAL GEORGE JEPSON: As a practical matter, it almost certainly means an increased cost to consumers.

The typical case, we have one woman who complained to our office. She went to her regular dermatologist and the professional fee was normally like 345 or 390, something like that. And then she went -- after the group had been acquired without her knowledge by a hospital, and it was exactly the same professional fee but -- and a 175-dollar facility fee. There's an --

(Inaudible) I got this phone and I don't know how to use it. It talks to me when I don't know how I told it to talk to me.

ROBERT CLARK: I -- I think that was one of -- that

was one of the hospitals that doesn't like the bill.

SENATOR WITKOS: So how would this affect the -- are you aware of any costs associated -- I know there has been talk from the hospitals that they felt that they were cut from some state funding before.

Would this offset that state funding? Is this the impetus from why they are bringing this initiative forward to -- to be able to realize additional revenue streams?

ATTORNEY GENERAL GEORGE JEPSON: That's a question better asked to the -- the hospital (inaudible). We're not against facility fees per se. There -- there can be legitimate costs incurred by hospitals when they've acquired a physician group, for example, providing the information technology that's beyond the reach of many independent physicians.

So this is not a -- a blanket criticism of facility fees. This is geared at transparency so the consumers are better able to make choices about whether they want to seek the particular healthcare or where they would seek it.

SENATOR WITKOS: Well, I noticed in -- in my neck of the woods, they have -- there's a lot of hospital-sponsored clinics, wellness centers. And are those covered under this bill? I -- I thought I saw some language that says or any other area that has been caring on individual cases, case-by-case basis by the centers through part of a hospital's campus, so. You know where I'm going with the question?

ROBERT CLARK: Yeah, yeah. Whether -- whether someone's covered by this bill in terms of

having to require the notice that's -- there's two different types of notices that are described depending on the types of procedures and how they're coded for billing purposes.

But the short answer is the -- the entities that will be covered and required by this notice are the ones that meet the definitions under this bill for being hospital affiliated, providing outpatient treatment, and charging two separate fees, both professional fee and facility fee.

And there are a whole host of different relationships between hospitals and health systems and medical practices, some of which will meet that definition, others won't. What you've pointed out is that there's -- there's a definition in this -- in this bill that tries to set out the definition of what's an on-campus facility.

That has significance under a set of -- one of the sections of the bill that describes which types of facilities, whether they are on or off, are going to be covered by the notice requirement. But it -- it doesn't address whether or not they will, in fact, be charging a separate facility fee.

And, in fact, that's all going to be governed by the -- by the Medicare rules and by the -- by the rule -- by the -- by the terms of the contracts that exist between the providers and the -- and the private carriers.

SENATOR WITKOS: Do you know, have the providers and -- and the insurance carriers been involved in discussions before the legislation that's here today.

Because I'd hate to see a consumer, you know,

if most of them aren't going to cover a facility fee, I don't know if they're -- if they're required to or not, but the patient all of a sudden that normally they would get their bill and they look down what their co-pay is or what they have to pay out of pocket, it's one; now all of a sudden the insurance carriers aren't covering it, then they -- then they're paying more out of pocket. So I just want to know if they've been involved in the discussion?

ROBERT CLARK: Well, so -- so we've been involved in discussions with just about all of the major insurance carriers in the state; the hospital association, many of the larger hospitals and health systems, the medical society, a lot of patient groups.

But, again, this -- Kevin Lembo and Vicki Veltri bought some of the larger self-funded plans like UTC and Pitney Bowes, so we've really talked to just about every stakeholder that I can think of that would likely be affected by this.

But just to be clear, this legislation will have no impact on -- on which providers can charge facilities. It will have no impact on which insurance plans will cover and how much they'll cover. This is strictly about giving consumers as much notice as possible and as far in advance as possible that there is this possibility for this separate liability.

So that they then can act, as the Attorney General said, like educated consumers do generally just about every other competitive market in the state and in the country.

SENATOR WITKOS: Thank you.

Thank you, Mr. Chair.

SENATOR DOYLE: Thank you.

Representative Nicastro.

REP. NICASTRO: Thank you, Mr. Chairman.

My question was just answered by Senator -- asked by Senator Witkos. So I want to thank you for asking it.

I find it very unusual -- well, I could say this. Why couldn't we make the hospitals have some sort of notification to the patients that say, you know, when you come -- or the doctor, when you go here, you're being charged a fee for a hospital like we -- you say here in your testimony. Why couldn't we do that? Have it pasted right there like they have their calling hours and things like that?

ATTORNEY GENERAL GEORGE JEPSON: That's essentially what this bill does.

REP. NICASTRO: So we're saying we're going to do that?

ATTORNEY GENERAL GEORGE JEPSON: Yes, sir.

REP. NICASTRO: Okay. That's what I thought. I wanted to make sure.

Thank you, thank you, thank you.

SENATOR DOYLE: Thank you.

Representative Esposito.

REP. ESPOSITO: Thank you.

Thank you for coming this afternoon, Attorney

General.

As I read the bill, it seems more like more of the onus is being put on the consumer, the patient, rather than on the hospital as it was brought up by Senator Kissel earlier. If they were to combine the bill, it could potentially eliminate two co-pays or two different structures for settling out the bill.

And as I read some of your comments in here that the facility in question doesn't even have to be on the hospital, not even near the hospital. It could be in a different town. And I -- I think this is an expansion of -- of the hospital's role to say we want more money for -- for what we're doing, whether it was money that was cut from them.

And I think this is something that is drafting further that where it was intended to go, number one, and I think it's going to wind up costing the consumer more in the end run. And I -- I think we should look a lot closer at this bill and put stronger controls in that would require more oversight on -- on the part of the hospitals to not be charging a fee.

I'll use the hospital down by us, and I hope I never have to go to it in the near future, but if -- if you have Yale New Haven as a -- as a facility in North Branford and it's not even, you know, it's not really in the hospital, but yet they're going to charge a physician fee plus the facility fee. And if -- if I strictly went to a doctor's office and got the same procedure done as I do with my doctor now in West Haven, I pay his fee and I'm done.

But if he gets affiliated with the hospital could be an additional fee tacked on, and I don't know whether that's a good route for us

to be taking going forward.

Thank you.

ATTORNEY GENERAL GEORGE JEPSON: But that's -- that's the current law. The -- the current law allows that tacking on of a -- of a fee. So we're not -- we're not saying -- telling hospitals in this bill go charge people an extra fee. This is what is taking place right now. And this -- what this bill does is to bring transparency to that process so consumers can say, oh, I'm going to be charged a facility fee. It looks like it's going to be 175 bucks. I'll drive ten minutes further down the road to an independent physician so that I don't have to pay that.

REP. ESPOSITO: But it seems that they're expanding their facility fees to include any -- any doctor that is now going to be affiliated that's with the hospital. And I don't know, I mean, it might be current law, but it seems like they're expanding their -- their scope of what they can -- of where they can charge their fee.

ROBERT CLARK: Representative, this -- this bill doesn't -- it does not expand anyone's ability to bill any differently than they do today. Whatever -- whatever providers or hospital-based providers in this instance are permitted to bill is -- is a function of Medicare rules and private insurance contracts between payers and providers.

This bill simply says to the extent they are permitted to bill as a hospital-based provider and, therefore, charge a separate facility fee, they have to tell the consumer so the consumer can decide for him or herself whether I like this doctor, I'm willing to incur that extra

liability; or I don't, I'm going to shop around and look.

I should also point out that even your doctor, the one that's not affiliated with the hospital, you may only see and get a single bill with a single co-pay. That bill itself, as it turns out, is between the doc and -- and your insurer itemized as well. And there's a professional component to it and a technical component to it. It's just that for your purposes on your end and your co-pay liability and your deductible, you're only getting one bill.

And as -- as in reality, a hospital-based provider is generally going to be able to, both because of its overhead and its leverage in negotiations with insurers, get higher reimbursable rates which will be reflected not only in the facility fee, but in the separate professional fee. And, therefore, if you have a -- you have a deductible or a high deductible could -- could cost you more money in the long run.

REP. ESPOSITO: Can you, using your scenario of my doctor versus a hospital-based provider -- so if there's a hospital-based provider, then he won't be putting on a facility fee in addition to his professional fee and that the hospital alone will be charging a facility fee? Because if you're saying my doctor's (inaudible) and charging a facility fee --

ROBERT CLARK: No.

REP. ESPOSITO: -- will that be two facility fees being charged for the same procedure?

ROBERT CLARK: No, so --

REP. ESPOSITO: Okay.

ROBERT CLARK: -- no, no. So if -- if your doctor is not affiliated with the hospital, you will only get one bill, okay? If -- if your hospital -- if your doctor is affiliated in a way that -- that makes it a provider-based practice for purposes of Medicare or your private insurance contract, you're going to get two separate bills.

And that's not because of this legislation at all. As I said, that's a function of Medicare rules and -- and the insurance contracts between providers and payers. All -- all what the hospital association and whoever else, maybe the carriers to the extent they're here today, talk to you about what -- what ability the Legislature may or may not -- may or may not have to outright prohibit providers and payers from negotiating arrangements that result in two separate bills.

And there may have been attempts in other states to prohibit and regulate that and there may have been some legal challenges involved. This bill, though, doesn't go there. It doesn't expand who can charge what. It's really all about getting more notice to consumers so at least they're not caught off guard after the fact to the bill they should have seen coming.

SENATOR DOYLE: All set, Representative?

Representative Carter.

REP. CARTER: Thank you, Mr. Chairman.

And thank you, Mr. Attorney General, for being here today.

When -- when we're talking about these facility fees, this is strictly -- or I should say, to the best of your knowledge, is it only a hospital can charge a facility fee right now, or a health system connected with a hospital?

ROBERT CLARK: Well, it -- it -- no. If it's a -- if it's a -- if it's what's generally known under Medicare rules as a provider-based practice, hospital-based, hospital-affiliated practice, it -- it can -- it can whether it's on the campus of the hospital or off the campus of the hospital it generally can charge two different fees.

REP. CARTER: Right. Let me -- let me rephrase this because then it will -- it will make more sense. I'll -- I'll say it in more of a statement.

You know, I've known for a long time hospitals been able to do this. It's usually surrounded with procedures. For instance, I went for an MRI for my arm three weeks ago and I know they were going to charge me a separate hospital fee, because the MRI is in the hospital. And they did the same, or they may have done the same in the surgery center I went to because it was hospital owned.

Now that physician practices are being purchased by hospitals, I'm understanding the physician practices now are able to surcharge this fee and, of course, consumers are like, what the heck? What, another bill? It's extra, it doesn't make any sense.

So here's my question; we have a lot of large physician groups that are not coming under the hospital and they are very well connected. They're almost a health system of their own because they're multispecialty. Are they able

to charge a separate facility fee by law?

ROBERT CLARK: As far as I know, if they're not affiliated with a hospital and not considered a provider-based practice for the Medicare rules, they don't charge a separate fee.

That doesn't mean they can't negotiate what in the aggregate is a better rate or an equal rate to what the hospitals are getting bottom line in their pocket. But, yeah, no as far as what you'll see as a consumer unless they're provider-based, I don't think you're going to see anything other than a single charge in those instances.

REP. CARTER: Okay. I ask that because I want to make sure that the -- the bill sounds good. It sounds like it's a really great thing to notify consumers. I want to make sure that we're notifying all consumers you could be hit with a facility fee whether it's hospital-based or whether it's a large practice.

