UNIVERSAL HEALTH CARE
FOUNDATION OF CONNECTICUT

Testimony In Support Of
Senate Bill 451: An Act Protecting Patients From Unreasonable Medical Bills
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Universal Health Care Foundation of Connecticut supports Senate Bill 451: An Act Protecting Patients From Unreasonable Bills, whose purpose is to "close loopholes and increase patient protections regarding facility fees charged at hospital-owned and hospital-affiliated facilities."

The bipartisan Public Act 15-146[i] began putting in protections for patients in facility fees. As is the case with most comprehensive legislation, PA 15-146's provisions on facility fees need revision to ensure that consumers are protected from unreasonable medical bills.

We encourage you to see the attached pages from the summary of PA 15-146 pertaining to facility fees, for those of you who are not familiar with the existing statute.

What is a facility fee?
A facility fee is charged by a hospital, in addition to any other charges, to account for the overhead costs of running a hospital. As hospitals have grown to become health systems, and acquired other facilities off the hospital campus, patients are being charged facility fees at their once-independent doctor's offices that have been acquired by a health system – even if the doctor's office is miles away from the hospital.

While Medicare and Medicaid pay facility fees, private insurance often does not cover these fees, and this adds to the out-of-pocket costs of the privately insured. This problem was part of the reason that PA 15-146 addressed facility fees in the first place – consumers were outraged that they were paying additional fees to see the doctors or access the ambulatory services that they have been using for years. The proliferation of high deductible health plans, where a consumer is responsible for an ever-higher deductible for certain services before the insurance plan will cover payment, makes the addition of facility fees to a bill even more unaffordable for the consumer.

Please note that we also support Senate Bill 23: An Act Requiring Site-Neutral Payments for Health Care Services, for which we submitted testimony[ii] to the Insurance and Real Estate Committee (you can see our written testimony here). Medicare has begun to establish rules for site-neutral reimbursement, which may limit facility fees.

Why the need to "close loopholes"?
Despite protections established in PA 15-146, patients are still being charged facility fees. There are specific responsibilities and restrictions in PA 15-146, both for providers and insurers. Providers are only allowed to charge facility fees in certain instances, and there are specific notification regulations when a

hospital purchases a practice that must inform patients of the impending changes. Insurers are prohibited from imposing a separate cost-sharing amount on facility fees. Again, please see the attached pages for the specific restrictions and requirements around facility fees.

If insurers or providers are utilizing loopholes in the existing statute to charge patients unlawfully, we must strengthen the protections of the current law. As state legislators, it is imperative that the intent of the existing protections are implemented and that consumers aren't being wrongfully charged facility fees.

There is no one easy solution for making health care more affordable. There are many players, many stakeholders, and many factors affecting our health. Affordable health care requires a coordinated approach with interconnected measures. This is one such measure, protecting consumers from unreasonable medical bills, and preventing providers and insurers from taking advantage of loopholes in statute to squeeze consumers even more than they already are.

We have to remember that health care affordability isn't just about lowering costs in the larger system – it's also about consumers getting the high-quality health care they need, at a price they can afford.

Universal Health Care Foundation of Connecticut's mission is to serve as a catalyst that engages residents and communities in shaping a democratic health system that provides universal access to quality, affordable health care and promotes health in Connecticut. We believe that health care is a fundamental right and that our work is part of a broader movement for social and economic justice.

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[i] Public Act 15-146: https://www.cga.ct.gov/2015/ACT/pa/pdf/2015PA-00146-R00SB-00811-PA.pdf

[ii] Universal Health Care Foundation of Connecticut's testimony in support of Senate Bill 23: An Act Requiring Site-Neutral Payments for Health Care Services: https://www.cga.ct.gov/2017/insdata/tmy/2017SB-00023-R000207-Universal%20Health%20Care-TMY.PDF

The act also makes it an unfair trade practice for a health care provider to report to a credit reporting agency an enrollee's failure to pay a bill for the above listed items when a health carrier has primary responsibility for paying. Under prior law, it was an unfair trade practice to report to a credit reporting agency an enrollee's failure to pay a bill for medical services that a managed care organization had primary responsibility for paying.

The act requires contracts between HMOs and participating providers to reflect what constitutes an unfair trade practice, as described above. It also makes technical and conforming changes.

EFFECTIVE DATE: July 1, 2016

§§ 13 & 14 - FACILITY FEES

Limits on Allowable Fees

By law, a "facility fee" is any fee a hospital or health system charges or bills for outpatient hospital services provided in a hospital-based facility that is (1) intended to compensate the hospital or health system for its operational expenses and (2) separate and distinct from the provider's professional fee.

On and after January 1, 2017, the act places certain limits on facility fees collected by hospitals, health systems, and hospital-based facilities. It prohibits them from collecting a facility fee for outpatient services that (1) use a current procedural terminology evaluation and management code and (2) are provided at a hospital-based facility, other than a hospital emergency department, that is not on a hospital campus. It prohibits them from collecting a facility fee from uninsured patients for outpatient services, other than those provided in off-site emergency departments, that exceeds the Medicare facility fee rate. A violation is an unfair trade practice.

If an insurance contract in effect on July 1, 2016 provides reimbursement for facility fees that are prohibited by these provisions, the hospital or health system may continue to collect reimbursement from insurers for these fees until the contract expires.

Billing Statement Notice

Beginning January 1, 2016, the act requires each billing statement that includes a facility fee to:

1. clearly identify the fee as a facility fee that is in addition to, or separate from, the provider's professional fee, if any;

2. provide the comparable Medicare facility fee reimbursement rate for the same service;

3. include a statement that the fee is intended to cover the hospital's or health system's operational expenses;

4. inform the patient that his or her financial liability might have been less if the services had been provided at a facility not owned or operated by the hospital or health system; and

5. include notice of the patient's right to request a reduction in the facility fee, or any portion of the bill, and a telephone number that the patient may use to make thisrequest.

