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TESTIMONY OF
ATTORNEY GENERAL GEORGE JEPSEN
BEFORE THE GENERAL LAW COMMITTEE
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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.