ROBERT CLARK: Okay. Okay, I -- I think this bill does that. There -- there may be some instances that are not covered, but certainly the one that you described is -- it's possible that some ambulatory surgical center -- so if you go see a surgeon who him or herself isn't affiliated with the surgical center but is using it, you may get a bill both from the facility and the surgeon.

But I think -- I think, generally, consumers are more used to see that than when they've been going to the same doctor repeatedly for years and only getting one bill and now suddenly get two, but.

REP. CARTER: And -- and don't forget the anesthesiologist and everybody else who will

21
dr/gbr GENERAL LAW COMMITTEE

March 6, 2014
1:00 P.M.

bill you.

ROBERT CLARK: Right.

REP. CARTER: Thank you very much for being here today and for your testimony.

Thank you, Mr. Chairman.

SENATOR DOYLE: Thank you.

Anybody else?

Representative Rovero.

REP. ROVERO: You know, I -- I'm learning a lot here today. I -- I was on a board of directors at a hospital and, unfortunately, I've used a lot of hospitals. But I think what you're telling me is I went to a primary care doctor prior, paid \$200 for a visit. Now I go to the same doctor, same office, the same everything, and I could be paying \$300 for that same visit because there is a 100-dollar facility fee added on.

If that is what is happening, I guess, the next time the hospital comes crying to me yelling about the Governor cut their funding, I shouldn't feel as bad as I do because they are making up it some other place. Am I correct in assuming that?

ATTORNEY GENERAL GEORGE JEPSON: I -- I'm not -- I'm not sure I would phrase it exactly that way, but I -- I think that's one way you could phrase it.

REP. ROVERO: Okay. Thank you very much.

Thank you much, Mr. Chairman.

SENATOR DOYLE: Thank you.

Representative Baram.

REP. BARAM: Thank you, Mr. Chairman.

And welcome, Mr. Attorney General, and Bob Clark.

A couple of questions. One is are there any payment agencies or -- or insurers that do not accept a facility fee like worker's comp, Medicare, Medicaid? Could you give us a rundown where by virtue of their rules or contracts it would be prohibited to charge such a -- such a fee?

ROBERT CLARK: I don't know other than -- I -- I don't think Medicaid pays facility fees. That's a whole separate reimbursement system. But, you know, I -- I'm not sure, I mean, other than Medicaid, I think all payers work off of the codes that are established by the centers for Medicare studies at CMS and the AMA.

I know Medicare, for instance, does pay facility fees. I'm not sure about worker's comp, but worker's comp is carved out of this bill in part because patients don't come out of pocket at all for worker's comp, so giving them notice to shop elsewhere is not a lot of incentive for them to do that.

Medicare does already have its own set of rules around facility fees which is why we also carve them out of this bill. We -- we don't want to get in a situation where someone might claim that, you know, that the law is preempted to be extended -- it's trying to regulate in an area that Medicare regulates it.

It's my suspicion, though, that it's going to be easier for providers to simply follow these

rules which go further than any of the other rules and -- and as long as they do that, they're going to be covered no matter which payer they're dealing with.

And -- and so finally -- and then finally I don't know whether there are any private payers who've negotiated under insurance plans with -- with providers to not pay the same way that Medicare does with -- you know, in terms of having two separate fees.

REP. BARAM: Thank you.

Another question in the proposed bill, there seems to be a distinction between a -- a healthcare facility and one that's located outside a certain distance that's off campus. And what I'm trying to understand is why is there a distinction? Does that have anything to do with billing procedures? Why couldn't the bill be simplified just to say, you know, if you're associated with a hospital whether you're on campus or 20 miles away, you all have to comply with the same rules?

ROBERT CLARK: Right. So, yeah, and I'm glad you -- you brought that up and we've -- we've -- I think tried to make a point in our testimony, and I know I've spoken with you and Senator Doyle and Attorney Hanratty from LCO about this.

So there are two separate buckets, I'll call them, with notices under the bill. The first is -- and it's not reflected in its language, but we're hoping the committee will vote it out with substitute language that will address this. Under 2a -- Section 2a of the bill, the notice that's provided, it is covered in an instance where the hospital-based provider is billing under what should say CPT/evaluation of

management code.

And in those instances, what's happening -- what Steve Frayne from the hospital association will talk more about this later because he really is sort of the guru on this stuff, and we've been lucky, frankly, to have cooperation. As I said, the Attorney General sent from the hospitals on a lot of this very technical -- a lot of the technical aspects of this.

But -- so, anyway, it -- it -- under 2a what -- what we're trying to capture is a provider who's utilizing an evaluation of management code which is a subset of a CPT code. Those are typically instances where a provider is actually seeing the patient and -- and performing a service on the patient while the patient is there.

And in those instances, there's going to be a facility fee whether it's on campus or off campus, the notice requirements that is described under 2a are triggered, okay?

Under 2b what we have is a different type of scenario. A CPT code is being utilized, at least that's what we're hoping the substitute language will say, but a CPT code is the subset, the evaluation of management subset of CPT code isn't being utilized. And -- and that is more often an instance where some service is being provided, but not at the same time the patient is there.

So it's some -- if -- if the doctor is looking at an x-ray and performing a professional service in interpreting an x-ray or a MRI or blood lab results, that's a whole different type of situation. It's -- it's very difficult for the facility at which that's happening to know in advance exactly what the fee's going to

be and be able to provide that kind of information to the consumer.

And it's in that instance that the notice is not only deluded so that at least really all that's required is that the -- when the patient -- that the patient be notified that there will, in fact, be two different fees as opposed to the actual liability for the patient for each fee, which is what's required under 2a, but it's also limited to off campus.

And I think the reason for that is that these services traditionally were performed on campus by hospitals when they were -- so when people go and get something done, whether it's radiology or lab work at -- at a hospital they're used to getting two different bills for this type of service. And so if even though it's -- so when it's on campus what we've negotiated with the hospitals is that the -- the notice trigger doesn't apply.

It's when those things are being provided off campus where they traditionally haven't been provided and where more often it's a case of there's been an acquisition, it's -- it's there where -- where the notice is going to be acquired.

But these -- these are -- these are less common, I think, than -- than the situations that we started out looking at when we got into this, which is it's the person who's been going to see the same doc for -- for many years and then shows up, everything looks the same, it's the same space, it's the same doctor, it's the same procedure they are used to getting done. And then after the fact they get the separate liability that they -- that they didn't expect.

But I think -- I tried to explain to this.

It's pretty technical, but I think Steve Frayne who is here today for the hospital association might -- might be able to do a better job than me in terms of explaining the difference between those two codes and the rationale from the hospital's perspective, which we were persuaded by (inaudible) great job, you know, relaying -- made sense to make a distinction between on and off campus, but only for that different type of situation.

REP. BARAM: It is, obviously, complicated and -- and I wish there was a way to simplify it and just condense everything. But certainly I guess we'll find out later on.

My last question is just a hypothetical because I'm trying to understand the difference. If I needed a medical service and I just went to the hospital directly for that service, would I still get a facility bill or would the facility bill be integrated in all their other charges so that it would be more likely that my insurance company would cover it?

Whereas if I go to a clinic off campus, get the same service, I'm likely to get a separate facility bill that there's a good likelihood my insurance company won't pay for?

So for the average consumer when they're shopping around, I mean, they can obviously, look for doctors who are not associated with hospitals, but is there an advantage for a consumer to go directly to the hospital, have the medical procedure performed there knowing that if there's any facility bill it's -- it's integrated with, you know, room and board, food, nursing, equipment, and all of that stuff that the insurance companies tend to pay as opposed to going to a clinic and just getting separate (inaudible)?

ROBERT CLARK: Yeah. I -- I think know where that's coming from and I've -- I've heard that argument made to me by some of the hospitals. I think what you're referring to is the possibility that by giving consumers more information that if they go off campus, they're going to get two bills that may drive some of them into -- really the only instance that I can think of where they might not get two on campus at a hospital and that's the emergency room.

And so hospitals have made the arguments to me that if we give consumers too much information they're going to go to the emergency room and at the emergency room they're not going to get hit with two separate bills. I don't know that that's terribly likely. I don't think people who have insurance like going to emergency rooms when they don't have to.

And let's face it, insurance, you know, people -- this is really going to incentivize people who have deductibles under their plans more so than people who are fortunate enough, like a lot of us who have the state plan who don't really have deductibles, and then -- so then -- and so incentive to shop.

But, you know, if someone has a high deductible plan, put aside whether they're going to get hit with two different co-pays, an emergency room visit is going to be very expensive and it's going to come out of their pocket because of -- because of their deductible.

And they're going to have a higher deductible typically to meet on the hospital side than -- than in the non-hospital setting. So I -- I get the argument. I -- I guess I'm not convinced, generally speaking, that it's better

to just keep consumers in the dark because if we give them too much information they're going to start doing things that policy-makers don't -- don't think are a great idea.

But I don't even buy it anyway, because I think in the end folks are going to end up coming out from their pocket for more if they go to an emergency room than if they don't.

REP. BARAM: But let's just say Representative Carter who needed an MRI, he went directly to the hospital for that MRI. Would he get a separate facility bill?

ROBERT CLARK: Yes.

REP. BARAM: He would? So -- so it's -- it's not true then --

ROBERT CLARK: Oh, right --

REP. BARAM: -- that the information that's -- that's been circulating that if you go to the hospital, you won't get this (inaudible) --

ROBERT CLARK: No. Yeah, no, I don't think that's right, no. No, I think in most instances you're going to get two separate bills when you go to the hospital. The emergency room may be a -- an anomaly, but for the reasons I've described, I'm not sure that that would be the rational choice for a lot of consumers.

REP. BARAM: Thank you very much and thank you both for your good work.

ATTORNEY GENERAL GEORGE JEPSON: Thank you.

ROBERT CLARK: Thank you.

SENATOR DOYLE: Thank you.

Any more questions?

Representative Carter. Sorry, Attorney General.

REP. CARTER: Just one quick question because it came up. We're talking about the MRI. I just want to make sure I understand this. If I had chosen to go to an MRI that was not owned by the hospital, they cannot legally charge me a facility fee because that's -- that's only -- this only facility fee is set up basically because of the Medicare rules that they're allowed to charge facility fees.

ROBERT CLARK: Yeah. You know, radiology is -- is tricky for the reasons we've already been talking about. And we actually define facility fee under this bill more broadly than Medicare does. So -- but if you were to go to an independent physician practice who wasn't owned by -- the practice wasn't owned by the -- the property wasn't owned by, and it was the physician that did the x-ray and did the interpretation, I -- I don't think you're going to get a facility fee for purposes of -- of this bill.

But, you know, radiology is tricky when it comes to billing in terms of how you get billed. And so I -- I don't want to -- I don't want to say anything that might turn out not to be accurate. But if it's not a provider-based practice, you're not going to generally get a facility fee charged.

REP. CARTER: Thank you very much for clearing that up.

Thank you, Mr. Chairman.

SENATOR DOYLE: Thank you.

Any further questions from the committee?

Thank you very much, gentlemen. Have a good afternoon.

Next speaker from the public officials is Kevin Kane from Chief States Attorney office. Then we -- I see we'll be going -- alternating with the public, but the next public official after that is Victoria Veltri and Representative Laura Hoydick. But we will have to intersperse public officials.

But Attorney Kane is up right now.

