



**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.