These requirements do not apply to billing statements for Medicare or Medicaid patients or those receiving services under a workers' compensation plan.

Notice of Transaction Resulting in Hospital-Based Facility; Stay on Collecting Facility Fees

Under the act, on and after January 1, 2016, if a transaction materially changes the business or corporate structure of a physician group practice and establishes a hospital-based facility at which facility fees will likely be billed, the hospital or health system purchasing the practice must notify each patient the practice served in the previous three years. The purchaser must send the notice by first class mail, within 30 days after the transaction.

The notice must include the following:

1. a statement that the purchased facility is now a hospital-based facility and is part of a hospital or health system;

2. the purchaser's name, business address, and telephone number;

3. a statement that the hospital-based facility bills, or is likely to bill, a facility fee that may be in addition to, and separate from, any provider professional fees;

4. a statement that the patient's actual financial liability will depend on the medical services provided him or her;

5. an explanation that the patient may incur greater financial liability than if the facility were not hospital-based;

6. the estimated facility fee amount or range of amounts the facility may bill or an example of the average facility fee it bills for its most common services; and

7. a statement that, before seeking services at the facility, an insured patient should contact his or her insurer for additional information on hospital-based facility fees, including any potential financial liability for the patient.

Some of these requirements are similar to existing notice requirements for facilities that already charge facility fees.

The purchaser also must provide a copy of this notice to OHCA, which must post a link to the notice on its website.

The act prohibits a hospital, health system, or hospital-based facility from collecting a facility fee for services provided at a purchased facility subject to these notice provisions from the transaction date until at least 30 days after the required notice is mailed to the patient or a copy is filed with OHCA, whichever is later. A violation is an unfair trade practice.

Form of Written Notices

Existing law sets certain notice requirements for hospitals or health systems that charge facility fees, and requires notices to patients to be in plain language and in a form reasonably understandable to someone without special knowledge of these fees. The act extends this requirement to the (1) billing statement notice and notices following certain group practice acquisitions as described above and (2) other existing notice requirements (such as required signs in waiting rooms about potentially greater financial liability due to facility fees, compared to facilities that are not hospital-based).

Annual Reporting

Beginning by July 1, 2016, the act requires each hospital and health system to annually report to the DPH commissioner on the facility fees it charged or billed the prior year at hospital-based facilities outside a hospital campus. The commissioner must publish the reported information or post a link to the information on OHCA's website.

Each report must include:

1. the name and location of each such facility that the hospital or health system owns or operates and that provides services for which a facility fee is charged or billed;

2. the number of patient visits at each such facility for which it charged or billed a facility fee;

3. the number, total amount, and range of allowable facility fees paid at each facility by Medicare, Medicaid, and private insurance policies;

4. the amount of the hospital's or health system's facility fee revenue from these facilities, per facility and in the aggregate;

5. a description of the 10 procedures or services that generated the most facility fee revenue and the total revenue derived from these fees for each such procedure or service; and

6. the top 10 procedures for which facility fees are charged, based on patient volume.

Insurance Copayments and Deductibles

The act prohibits health insurers and similar entities that reimburse a hospital, health system, or hospital-based facility for facility fees for outpatient services provided off-site from a hospital campus from imposing a separate copayment for these fees. If an insured person has not satisfied his or her deductible, the hospital, health system, or hospital-based facility may not collect from the person a facility fee exceeding the agreed-upon reimbursement rate under that contract.

These provisions apply to health insurers, HMOs, or other entities delivering, issuing, renewing, amending, or continuing individual or group health insurance policies or health benefit plans on or after January 1, 2016, that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; and (4) hospital or medical services, including coverage under an HMO plan. The provisions apply to reimbursement agreements under contracts entered, renewed, or amended between these entities and a hospital, health system, or hospital-based facility on or after October 1, 2015. Due to the federal Employee Retirement Income Security Act (ERISA), state insurance benefit mandates do not apply to self-insured benefit plans.

EFFECTIVE DATE: October 1, 2015

§ 15 - PATIENT NOTIFICATION OF AFFILIATED PROVIDERS

The act requires health care providers to give patients written notice when referring them to an affiliated provider. The notification must (1) inform them that they are not required to see the affiliated provider and they have the right to seek care from the provider of their choice and (2) provide the website and toll-free telephone number of their health carrier to obtain information regarding in-network health care providers and estimated out-of-pocket costs for the referred services.

The act applies to providers referring patients to an affiliated provider who is not a member of the same partnership, professional corporation, or limited liability company as the referring provider. "Affiliated" means a relationship between two or more health care providers that permits them to negotiate, jointly or as members of a health care provider group, with third parties over rates for professional medical services.

The act exempts health care providers who provide a substantially similar notice pursuant to federal law.

EFFECTIVE DATE: October 1, 2015

§ 16 - TIERED NETWORKS

The act requires Access Health CT to (1) encourage health carriers to offer tiered network plans and (2) offer any such plans through the exchange. A tiered network plan has different cost-sharing rates for different health care provider tiers, and rewards enrollees with lower copayments, deductibles, or out-of-pocket expenses for choosing providers in certain tiers.

EFFECTIVE DATE: October 1, 2015

§§ 17 & **18** -HEALTH CARE CABINET

The act renames the 28-member "Sustinet Health Care Cabinet" the "Health Care Cabinet" to conform to