CHIEF STATES ATTORNEY KEVIN KANE: Thank you, Senator Doyle, and members of the committee.

I'm here to testify very briefly on -- in support of one bill, 5336. That's a bill to make what really is a technical amendment to one of the subsections of 30-89, which is the statute that makes it a misdemeanor for two -- essentially two types of closely related, but slightly different types of conduct.

Subsection 1 of that bill is written fine and that makes it a misdemeanor for anyone to commit any minor -- for a property owner to permit a minor to possess alcohol -- alcohol or liquor in violation in Subsection b of 30-89 on -- on the property.

Subsection 2 was intended to make it a misdemeanor for somebody who -- to -- to fail to halt such possession even though if he doesn't initially permit it or even if it -- he doesn't permit it, if he or she, the property owner, becomes aware that such conduct is going on. This section is intended to make it a

33
dr/gbr GENERAL LAW COMMITTEE

March 6, 2014
1:00 P.M.

steps to cease the conduct. And it's a question of what's reasonable (inaudible).

REP. CARTER: Thank you very much.

REP. BARAM: Any other questions?

Thank you very much. I know that I was one of the people who had questions with the language last year because it -- it didn't flow or make much sense. But I -- I think has been cleaned up and makes a lot of --

CHIEF STATES ATTORNEY KEVIN KANE: Probably asked me when I was busy on something else, and I -- I -- and I couldn't think straight to explain it to you and -- and that's maybe what happened.

REP. BARAM: Well, (inaudible).

Okay. Thank you.

Next is Victoria Veltri.

VICTORIA VELTRI: Good afternoon, Representative Baram, Senator Doyle, Senator Witkos, Representative Carter, members of the General Law Committee.

I'm Vicki Veltri. I'm the state healthcare advocate, and I am to testify on H.B. 5337, in short on facilities fees and their notification bill. We do support the bill. I don't want to -- I don't want to rehash everything you've already asked the AG and the efforts to all the people here waiting to testify, but I would just highlight a little bit of what's been going on from our perspective.

We started seeing this problem a while back, even a few years ago this was going on and it just started kind of coming to a head a little

bit in the last couple of years. What's happening is, as you know, and the AG described, is this -- without notice, this becomes a giant burden to consumers.

We've had consumers -- we've had one consumer come out with a 5,000-dollar facility fee bill when she went to a hospital and did not know that she was going to be facing that bill. That's just from a consumer advocate perspective unacceptable.

So we applaud the cooperation when the hospital association and the AG's office can negotiate a notification bill. I will say increased transparency is becoming -- or transparency is becoming a hallmark of healthcare reform efforts more broadly.

Consumers do need to know information to make informed choices. In my opinion, no information is meaningless to a consumer and the more information you can give a consumer, it will empower consumers.

In fact, the fact that the carriers often times, whether it's private coverage or fully - or self-funded coverage, cover these fees leaves consumers in the dark about what these fees are and actually, you know, doesn't empower consumers to question those fees, and whether or not, quite frankly, they're impacting our bottom line on healthcare costs and premiums that we're spending when it comes to healthcare.

I think about these fees like the way I think about people who talk about their electric bill and their cable bill. Most of us would see our cable bill. If we saw a fee like this we'd be on the phone in five minutes with our cable companies.

Or a few weeks ago when the issue about the suppliers came up here about electricity and the lack of transparency to consumers, that was a major issue. The same kind of reaction, in my opinion, should be happening with respect to healthcare costs and healthcare fees.

I do want to bring up one thing. You asked a couple questions that I think I have answers to, actually. Somebody talked about equalizing -- I think equalizing costs. There is a Medicare payment advisory commission that advises Congress on Medicare payments.

In the last two years they have issued reports, which I will gladly provide the committee if you're interested just for background, in recommending that the fees in some of these cases start to be equalized between the private practice setting and the hospital-owned practice settings because the same services are being provided.

That is not to disparage the extra kind of costs that hospitals do have to undertake to provide the kind of services they do. But is the reflection of the fact that adding fees to all of these costs does drive up the cost of Medicare. And so we do at some point need to get a handle on that.

So that was one issue. The other thing as I said in lots of cases these fees are covered, and in lots of cases they're not. And it does depend on the plan somebody has. Lots of the small employer plans do not cover these fees. State employee plans, I'm not sure if it's covering all the fees. I heard you not to be covering all the fees that they can or negotiating prices on them.

But the bottom line is that the notification is a great first step, but what it doesn't ultimately get to is addressing at some point something we all will have to address; not today maybe, but getting to the root causes of the increasing costs of healthcare and trying to rein them in so consumers can make informed choices and consumers can actually afford their healthcare.

So the last thing I'll just hint at to you is that in the next year or so we are going to have an all fair claims database in the State of Connecticut where lots of these claims will have to be -- actually, all these claims will have to be submitted to one location where there will be increased transparency about the cost of the healthcare being provided so consumers can shop more affordably.

I don't begrudge the hospitals, they are -- it is true that this is allowed by federal law, it most definitely is. It doesn't mean that it shouldn't start to be reined and that is something that Congress will have to deal with. So this is a good first step and we have to keep moving on it.

So I don't want to take up much more of your time because you've already had quite a bit of dialogue with the AG, so.

REP. BARAM: Thank you very much.

Any questions?

Senator Witkos.

SENATOR WITKOS: Thank you, Victoria. You mentioned that there's going to be a website where all the claims will be directed to. Is that website going to be managed for the feds or is

that something we would do here in the state or specific agency?

VICTORIA VELTRI: Yes. Actually, there's an all fair claims database that was established in state statute a couple years back. It resides over at Access Health right now and it's in a - - so it's in a quasi-public (inaudible) and next -- I think some time in 2015, we will be getting claims pouring into there and we will have -- we will be able to start analyzing variations in cost, price, by ZIP, all those kinds of things that I think most consumers would want to see if they could see it.

SENATOR WITKOS: So right now during your testimony and you tell about a story about a woman that got a bill -- an invoice from a hospital for \$5100 basically. And if somebody were shopping around saying this is a procedure, this is how much insurance coverage is.

And then we passed this law and it says you have to provide notification of the facility fee, and this patient before they have any procedure say, well, insurance will cover your professional fee, but your facility is \$5100 and they say, what? I can't afford that. Where else can I go? And then where ever (inaudible) it's not our job to tell you.

You know, is there any place now that a consumer can go easily to see what those fees are? Or is up to them going through the phone book and just start calling people?

VICTORIA VELTRI: There are sites online where you can compare costs. There -- they -- some of them are difficult to navigate and unless you know exactly what you're going in for, or at least a pretty good description of what you're going to have done, it is kind of hard to

navigate. Fair Health is one of them, there are a couple of others.

You may -- if you have CPT code you can go in or if you kind of know what the procedure is, you can put in a description of it and might be able to search based on that.

And that is, to me, the -- the crux of this situation is to allow informed choice --

SENATOR WITKOS: Right. It doesn't sound real user friendly in this field yet.

VICTORIA VELTRI: And -- and I do think with respect to the hospitals, though, on some of these fees, we have been able to negotiate with them in cases where these fees have turned out, like in this case -- that case, there was a negotiation that took place to resolve that issue.

But you don't want to have to do that on a one-on-one basis, so the notification is critical.

SENATOR WITKOS: And one more question, Mr. Chair.

If you could, -- I'd like to hear your thoughts on something that the Attorney General's office brought up that something they'd like to see added to the bill when it comes out. And my understanding was it was a -- was a new subset section for coding which would allow a different billing for facilities where the patient is not present, and they're reviewing and making professional diagnosis, looking at a MRI or an x-ray and it's billed (inaudible).

To me, red flags go (inaudible) just popped up. And I just want to know from your office's standpoint what -- if you could give any comment to that?

VICTORIA VELTRI: Well, I mean, I think medicine is changing rapidly and -- and it's not necessarily the way -- the practice is not happening the way it used to happen in lots of cases and -- and, in fact, the way we are paying for care is driving some of the kinds of changes in the way we do deliver care, including through e-consults and providers reading radiology, you know, through a -- a very high tech network connection or something.

That, to me, is a valid way to deliver medicine, but it's -- it's in my -- it's in my mind is it providing that service that it says it's providing and is it a high-value service? If it is, I have no problem advocating that there be payment for that.

It's -- it's more an issue of -- in my mind this whole thing boils down to how do we make sure that consumers know what they're getting for the dollars they are paying for their healthcare and ensuring that they're getting value for that healthcare.

Overall, that is to me the crux of decision-making around healthcare. We all know that certain things are out of our control, pricing setting and certain things, but without transparency, consumers just cannot make an informed choice and can't come here to tell you and be empowered enough to ask for change.

So the release of that information is really critical. I don't think that that issue -- I guess, I don't disagree with the AG's position on that issue. I don't, but it does require monitoring.

REP. BARAM: Thank you very much.

I was just going to suggest if you have a couple of those websites and you want to forward it to our clerk, I think some of us would enjoy perusing it and seeing what they --

VICTORIA VELTRI: I'd be happy to do so.

REP. BARAM: Thank you very much.

Next, we're going to sneak in a few more public officials because we started late.

Representative Laura Hoydick and Senator Gail Slossberg.

REP. HOYDICK: Thank you, Chairman Baram, for allowing my constituent to testify with me.

I'm State Representative Laura Hoydick. I represent the 120th in Stratford and I -- I appreciate that you are entertaining House Bill 5426. So, again, Chairman Baram, Ranking Members Witkos and Carter, members of the General Law Committee, thank you for hearing our testimony today.

This kind of industry about producing wine to wine kits is growing in popularity in Connecticut and I'm happy to introduce my constituent today, Bill Alletzhauser, who is -- has started this business relatively recently within the last few years. And he will explain to you the premise of our bill a little bit better than I can.

But I would like to in advance thank you very, very much for having this public hearing on behalf of this concept.

WILLIAM ALLETZHAUSER: Good afternoon to the General Law Committee Chair and Leadership and to the fellow chair people.

Seeing none, thank you very much.

ROSS HOLLANDER: Thank you.

SENATOR DOYLE: Next speaker is Steven Frayne, then Steve Matheson, Jude Malone.

So we're back to the first speaker? A time warp.

HB 5337
STEPHEN FRAYNE: Good afternoon. My name is Stephen Frayne. I'm the senior vice president of the Health Policy of the Hospital Association. I've provided you my testimony in writing, so I won't read from it, I'll just summarize it and then I'd be happy to answer any questions that you might have.

We -- we're here to actually testify in support of the bill that Attorney General Jepson has put forward to you. He came to us in the early fall of last year and, basically, had shared with us some concerns he was having about complaints that his office was receiving from patients regarding whether or not they knew they were, in fact, in a hospital.

Particularly when they were going to an office that was a remote location from the hospital, whether or not individuals should know that they're actually receiving two bills or not, how much the cost of those bills would be.

And after a whole series of discussions with his office, we concluded, basically, that there was a very legitimate point that was being raised and that we should do everything we can to make sure that folks are properly aware of the fact that they are, in fact, at a hospital, how many bills they are actually likely to receive when they go to the hospital, and what

they should be reasonably expecting the cost of that service to be, and that we should do our level best to make sure that that happens well in advance of a visit assuming the visit can, in fact, be scheduled.

In fact, we felt so strongly about it that through our board and through our entire membership, we essentially decided to do it whether or not there was a law passed. And we made a recommendation to our entire membership that beginning March 1st of this year, they should try to do everything they possibly can to make sure both the notice requirement, the signage requirements, the estimations and so forth are, in fact, put in place as -- as reasonably as soon as is possible.

So there are few other things that we're still talking to his office about relative to the law just to clarify some of the definitions, but we're reasonably confident that that clarification will occur and we look forward to -- to implementing it.

SENATOR DOYLE: Thank you.

I just want to -- time is of the essence if you guys are going to continue to discuss, because our deadline's in the near future.

Representative Aman.

REP. AMAN: Just a quick question. Someone who had major medical insurance only for many, many years, I don't know how many times I talked -- was in -- talked to a doctor or at the hospital or at the lab, and probably one of the few consumers that ever asked what something would cost, and I can't (inaudible) 90 percent of the time, the people, the doctors, the bookkeepers had no idea what the cost of this thing was.

And very recently even though we have very good insurance here, my wife asked what is this going to cost and, again, no one in the office had the faintest idea. They couldn't even give her a ballpark number.

How are you going to post prices if no one in the office knows what things are going to be -- cost?

STEPHEN FRAYNE: It is certainly going to be a challenge, and let me explain a little bit why there is a challenge. There are -- there are several factors that -- that make it more complex than one would -- would like it to be.

The first is often we don't know as a provider, in fact, where you are in the year relative to your deductibles, your co-pays, and so forth. So it's very hard for us to tell you exactly what your share of the expense is going to be. So that's one piece of it.

The second piece of it is while we may have a reasonable idea about what services actually you may need based on the appointment that's being scheduled, say you're going to a cardiologist's office. Maybe they're going to do some stress testing or something like that. We should be able to give you a reasonable estimate based upon the averages of what we've seen in the past.

However, we don't actually know because every individual is different exactly what's going to be done when you get there. You may have a routine visit, you may have a visit that becomes much more complex than the average. So that's -- that's some of the dilemma that we're trying to work through is to how can we provide folks reasonably meaningful information so they

have a good handle about what it's going to cost, but also put them in a place where they wind up being surprised after the fact.

In other words, let's say I come into the office and I'm told the average for this service will \$500, but when I get there, it's determined that maybe I have a lot more complicated medical stuff going on and the cost actually goes up. So we have to be careful about how to balance those -- both of those things.

But it's not going to be perfect. I'm sure there will still be complaints, but we're going to make our level best effort to try to make sure that consumers have that information in a meaningful way so they can make decisions about where they're going to go. We're going to try.

REP. AMAN: Is there any way that procedurally when someone is leaving the office so the procedures are complete? Because even at that, I can't get a price out of a doctor. Forget my deductible or where I stand, but what is the retail cost of this -- this procedure; they don't know. The usual answer they give is, well, every insurance company is different.

STEPHEN FRAYNE: Right. I think when they're -- when they're answering every "insurance company is different," they're answering you from the perspective of how much your insurance is going to cover for that service.

We're -- we are of the mind that we should be able to tell you exactly how much we're going to be charging you for that service. So we're not there yet, that's the goal of this legislation, that's the goal of where we want to be. It's a big transformation, but it's one that we're willing to undertake. Because we do

think it's important that folks have this information.

I -- I would note that what we're proposing to do, we're actually the first country in the nation, if we're successful, where this will actually be done. I mean, the first state in the nation.

REP. AMAN: I -- I wish it could be posted. I'd just be very curious to see what the 150,000 or so medical codes how you're going to be able to do that in a way a consumer can understand.

STEPHEN FRAYNE: Right.

REP. AMAN: Thank you very much.

STEPHEN FRAYNE: You're quite welcome.

SENATOR DOYLE: Senator Witkos.

SENATOR WITKOS: Thank you, Mr. Chair.

Steve, I had a question. Did we -- I know the Attorney General had testified that his office started to get -- received a lot of complaints (inaudible) started looking at this. And has this practice been going on for quite some time, and just the complaints just didn't rise to that level? Or it's a new development so that's why they started receiving complaints, that's why we're moving forward in that?

STEPHEN FRAYNE: Sure. Let me -- let me try to explain a little bit why this is occurring.

Under the Medicare program they have specific rules around how private physician offices will bill for services, and they have specific rules how hospitals will bill for similar services. And those rules basically say the following.

When a physician bills for a service, they're going to bill not only for their professional time, their knowledge and their skills and so forth in diagnosing somebody, but they're also going to include in that bill the amount of expense that relates to their office. So, you know, the staff they have at the reception desk, the nurses, whatever supplies they might have used, their medical practice insurance.

So when they submit a bill, that bill, let's say if it was a 200-dollar bill, roughly half of that bill relates to their professional services, their skill in diagnosing me, and half of that bill relates to the expense for their office.

For that very same service, the Medicare program would say to a hospital, okay, you're a hospital. We want you to separate that \$200 into two separate parts. So we're going to pay you \$100 for the professional services of the physician, the same amount that they would pay a private office. There's no difference.

So professional services for a hospital, the professional services for a physician are identical. However, what they do do is they pay more for the facility part. You might say, well, why would the Medicare program pay more for the facility part? They pay more for that because they recognize that being integrated as part of a hospital puts on that department certain obligations that would not otherwise exist if it was a private physician's office.

For example, that department now has to comply with all of the oversight rules for quality insurance. They have to be under the same licensure of the hospital. They are no longer licensed as a private physician office. They

have to comply with the anti-dumping rules, the anti-discrimination rules. And they also have to bear some of the expense for the overall operations of the hospital. So they're willing to pay slightly more for those services.

I think the reason why you're seeing more complaints coming about, quite frankly, is because of the movement in the direction of plans actually expose individuals to a higher share of those overall expenses. So if you have a plan where before you used to be paying \$10 for the visit or \$15 for the visit, maybe you didn't notice it as much. You now have a plan where you have a 2,000-dollar deductible or a 3,000-dollar deductible, all of a sudden more of this is coming out of your pocket and - and you would have much more significant concern.

SENATOR WITKOS: So the Medicare rules really haven't changed --

STEPHEN FRAYNE: Correct.

SENATOR WITKOS: -- it's just (inaudible) because the policies and the coverages themselves have changed and that's the impetus of why maybe more complaints are being generated.

STEPHEN FRAYNE: Correct. And in terms of the -- the requirements the federal government puts on the hospital, if in fact you convert this to an outpatient department, we're not going to allow to treat non-Medicare patients differently than we would treat Medicare patients.

So there are certain rules that we have to comply with from a federal perspective that says once it's an outpatient department of the hospital, you must separately bill for these services and then you have to do that same

separate billing for every other single payer as well. We're not allowed to discriminate against Medicare patients, so.

SENATOR WITKOS: Is it fair to say that the majority of the folks that go to hospitals are Medicare covered or Medicaid covered versus private pay or self-insured?

STEPHEN FRAYNE: I would say the -- well, it varies by institution. Typical volume of services for Medicare is probably 45 percent out of all of the services we deliver in the Medicare population. And now we're approaching probably close to 20 percent for the Medicaid population. So when those government payers define certain rules and practices, it pretty much flows through the whole balance of how we pay.

SENATOR WITKOS: And do you think that that's the reason why we see more of a purchase of the individual professional groups -- one of the reasons why by hospitals, because now the reimbursement rates, because of what they pay for on the -- not the professional fee, but the facility fee is greater, so they get more money.

Because we constantly hear that the reimbursement rates are so low that it's difficult for doctors in the private industry or their own facility to see them. But if they're affiliated with a hospital, (inaudible) what I'm hearing in testimony is that they're able to get a higher fee, you know, be reimbursed because of the association with the hospital now.

STEPHEN FRAYNE: I -- I think what the real motivation here is under the Affordable Care Act there is a real push for the provider

community to become more integrated. In order to make that happen, you have to have an integration of medical records. You have to have an integration of quality assurance programs. You have to have the ability to communicate from the private physician's office to the hospital to the home health agency to the skilled nursing facility and so forth.

That level of interaction is extraordinarily complex to do, and I think what we're finding is that more and more smaller organizations are saying they need to be part of a larger organization to be able to accomplish some of those things, which are the -- which are the real expectations that I think everyone has.

So as part of that integration occurs, you're seeing them joining these larger hospital-based organizations that does occasion higher funding from the Medicare program and from commercial payers. But I will tell you that even though there is that higher funding, for the last year for which there's full data which is 2013, the hospitals in addition have subsidized those practices that they've purchased to the tune of \$150 million a year.

So even with this higher level of funding, the added level of cost that we're experiencing bringing these practices in and integrating them, the revenue to support it is just not there. At the moment it's still operating at a huge financial loss.

SENATOR WITKOS: And what's the -- what's the payback period be spread -- have them spread that out because that's a one-time integration?

STEPHEN FRAYNE: There really -- people are not doing this because they think there's a return on investment in the classic sense. You know,

it's not a financial investment. It's an investment they believe they need to make in order to be able to integrate that care. So I don't think they're looking at as something that's going to have necessarily a -- pay for itself.

SENATOR WITKOS: And the -- the hospital association, are they involved with the -- or this bill impact the -- the federal qualified health clinics that we have in our state?

STEPHEN FRAYNE: I don't believe this would have any impact on the federally qualified healthcare centers.

SENATOR WITKOS: Are any of those associated with -- with any hospitals are you aware of?

STEPHEN FRAYNE: They have a variety of integration efforts with many of the local community health centers. There are -- in one instance I know actually lease space inside the hospital and in other instances they have clinical partnership arrangements.

So there's -- it depends on, you know, what you really need in that particular community. But usually it's a fairly good working relationship between those two entities.

SENATOR WITKOS: Okay. Thank you.

Thank you, Mr. Chairman.

SENATOR DOYLE: Thank you.

Any further -- Representative Carter.

REP. CARTER: Thank you, Mr. Chairman.

Just one question. We were talking about this

-- this move towards the accountable care -- or excuse me, the accountable care organizations, the ACOs. Do you see that Medicare will continue to ask for things to be broken down in an assessment? Because that seems to be all that's driving this. The way I understand it is Medicare says we want basically itemized billing (inaudible) going to happen. And then when we move to accountable care model, now the doctors will at that point will all be under the hospital is the idea.

STEPHEN FRAYNE: Right.

REP. CARTER: Will they continue to break these down and just look for an itemized effort? Is that all (inaudible)?

STEPHEN FRAYNE: The Medicare program is constantly reevaluating how it pays for things, how it's using its payment processes to incentivize certain behavior. And just to give you a very high level sense of it, on an annual basis, the rules that govern what we do in the inpatient area usually come out around May, and they're about a thousand pages every year.

And then say in September, the rules that govern outpatient and how that's done, usually comes out in around September and that's also about a thousand pages. And they're constantly reevaluating what they're doing and changing it as they learn.

So it would not be unreasonable to expect in the not-too-distant future they may begin to decide that there are certain services where the payment rates should be the same, whether it's in a private office for -- and a hospital-based service. They may choose to do that for ambulatory surgery as well. Then there may be certain services where they say well, really

the mix of the skills that are necessary to accomplish this really can only be accomplished in a hospital and, therefore, we're going to be compensating that at a higher level.

So it wouldn't surprise us to see that change because that -- those are the things that they look at all the time.

REP. CARTER: Well, isn't it already happening to some degree? I mean, I understand that with -- with the world of cardiology it did that, that they were getting better -- better reimbursements in the hospital, so cardiologists all of a sudden started being bought by the hospital.

STEPHEN FRAYNE: Right.

REP. CARTER: And then that -- that move was again to attract all these doctors, all these multi-specialty groups under one big ACO umbrella.

STEPHEN FRAYNE: Correct.

REP. CARTER: So at the end of the day, what we're doing with this bill, in your opinion as a consumer protection effort, we're just notifying how you're going to get billed --

STEPHEN FRAYNE: Right.

REP. CARTER: -- so you just know what's coming, right?

STEPHEN FRAYNE: Correct.

REP. CARTER: It doesn't change anything else.

STEPHEN FRAYNE: It -- I -- I think that's a fair characterization of it. It's to, hopefully, begin to demystify some of the process. It's -

- I know it's not going to be perfect, but at least we believe it's a -- it's a substantial step forward to make sure people know that they are, in fact, in a hospital, that they are going to get two bills, and to the level best ability that we can that we actually provide them some notice about what we think those costs are going to be.

And then, you know, if they have that information in advance, they can make decisions about do they want to go there, or should they go someplace else.

REP. CARTER: Thank you very much.

Thank you, Mr. Chairman.

STEPHEN FRAYNE: You're quite welcome.

SENATOR DOYLE: Thank you.

Any further questions from the committee?

Seeing none, thank you.

You do -- you were aware that Attorney General gave you a great compliment by your knowledge of the (inaudible). It was pretty impressive.

STEPHEN FRAYNE: Thank you.

SENATOR DOYLE: Thank you.

Next speaker, Steve Matheson, then we have Jude Malone, and then Tom Swan.

STEPHEN MATHESON: Good afternoon. I'm Steve Matheson. I'm the former president of a large managed care company, but I'm here as a consumer who's recent experience with John Dempsey Hospital relates to legislation in Bill

5337. I have three issues.

First is communication. I've been a patient at UCONN Dermatology for years. In 2013, for each visit I started getting a second bill from John Dempsey. There was no warning this bill was coming and no reduction in the normal charges from the doctor's office.

The admin person said they were now a hospital-based facility and have the benefits of accreditation by JCAHO. Knowing JCAHO, I felt this was largely pabulum for public consumption. If I had been told, one, that there would be a second bill with no added services; and two, by calling my insurer, I would find that a second bill brings a second co-pay, I would never have gone to UCONN Dermatology.

The second issue is enforcement. This legislation mimics current Medicare regulations. Therefore, UCONN was already required to give me an estimated cost for facility billing. This did not happen for me, and I would guess has not happened for many other Medicare patients in Connecticut. I would encourage appropriate enforcement provisions. It's obviously easy to ignore rules when there are no consequences.

The third issue is facility billing itself. I went for a routine checkup, 15 minutes with a nurse with no unusual findings or procedures. Like in past, the bill was \$140, of which \$40 was my co-pay. Then I received a facility bill from John Dempsey for \$684. As insurers rightfully think a hospital bill indicates a higher intensity level of service, my copay on the second bill was \$250. Now, apparently, I (inaudible) the cost of \$290 for every routine checkup at UCONN.

Facility billing is fundamentally a revenue-raising scheme. The hospitals figured out quickly that a paper change to declare doctors and nurses to suddenly be hospital-based facilities, allows them to send a second bill for every visit without having to provide any additional services. Because something is legal does not make it right.

I went to the same building in the same office with the same provider using the same equipment as I have for years. Because of an organizational change, the total bill was six times what it had been one year earlier, and my out-of-pocket costs was 700 percent higher.

To me, facility billing is a hidden tax cloaked in the garb of pretend hospital involvement and hits the patient even harder than the insurance company. And if you look around the dermatology waiting room, it must hit seniors hardest of all.

It's unlikely you can make facility billing illegal, but you can certainly look at regulating rates to ensure that outrageous billing stops.

Thank you.

SENATOR DOYLE: Thank you.

Any questions from the committee?

Senator Witkos.

SENATOR WITKOS: Thank you, Mr. Matheson, for coming up today to testify.

What -- when you brought that complaint to the folks that you were seeing about the 200-dollar additional co-pay for the 600-dollar facility

change, what -- did they give you any type of a response? What was, you know, (inaudible)?

STEPHEN MATHESON: Well, it depends on who you call. I called the claim people who have their script and the claim people -- claim people said, oh, that's your co-pay, you need to talk to your insurance company. Again, I've very familiar with the business. It's how I started to learn about facility billing. I called the insurance company and they said here's what facility billing is.

When I've communicated directly with the dermatology people at UCONN, the first response I got was, well, it's JCAHO. I know JCAHO, not worth six times the bill. I have written letters to them saying let's talk about this because this doesn't seem to make any sense at all, and I have not heard anything back yet.

SENATOR WITKOS: Thank you.

SENATOR DOYLE: Thank you.

Any further questions from the committee?

Seeing none, thank you very much. Wait, sorry.

Representative Baram.

REP. BARAM: Thank you, Mr. Chairman.

You indicated that your insurer did not cover any of these facility fees?

STEPHEN MATHESON: No. My insurer covers the facility fee. I got a 684-dollar facility fee. The insurer is -- as is normal will go and look at it and say we will cut it back down to usual and customary what they've agreed the hospital to pay.

In my instance surprisingly enough \$687 got cut down to about \$287. So the hospital owed \$37 and I owed 250. So all of the leverage on this extra billing hits the consumer, even it's only a 50-dollar extra bill, 40 of it will be paid by the consumer and 10 by the insurance company.

REP. BARAM: And -- and you're getting the facility fee every time you have an appointment (inaudible)?

STEPHEN MATHESON: Starting -- starting 2013, you want to know when it started, that's when it started at UCONN. I've been going to UCONN Dermatology forever. It started then because there was a quick, brief, innocuous announcement saying we've changed our structure. The hospital is now part of our organization. That was it basically.

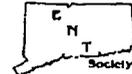
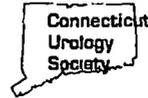
I started getting (inaudible) I thought I must've done something wrong and I kept calling. And finally when I had a routine visit where the bill was \$685 for the facility. Remember the 140-dollar charge already covered all of the overhead, all of the things UCONN Dermatology used to charge. So I would take exception to what was just previously said. No bills were divided. I got all of the exact same bills I used to get and I got a facility charge totally in addition to those bills at an outrageous level.

REP. BARAM: Thank you very much.

SENATOR DOYLE: Thank you.

Any further questions from the committee?

Seeing none, thank you very much.



**Connecticut State Medical Society, Connecticut Society of Eye Physicians, CT ENT Society, CT
Urology Society and the CT Dermatology and Dermatologic Surgery Society
On House Bill 5337 An Act Concerning Fees Charged
For Services Provided At Hospital-Based Facilities
General Law Committee
March 6, 2014**

Senator Doyle, Representative Baram and members of the General Law Committee, on behalf of the physicians and physicians in training of the Connecticut State Medical Society (CSMS) and other societies listed on this testimony thank you for the opportunity to present this testimony to you today on House Bill 5337 An Act Concerning Fees Charged For Services Provided At Hospital-Based Facilities

While CSMS fully supports the intent of the language to increase transparency regarding facility fees charged to patient for services provided by hospital owned facilities, we offer the following comments and concerns.

The issue before you today relates directly to the passage of Public Act 03-274. The Public Act not only required facilities (including physician offices) providing services under moderate and deep sedation to obtain a license from the Department of Public Health (DPH) but also to obtain a Certificate of Need (CON) from the then independent Office of Healthcare Access (OHCA).

At that time, CSMS raised significant concern that the legislation was not consistent with Federal Trade Commission (FTC) recommendations and that the legislation would ultimately lead to an increase (not a decrease) in health care costs. Unfortunately, as demonstrated by the need for the legislation before you today, our argument was not successful at the time but the results are what we had previously outlined and were concerned would occur in Connecticut.

During the debate, CSMS presented a significant amount of information and material demonstrating that the facilities and/or offices in question were accredited by comprehensive requirements of national organizations. Furthermore, we agreed with the need for licensure by DPH to ensure that those standards, as well as state and local requirements were met. We adamantly argued that the requirement for a CON would stifle competition, be a detriment to the private practice of physician practices and to the recruitment of new physicians and ultimately lead to a more expensive system. That unfortunately, has occurred in Connecticut, in a very short time, quicker than even we could have predicted.

We applaud the Attorney General for bringing forward this legislation that will provide transparency regarding the cost that the associated facilities (hospitals) charge in addition to the true cost of providing the service. We do, however, feel it necessary to raise a concern with the language of this bill as drafted.

We feel that it might raise red flags in terms of compliance with anti-trust laws and further create an imbalance between hospitals and the physicians in their service that unfortunately was the result of PA 03-274.

HB 5337 establishes a definition of "Affiliated Provider," in part, as any physician under an agreement with a hospital or health service to provide services. This is a very broad definition and could encompass physicians who provide part-time services for the hospital and those physicians who simply take call at a hospital through a services-based agreement. Section 2(a)2(A) contains language that would imply that the Affiliated Provider would be required to provide to the hospital information regarding the physician's professional fee for the service. This raises significant concern. Contractual relationships between hospitals and affiliated providers (physicians) are not employment agreements in which the physician is a salaried member the hospital staff. They are contracted providers and remain in independent practice outside of the hospital setting. The need for such independent "Affiliated Providers" to disclose professional fee components could provide the hospital with information that is prohibited under anti-trust laws. Fee sharing between providers is subject to significant scrutiny under anti-trust law and raises red flags in the mind of federal enforcement authorities. Physicians that operate under a services agreement with a hospital may in fact be seen as competitors outside the services provided under that agreement. Fee sharing in that scenario would raise even more significant anti-trust concerns. The proposed language in this bill may require fee disclosure that is to the benefit of the hospital and the detriment of the physician who is in many ways independent of the hospital and in fact in competition with the hospital for the provision of other services not expressly contracted for in the service agreement.

We suggest that language in Section 2 of the bill be amended to require that the hospital or facility inform the patient of the potential of a professional charge from the Affiliated Provider. Physicians should be required to provide this information to patients upon request but should not be required to provide proprietary, and potentially unlawful, information to a hospital or any other contractual partner.

Thank you for the opportunity to provide this information to you today.

GEORGE C. JEPSEN
ATTORNEY GENERAL



55 Elm Street
P.O. Box 120
Hartford, CT 06141-0120

Office of The Attorney General
State of Connecticut

**TESTIMONY OF
ATTORNEY GENERAL GEORGE JEPSEN
BEFORE THE GENERAL LAW COMMITTEE
MARCH 6, 2014**

Good afternoon Senator Doyle, Representative Baram and the members of the Committee. Thank you for the opportunity to testify in support of HB 5337, *An Act Concerning Fees Charged for Services Provided at Hospital Based Facilities*. This bill seeks to address an increasingly common and significant issue confronted by patients seeking medical care from physicians whose practices are owned or operated, in whole or in part, by hospitals or health systems. Patients frequently are surprised when charged a separate hospital fee for care they receive from these hospital affiliated providers. This bill would require such providers to provide patients with clear notice that they may be liable for two separate charges when receiving medical care -- one for "professional services" rendered by a healthcare provider and another for the administrative and overhead costs of the hospital that owns or operates the physician practice where care is received. This latter charge is oftentimes referred to as a "facility fee".

My office became aware of the scope of this problem through the work done by our health care competition working group, which in early 2013 began to examine the potential impact consolidation within the industry may be having on cost, quality, and access to health care. Through those efforts, we learned that "provider-based billing" or as it also is known, "hospital-based billing," enables hospitals that own physician practices and outpatient clinics to bill patients separately for the use of the facility as well as for the physician's professional services. Hospitals have reported that the "facility fee," also referred to as an "outpatient hospital charge," is a separate charge assessed to cover overhead costs like imaging, equipment, electronic health records, care for the uninsured, and even to maintain "disaster readiness," *i.e.*, to better respond to terrorist attacks or hurricanes.

Though hospitals always have charged patients a facility fee for the use of the hospital itself, they increasingly have begun charging facility fees for services rendered in the offices of the previously independent physician groups and clinics they have acquired. Many hospitals currently assess facility fees regardless of the physical location where the treatment is provided. They may do so if the physician's office is within the hospital, across the street, or in a different town, so long as the facility is deemed a "provider-based" facility for purposes of Medicare and their contracts with private insurers.

Because more and more previously independent clinics and physician practices are now owned or operated by hospitals, more and more patients are being charged facility fees. These facility fees are not inexpensive. They can range from hundreds to thousands of dollars per visit. They also often subject patients to additional, separate co-pays and deductibles. One of the

many complaints filed with my Office is illustrative. A patient had been going to a dermatologist's office for routine skin biopsies and was being charged a total of \$390 for both the office visit and medical procedure. The office was several hundred yards from the closest hospital and appeared to the patient to be unaffiliated with a hospital. After the dermatologist was acquired by that hospital, however, the patient returned again to the same office for the same procedure and was charged the same amount she previously had been charged, plus a \$170 facility fee. Adding insult to injury, it is not uncommon for facility fees to be applied to an insurance plan's hospital deductible, which can often be thousands of dollars more than the deductible for a physician visit, resulting in significantly more out of pocket costs to patients. In addition to higher direct medical costs to patients, these fees also result in elevated insurance costs, which in turn result in higher premiums and higher costs for employers who subsidize group health benefits.

Since learning about facility fees and their effect on consumers, my Office has met with many different stakeholders, including individual hospitals, the Connecticut Hospital Association, insurance carriers, and the Connecticut State Medical Society. We also began soliciting consumer complaints on our website and wrote letters to all Connecticut hospitals, seeking detailed information into their billing practices.

To date, our office has received nearly 70 complaints from Connecticut consumers who were surprised to learn that the medical services they received in an office setting triggered a hospital facility fee. While many of the complaints related to "off-campus" providers (those whose offices are not near the main hospital), others arose from instances in which care that frequently is provided in a non-hospital setting was provided at a hospital's main campus. Complainants nearly universally report having paid a single co-pay at the time of service. According to many complainants, no statements were made by the receptionists or physicians about facility fees; no additional requests were made for any facility fee co-pays or co-insurance payments at the time of service; and the co-pays were collected as if they were the *only* out of pocket expense for the patient. The common threads running through the complaints we received demonstrated that:

- Patients believed that they were receiving non-hospital services.
- Patients were given no effective notice that they would be charged an additional fee and no advance information pertaining to the amount of the fee, their financial liability for the fee or what steps they might have taken to arrange comparable care at a lower cost from an alternative provider.
- When they paid their co-pay to receptionists, patients were led to believe that they had satisfied their full financial liability for the service. The receptionists' request for and acceptance of a co-pay, without any disclosure that it did not constitute the full patient liability, led patients to believe that there were no additional charges.

- Patients were surprised, after their date(s) of service, to receive bills for either co-payments of facility fees, or full facility fees.
- Patients described the facility fees as a financial hardship, and felt they bore no relationship to the care they were provided.
- The complaints regarding lack of notice and price transparency came from patients covered by Medicare, private insurance and those with no insurance.

In November 2013, I sent letters to all of the state's acute care hospitals, seeking broad information about their acquisition of previously independent physician practices, free-standing ambulatory surgical centers and urgent care centers. I requested detailed descriptions of their disclosures of hospital affiliations and any facility and professional fees charged to patients seeking care. The letter also sought information about the extent to which hospitals ensure sufficient public awareness of hospital affiliations.

All 29 general hospitals provided written responses. Those responses revealed great variability in the information given to Connecticut patients regarding notice of a facility fee and their possible financial liability for separate facility and professional fees. The disclosure of actual patient liability, or a best estimate of the actual amount due, also varied greatly depending on the hospital involved, and even varied within single hospital systems. With respect to when Connecticut's hospitals provide notice of a separate facility fee, most noted that they provided such notice at the time the patient arrived for their scheduled medical service.

The responses we received from hospitals, as well as the number and nature of consumer complaints we received, led me to believe that legislation is necessary to ensure consumers are getting the information they need to decide whether or not to visit a practice that charges facility fees. This conclusion was reinforced when, in March 2013, two non-profit groups issued a report card for all 50 states on price transparency. Connecticut was among 29 states to receive an "F" in that report. See "Report Card on State Price Transparency Laws," Mar. 18, 2013, at www.catalyzepaymentreform.org/images/documents/reportcard.pdf.

The bill before you today is an important first step towards improving price transparency and protecting consumers. It will allow patients to understand how much a service may cost and to whom they may be liable. Price transparency is an accepted prerequisite in virtually all other commercial transactions. Without it, competitive markets simply cannot function and costs cannot reasonably be accepted to be contained.

The bill also seeks to strike a balance and accommodate the reasonable administrative concerns expressed by hospitals. Indeed, it largely is the product of a negotiation between my Office and Yale New Haven Hospital ("YNNH"). YNNH worked closely with my Office on the language contained in the bill and supports it with the minor changes I have proposed in substitute language I have shared with the Chairs and LCO. Those changes are discussed in more detail below.

In some circumstances, the bill would require hospitals and health systems to provide patients with specific information about their actual or estimated liability when receiving care from a provider that charges facility fees. Though minor changes to the bill were made by LCO that will require substitute language, the intent of the bill is to require hospital-based facilities that charge facility fees utilizing an "Evaluation and Management" Code to provide patients with notice of the amount, or a best estimate of the amount, of the patient's liability for any facility fees to be charged. In addition, if the hospital or health system controls the provider's professional rates or fees, the hospital or health system also would be required to provide such patients with the amount, or a best estimate of the amount, of the patient's liability for any professional fee. If, on the other hand, a hospital or health system does not utilize an "Evaluation and Management" Code to bill a particular service, the hospital or health system still would be required to provide patients with notice that the patient may be liable for amounts separate and apart from the professional fees charged by the provider.

The key distinction between services that utilize "Evaluation and Management" Codes and those that do not is that in the former instance, the provider is simultaneously providing direct care to a patient at a hospital-based facility. In those instances in which no "Evaluation and Management" Code is utilized, the provider is providing professional services, but not directly to the patient at the time of the visit. The best examples of such instances include professional services rendered by radiologists when interpreting x-rays or physicians interpreting laboratory results from blood tests. In these instances, the hospital-based facility may charge patients an amount separate and apart from the provider's professional services, but it is more difficult for the provider to know in advance the amount that will be charged. I have submitted substitute language to the Committee and LCO to capture this important distinction and the differences between the notices provided to patients in these settings.

In either case, however, if a patient makes an appointment for a visit that will occur at least ten days after the time the appointment is made, the hospital or health system will be required to send the patient the respective notice *in advance of the scheduled visit* – regardless of whether an "Evaluation and Management" Code is utilized. Such advance notice is crucial in order for consumers to make educated and meaningful choices about where to receive care. If consumers learn they will be charged a facility for the first time when they actually arrive for a visit, they obviously are far less likely and willing to seek care from an alternative provider.

Lastly, the bill would require hospital-based facilities to hold themselves out clearly to the public as being part of a hospital or health system. Such disclosures would be required at the facilities themselves, in their signage, and on their websites, marketing materials and stationery.

Thank you for your consideration of this very important proposal. I would be happy to answer any questions from the Committee.

TESTIMONY PRESENTED TO THE GENERAL LAW COMMITTEE
March 6, 2014

Benjamin Barnes
Secretary
Office of Policy and Management

Testimony Supporting House Bill No. 5337

AN ACT CONCERNING FEES CHARGED FOR SERVICES PROVIDED AT HOSPITAL-BASED
FACILITIES

Senator Doyle, Representative Baram and distinguished members of the General Law Committee, thank you for the opportunity to submit testimony in favor of House Bill No. 5337, An Act Concerning Fees Charged for Services Provided at Hospital-Based Facilities.

By requiring that consumers be notified of the imposition of facility fees on top of the cost of the procedure prior to such procedures being performed, this bill represents an important first step toward achieving transparency with respect to provider billing. The charging of these additional facility fees (over and above the fee for the professional services rendered) has become an increasingly widespread practice that often catches the consumer off guard and will likely become even more prevalent with the expansion in the number of insured under the Affordable Care Act. I find the practice of charging facility fees to health care consumers - and the lack of information to consumers about their potential liabilities when accessing care - troubling. As Secretary of the Office of Policy and Management, I am also concerned about the fiscal impact to the State of Connecticut of such fees on the thousands of state employees, retirees and their families who are impacted by this practice without their informed consent. This practice results in significant unanticipated costs to the State for the care we support on behalf of these individuals. While this bill does not prohibit these charges, it represents an important first step in ensuring consumers have the tools to make informed choices.

I have reviewed the testimony of Attorney General Jepsen and concur with his arguments supporting this bill and the substitute language he proposed in his testimony.

Again, I would like to thank you for the opportunity to submit testimony on this very important bill. I respectfully request that the Committee support the bill

with the proposed amendments highlighted in the Attorney General's testimony and would be happy to discuss this topic at a later date if you so desire.



Office of the
Healthcare
Advocate
STATE OF CONNECTICUT

**Testimony of Victoria Veltri
State Healthcare Advocate
Before the General Law Committee
In Support of HB 5337
March 6, 2014**

Good afternoon, Representative Baram, Senator Doyle, Senator Witkos, Representative Carter, and members of the General Law Committee. For the record, I am Vicki Veltri, State Healthcare Advocate with the Office Healthcare Advocate ("OHA"). OHA is an independent state agency with a three-fold mission: assuring managed care consumers have access to medically necessary healthcare; educating consumers about their rights and responsibilities under health plans; and, informing you of problems consumers are facing in accessing care and proposing solutions to those problems.

HB 5337, An Act Concerning Fees Charged For Services Provided At Hospital-Based Facilities is a critically important consumer protection upon which currently there is little consensus or clarity.

Over the past several years, Connecticut's healthcare market has experienced an increase in the number of hospital-based outpatient clinics ("HBOC") or hospital-based facilities. Hospitals or systems that own these HBOCs may charge facility fees in addition to the physician's professional charges. Facility fees are generally defined as those charges necessary to cover the non-professional costs related to the delivery of care including, but not limited to, building, electronic medical records systems, billing, and other administrative and operational expenses. It is important to note that not all patients receiving treatment in a HBOC will be subject to these charges - only those who undergo a procedure of some type in a HBOC are subjected to a facility fee charge.

Transparency about how these charges are calculated remains elusive. In situations where these two expenses are being billed and reimbursed separately, one would expect that the sum of these charges would approximate the original reimbursement for that specific procedure. Unfortunately, consumers are instead receiving facility charges from hospitals that mirror professional charges and do not appear to be related to the actual overhead necessary to provide the delivered service. This is especially burdensome for consumers because many commercial insurers do not cover facility fees, often leaving the consumer faced with a bill for thousands of dollars that they had no meaningful advance notice, much less an opportunity to identify

alternate, non-HBOC, treatment that would not impose such a great financial burden. One of OHA's clients had an echocardiogram last year. The professional fee for this test was \$210, and was covered under her commercial insurance. However, she was shocked to also receive an invoice from the hospital with a facility fee in the amount of \$5,133. The average cost for this procedure in that region of the state is approximately \$1,100, and yet this woman was charged more than \$5,300 for the same procedure, simply because she had the test in a HBOC. Ironically, her father had exactly the same test performed with identical CPT codes at a non-HBOC just months earlier, and had a liability under his insurance policy of only \$160 out of pocket.

HB 5337 begins to address these issues, enhancing consumer protection by requiring HBOCs to provide advance notice to consumers who are expected to receive treatment that may subject them to a facility fee. This notice must contain reasonable estimates of the expected charges as well as information directing consumers to verify healthcare coverage of said charges, if available. It additionally requires that HBOCs notify patients that they may receive the recommended treatment without the imposition of facility fees at a non-HBOC. For consumers who receive notice prior their appointment should also be informed of the specific CPT codes to be used, so they may get accurate information from their insurer concerning coverage.

That there is a marked lack of transparency concerning these charges is well known. I applaud the Connecticut Hospital Association's recent initiative independently recommending that its members enhance their consumer notice policies to include more detailed information concerning these charges. However, while this recommendation acknowledges and offers some suggestions to mitigate the issues inherent in this practice, it is purely voluntary. HB 5337 would provide consumers with consistency and certainty as they navigate Connecticut's healthcare market. Other states have already begun to recognize this problem with this practice as well, with Washington State passing legislation last year that required all hospitals with HBOCs to report the number of HBOCs, number of patients at each site charged facility fees, and the total revenue generated through these fees.

HB 5337 is a first step to providing consumers with meaningful and timely notice about potential costs and liability for their healthcare and allow them another resource to make meaningful choice about accessing care at HBOCs or other settings, and I encourage passage.

Thank you for providing me the opportunity to deliver OHA's testimony today. If you have any questions concerning my testimony, please feel free to contact me at victoria.veltri@ct.gov.



**TESTIMONY OF
CONNECTICUT HOSPITAL ASSOCIATION
SUBMITTED TO THE
GENERAL LAW COMMITTEE
Thursday, March 6, 2014**

HB 5337, An Act Concerning Fees Charged For Services Provided At Hospital-Based Facilities

The Connecticut Hospital Association (CHA) appreciates this opportunity to testify on **HB 5337, An Act Concerning Fees Charged For Services Provided At Hospital-Based Facilities**.

It's important to detail the critical role hospitals play in the health and quality of life of our communities. All of our lives have, in some way, been touched by a hospital: through the birth of a child, a life saved by prompt action in an emergency room, or the compassionate end-of-life care for someone we love. Or perhaps our son, daughter, husband, wife, or friend works for, or is a volunteer at, a Connecticut hospital.

Hospitals treat everyone who comes through their doors 24 hours a day, regardless of ability to pay. In 2012, Connecticut hospitals provided nearly \$225 million in free services for those who could not afford to pay.

Connecticut hospitals are committed to initiatives that improve access to safe, equitable, high-quality care. They are ensuring that safety is reinforced as the most important focus—the foundation on which all hospital work is done. Connecticut hospitals launched the first statewide initiative in the country to become high reliability organizations, creating cultures with a relentless focus on safety and a goal to eliminate all preventable harm. This program is saving lives.

Providing culturally competent care, eliminating disparities, and achieving health equity are also priorities of Connecticut hospitals. The CHA Diversity Collaborative, a first-in-the-nation program to achieve these goals, has been recognized as a national model.

The benefits of hospitals extend well beyond their walls, as they strive to improve the health of our communities and play a vital role in our economy. Connecticut hospitals provide great jobs to more than 55,000 people who make sure we have access to the very best care whenever we need it. Every hospital job creates another job in our community. In total, Connecticut hospitals generate more than 110,000 jobs in our communities and contribute more than \$20 billion to the state and local economies.

Generations of Connecticut families have trusted Connecticut hospitals to provide care we can count on.

Connecticut hospitals support initiatives to improve transparency, so patients know what the healthcare services they receive will cost. Hospitals took very seriously the concerns the Attorney General brought forward last fall about patients not understanding how many bills they would receive, how much their care would cost, or the options available to them to get more information. In response, hospitals took the time to develop and unanimously endorse a set of recommended policies to address those concerns. Attached to this testimony is a copy of the statewide CHA Board-approved policy.

We understand that the Attorney General has requested that the language of the section 2(a) and 2(b) be amended to replace the phrase "current procedural terminology (CPT)" with "current procedural terminology evaluation and management (CPT E/M)." This is a welcomed change that provides the bill with additional clarity.

We appreciate the willingness of the Attorney General's Office to work with us to craft legislation that supports our mutual goal of transparency, and look forward to working with the Attorney General's Office after today's hearing to review several of the definitions, including "affiliated provider," "health system," and "hospital-based facility," to better understand to whom the bill would apply and to further improve clarity. We appreciate the effort the Attorney General has made to bring this issue to light and look forward to supporting this important legislation.

Thank you for your consideration of our position. For additional information, contact CHA Government Relations at (203) 294-7310.



Connecticut Hospital Association Policy Position on Facility Fees and Physician Services

Last fall, Attorney General George Jepsen brought to light a concern that patients seeking care at physician offices that are part of a hospital might not know they are being treated at a hospital, that they would receive two bills for that care, and that the cost for the care would be higher because the hospital facility fee now covers a portion of the hospital's ongoing operating expenses. The Attorney General solicited feedback directly from patients as he crafted legislation to provide meaningful notice and pricing transparency for consumers.

Connecticut hospitals agree that when seeking a physician, patients should not be surprised to learn after the fact that they are being treated at a hospital, or that they will receive two bills and the facility fee covers a portion of the hospital's ongoing operating expense.

On January 27, 2014, the CHA Board of Trustees approved the following policy position on facility fees and physician services:

We believe it is important for patients to understand both the care they are receiving as well as the cost of that care. To help patients better understand the cost of care, we believe patients should know when they are receiving care at a department of the hospital, how many bills they are likely to receive, and an estimate of the typical charges.

To accomplish a better understanding of the cost of care, we recommend that by March 1, 2014, at every off-campus hospital-based provider location, Connecticut hospitals provide written notice to every patient of the following:*

- *That he or she is receiving services in an outpatient department of the hospital;*
- *The amount of the patient's potential financial liability; or*
- *If the exact type and extent of care needed are not known, an explanation that the patient will:*
 - *incur a coinsurance liability to the hospital that he or she would not incur if the facility were not a hospital outpatient department,*
 - *receive an estimate based on typical or average charges for visits to the facility,*
 - *be given a statement that the patient's actual liability will depend upon the actual services furnished by the hospital, and*
 - *receive a statement that the patient should contact his or her insurer for information about what his or her insurance covers, and his or her financial responsibility for the services.*

The written notice must be one that the patient can read and understand, and if the patient is unconscious, under great duress, or for any other reason unable to read a written notice and understand and act on his or her own rights, the notice must be provided, before the delivery of services, to the patient's authorized representative. In cases where a hospital outpatient department provides examination or treatment that is required to be provided by the Emergency Medical Treatment and Active Labor Act (EMTALA), the notice must be given as soon as possible after the existence of an emergency has been ruled out or the emergency condition has been stabilized.

** Except those patients covered by Medicaid or Workers' Compensation, who are not subject to insurance co-pays.*

DOUGLAS A. GERARD, MD

March 6, 2014

General Law Committee
Room 3500, Legislative Office Building
Hartford, CT 06106

Dear Sirs:

I am a physician practicing as a general internist in New Hartford. The following comments are pertinent to HB 5337, An Act Concerning Fees Charged for Services Provided at Hospital-Based Facilities.

In the past two years I have had multiple patients complain about fees charged by the Charlotte-Hungerford hospital in relation to their hospital employed physicians. In the Torrington area, all the surgeons, urologists, cardiologists, and an orthopedist are now hospital employees.

Last April, I personally saw one of the surgeons for a simple skin biopsy performed in his usual office. Aetna allowed \$132 for the physician's bill and \$213 for the hospital facility fee, though Aetna "pays" \$1088 toward that facility fee. Since I had not met my deductible yet for the year, those charges were ultimately paid by me. A subsequent visit 6 weeks later resulted in similar charges. Those of us that have high deductible health care plans such as HSA plans and the newer health care exchange plans offered by this state are particularly vulnerable to these hospital facility fees.

As a physician, I am also placed in a difficult position with regards to hospital facility fees. I am now part of an Accountable Care Organization associated with St. Francis Hospital in Hartford. This organization formed as a result of healthcare reform measures adopted in the past several years. The hospital and its doctors, including doctors in the outlying community, will be entering into downside financial risk bearing contracts with not only Medicare, but several commercial insurance companies. The entire organization's "bottom line" will be influenced by the cost of rendering care to its thousands of patients. Because of this, I am now avoiding referring my patients to any hospital employed physicians in the Torrington area, opting instead to find better value care in surrounding towns.

The measures proposed in HB 5337 are a move in the right direction. I would also like to see the need for notification of patients of these fees at the time they first make an appointment. Walking into a physician's office after waiting several weeks for an appointment and finding out that there are extra charges, sometimes exorbitant, imposed on that visit is not "transparent" enough. The patient will not likely choose to cancel that

536 MAIN STREET, PO BOX 202 • NEW HARTFORD, CT • 06057
PHONE: (860) 379-4942 • FAX: (860) 379-2067
EMAIL: douglasgerard@hotmail.com

March 6, 2014

visit and wait to find care elsewhere.

On behalf of the patients and physicians in this state, I want to thank you for your attention to this problem.

Sincerely,

Douglas A. Gerard MD



STATE OF CONNECTICUT
OFFICE OF THE STATE COMPTROLLER
55 ELM STREET
HARTFORD, CONNECTICUT
06106-1775

Kevin Lembo
State Comptroller

Martha Carlson
Deputy Comptroller

WRITTEN TESTIMONY
Kevin Lembo
State Comptroller

Concerning H.B. 5337 An Act Concerning Fees Charged for Services Provided at Hospital-Based Facilities

March 6, 2014

Senator Doyle, Representative Baram, Senator Witkos, Representative Carter and Members of the Committee:

Thank you for the opportunity to testify in support of H.B. 5337 An Act Concerning Fees Charged for Services Provided at Hospital-Based Facilities.

In recent years the health care service delivery landscape has been changing rapidly in Connecticut. In the past, doctors were primarily independent or part of small group practices. Over the last few years, however, hospitals and provider practices have found it in their mutual interest to merge.

The changes in the health care delivery system that we are witnessing have great potential to improve health outcomes and lower health care utilization. Hospital systems and large provider practices with sophisticated health information technology systems and electronic health records have the potential to improve care coordination, chronic disease management and eliminate the need for redundant tests and procedures.

On the other hand, the consolidation of provider practices and hospital groups also has the potential to increase prices for health care services. One area where this potential is manifesting is in the expanded use of facility fees by hospital-based (associated) practices. Facility fees are charges designed to offset some of the costs of maintaining and operating a hospital facility and are in addition to the standard professional service charges generally associated with medical care. Historically, facility fees were limited to services received on a hospital campus. Recently, however, facility fees have been charged when services are provided at locations far from the hospital campus. For patients this can be confusing and lead to significant unexpected costs.

Many patients don't realize they may be subject to a hospital facility fee. This is especially true when facilities change ownership. A patient may have visited a certain facility in the past and was only billed for professional services; now a patient will receive both a bill for professional services and a facility fee.

HB 5337 works to address this issue by requiring hospital-based facilities to provide written notification to a patient that informs them:

- The facility is part of a hospital or health system and that the hospital or health system charges a facility fee separate from the professional fee charged;
- The amount of the patient's potential financial liability; and,
- That they may incur financial liability that is greater than the patient would incur if the services were provided at a non-hospital based facility.

The bill also includes provisions requiring that hospital-based facilities clearly display their affiliations.

Combined, these provisions will assist patients in understanding and managing their potential out of pocket costs for their health care. It may also assist in reducing prices. A recent study by the University of Chicago found that price transparency regulations had the effect of lowering the price charged for "common, uncomplicated, elective procedures" by approximately 7% on average, with the bulk of that reduction resulting from high price providers lowering their prices.¹

In the case of HB 5337, the transparency requirement is contingent upon a facility charging a facility fee. The extra burden of providing each patient with written notice of their potential financial liability may discourage the use of facility fees altogether.

To further enhance the transparency provisions of HB 5337, the committee may want to consider expanding the language to require hospital-based facilities that charge such fees to report their charges to the Office of Health Care Access, who can then post them on a publicly available website. Making this information public would allow patients to easily weigh their cost when selecting a provider prior to making an appointment or receiving services. If requested, my office would be happy to assist with this effort.

Overall, I continue to have concerns about the price implications of hospital system consolidation. In the state employee plan, which my office administers, we are seeing significant increases in the price per service, even while the Health Enhancement Program (HEP) is helping to lower increases in utilization. The increasing prices are not exclusive to the state employee plan as payers across the state and country are facing similar issues. A recent report by the Health Care Cost Institute found that inpatient

¹ Hans B. Christensen, Eric Floyd and Mark Maffett. *The Effects of Price Transparency Regulation on Prices in the Healthcare Industry*. The University of Chicago, October 2013.

admissions actually declined in 2012, but overall costs rose due to increased prices. Similarly outpatient services saw a very modest increase in utilization (1.4%), but prices for those services rose by more than 6%.² As my office continues to work on lowering utilization rates through improved plan design, and increased focus on preventive care and chronic disease management, a broad based effort must be made to work toward a policy for retaining health care price increases so lower utilization will also mean lower cost.

If passed, HB 5337 will assist patients in understanding their potential financial liability associated with services received at hospital-based practices and may place downward pressure on the proliferation of facility fees. It is a good step in tackling one aspect of rising health care prices; I hope you will join me in supporting its passage.

² Health Care Cost Institute. *2012 Health Care Cost and Utilization Report*. September 2013, <http://www.healthcostinstitute.org/files/2012report.pdf>

Testimony of Tom Swan, Executive Director of CCAG

Before the General Law Committee

In support of HB 5337 AAC FEES CHARGED FOR SERVICES PROVIDED AT A HOSPITAL-BASED FACILITIES

March 6, 2014

Senator Doyle, Representative Baram and other members of the General Law Committee my name is Tom Swan and I am the Executive Director of the CT Citizen Action Group (CCAG) with over 25,000 member families. I want to thank you for raising HB 5337 AAC FEES CHARGED FOR SERVICES PROVIDED AT A HOSPITAL-BASED FACILITIES and urge its passage. It is a basic consumer right to know issue.

Attorney General Jepsen has done a good job documenting the scope of the problem. Families facing health problems should not be surprised by hidden fees for services they receive.

I consider myself an informed consumer and have what is considered very good insurance coverage. I recently was diagnosed with a condition that called on me to see a hospital based specialist and to purchase some related equipment. It was at least implied to me that my insurance would cover it.

Several weeks later I began receiving a bill from a company I had never heard of for things that I was not sure what they were. I was not sure if this was a scam or if I needed to pay them. I made a series of phone calls and realized what they were for, but am concerned about how such fees could impact someone with more limited income and how the lack of up front disclosure could lead people to become victims of scams.

I know the Hospital Association has called for voluntary disclosure from its members after press reports on this problem, but that is not enough. We need legislation to protect consumers and I want to once again thank you for raising this bill today and urge its passage.



**TESTIMONY OF YALE NEW HAVEN HEALTH SYSTEM
SUBMITTED TO THE
GENERAL LAW COMMITTEE
Thursday, March 6, 2014**

**HB 5337, AN ACT CONCERNING FEES CHARGED FOR
SERVICES PROVIDED AT HOSPITAL-BASED FACILITIES**

Yale New Haven Health System (YNHHS) appreciates the opportunity to submit testimony concerning **HB 5337, AN ACT CONCERNING FEES CHARGED FOR SERVICES PROVIDED AT HOSPITAL-BASED FACILITIES**.

It is our understanding that this bill will require hospitals to provide patients with an estimate of their potential out-of-pocket liability in advance of their treatment in a hospital-based facility. YNHHS supports the spirit and intent of this bill, but we urge you to make a minor, but important amendment (described below) before its passage.

YNHHS is Connecticut's leading healthcare system with over 19,000 employees and nearly 6000 medical staff who provide high quality care to Connecticut residents from across the state (and beyond) every day. Through Bridgeport Hospital, Greenwich Hospital, and Yale-New Haven Hospital, we offer our patients a range of healthcare services, from primary care to the most complex care available anywhere in the world.

Our facilities include those that are not located on a hospital campus, and provide services that, traditionally, have been hospital-based. The hospital services provided in these facilities include emergency medicine, diagnostic radiology, and laboratory medicine. For each of these services, the hospital and the physicians separately bill for their respective services, just as they do for on-campus services.

In recent years, our facilities began to include locations that formerly were physician practices. In this unprecedented time of change in healthcare, market forces and the implementation of the Affordable Care Act are causing providers to seek new ways to collaborate and coordinate care within an otherwise fragmented system, while at the same time improving quality and reducing costs. A hospital's ability to influence the coordination, efficiency or quality of care provided in physician's offices is limited. In fact, certain federal laws impose significant limits on arrangements between hospitals and private physician practices. To further the objective of establishing a more coordinated and cost-effective continuum of care, hospitals are establishing off-campus outpatient departments throughout the state.

Our hospitals already undertake a series of actions to inform patients and the public when acquiring a physician practice. These steps include the installation of signage identifying the facility as part of the hospital, and mailing letters informing them of the transition and the separate billing by the hospital and the physicians. We may have made it clear to patients that they are being treated in a hospital facility, but patients are still confused about how that impacts their out-of-pocket expenses – an impact that becomes increasingly significant as health insurance plans are shifting more costs directly to the patient through higher deductibles and coinsurance liability.

It is our understanding that a small, but critically important phrase was inadvertently left out of the bill during the drafting process. We urge you to insert the phrase “evaluation and management (E/M)” into Sections 2(a) and 2(b) so that the first sentence of each section reads, respectively, as follows:

“2(a) If a hospital or health system charges a facility fee utilizing a current procedural terminology (CPT) evaluation and management (E/M) code for outpatient services provided at a hospital-based facility where a professional fee is also expected to be charged, the hospital or health system shall provide the patient with a written notice that includes the following information.”

“(b) If a hospital or health system charges a facility fee without utilizing a current procedural terminology (CPT) evaluation and management (E/M) code for outpatient services provided at a hospital-based facility, located outside the hospital campus, the hospital or health system shall provide the patient with a written notice that includes the following information:”

The above distinction is important for a few reasons. First, the elimination of the distinction renders Section 2(b) of the bill superfluous because every hospital facility fee (as that term is defined in the bill) is charged utilizing a CPT code. Second, and more importantly, the treatment scenarios under which E/M codes are utilized are the most significant source of patient confusion with respect to hospital facility fees. E/M codes are generally used to represent physician visits or consultations. When a patient sees his/her physician in a hospital-based facility, the physician charges the patient (or the insurer) for the professional service utilizing a professional E/M code, and the hospital charges the patient (or the insurer) its facility fee utilizing a facility E/M code. As a result of these separate bills, the patient will generally be charged more than the patient would have been charged if the physician service had been performed in a non-hospital-based setting, and some patients are confused about why they are being charged by the hospital.

Sometimes, however, a patient will get a hospital service without a corresponding physician service. For example, a patient may come to one of our hospital-based facilities for radiological or lab services. The hospital will bill only for the hospital services provided, and not a bill an E/M code solely representing the use of the facility. At some point, a physician might also bill for analyzing the lab sample or reading the x-ray, but that service is a separate, related physician service, which is not necessarily

performed at the same time, or in the same location as the hospital service. We have very little evidence of patient confusion under this scenario.

The E/M code distinction strikes the right balance with respect to the administrative burden this bill imposes on Connecticut hospitals. This distinction targets the scenario that causes patient confusion (i.e., when a professional and hospital service are provided simultaneously, such that the patient receives a bill from both the professional and the hospital for services provided at the same time). It also allows hospitals to comply with the requirements of the bill and provide meaningful estimates of patient liability by appropriately limiting the universe of CPT codes where such an estimate is required.

If amended as described above, YNHHS supports HB 5337 because it is consistent with our goal of increased transparency with respect to the cost of the services we provide to our patients, and their potential responsibility with respect to those costs. This bill will provide hospital patients with the information they need to make more informed decisions before they receive services. Provided that the E/M code distinction is restored, we do not feel that the requirements of this bill pose an unreasonable burden on Connecticut hospitals. Although the implementation of the requirements of this bill may present logistical challenges (even with the E/M code distinction), the patient notices required under the bill will reduce patient confusion about their healthcare bills. To us, that benefit to our patients outweighs the administrative burden.

We support the spirit and intent of this bill because it is in the best interests of the patients we serve. We cannot support it in its current form because it is overbroad and imposes an unreasonable burden on Connecticut hospitals. We urge you to amend HB 5337 as we have recommended, and to support it. Thank you for your consideration of our position.



Quality is Our Bottom Line

General Law Committee Public Hearing

Thursday, March 6, 2014

Connecticut Association of Health Plans

Testimony in Support of

HB 5337 AAC FEES CHARGED FOR SERVICES PROVIDED AT HOSPITAL-BASED FACILITIES

The Connecticut Association of Health Plans (CTAHP), including Aetna, Anthem, Cigna, ConnectiCare, United and Harvard Pilgrim, is pleased to support HB 5337 and commends the Attorney General for bringing forth a discussion on the fees associated with care provided at hospital-owned facilities

CTAHP would also like to state for the record that we appreciate the efforts of the Connecticut Hospital Association in working toward a resolution on this critically important issue to assure that our members and Connecticut citizens at-large are well informed as to the policies and procedures in place

Passage of the Affordable Care Act (ACA) has dramatically altered the health care landscape not only in Connecticut, but across the nation. All stakeholders are facing unprecedented challenges in the effort to deliver on the promise of health care reform and while the health insurance carriers remain committed to overall vision, the industry acknowledges there will be obstacles to overcome along the path to success. With strong leadership from our state policy makers and partnership among the various stakeholders, we will achieve that goal together. CTAHP urges the Committee's passage of HB 5337.

Many thanks for your consideration.