Testimony of Victoria Veltri
State Healthcare Advocate
Before the Public Health Committee
Concerning SB 809, SB 810, SB 811, SB 812, SB 813, SB 687 & SB 993
March 11, 2015

Good afternoon, Representative Ritter, Senator Gerratana, Senator Markley, Representative Srinivasan and members of the Public Health 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.

This series of proposed bills strives to address the complexities of Connecticut's evolving healthcare system and the need for a robust, dynamic, transparent and sustainable model for the future.

Transparency and consistency in healthcare costs are crucial to this goal. Currently, consumers have little opportunity to understand or even be informed of the expected cost of their healthcare until after the service has been delivered. These proposed bills support the development of a system to study and monitor healthcare costs. In order for such an entity to be responsive the needs of our citizens, it must have participation from all stakeholders, payers, providers and consumer, and evaluate the provider charges,

consumer costs, payer reimbursement and quality of healthcare in our state. The All-Payer Claims Database (APCD) has potential to provide significant insight into these trends to help guide informed policy decisions, but additional granularity in the evaluation of pricing trends as well as quality metrics are essential to the realization of the goals promoted here, and must be developed thoughtfully. The concepts promoted by these bills continue our state's discussion and commitment to our ongoing efforts. SB 813 establishes a central resource for consumers to compare the cost and quality of healthcare services across providers and hospitals, a comprehensive educational component concerning health insurance and clinical terminology and concepts and requires that communications to consumers clearly state the charges. While many of these functions already exist and are done well, by both public and private entities, there is no one singular resource for consumers to refer to when seeking information or clarity about their healthcare options.

Additional measures must be undertaken to provide consumers with accurate and timely information concerning their healthcare needs. SB 809, SB 993 and SB 687 all seek to enhance transparency and equity in the charges for these services. Hospital mergers and provider practice acquisition have augmented the trend of increasing utilization of hospital based outpatient departments, but consumers may not always be aware of the additional costs that can be associated with the delivery of care in these settings, in particular, the imposition of facility fees. The Medicare Payment Advisory Commission (MedPAC) recently modified its position concerning the imposition of these fees and developed a test that assesses several distinct criteria for a given service to determine if reimbursement should be site-neutral, meaning that the reimbursement should be the same regardless of where the service is delivered. This test assesses whether the additional quality measures inherent in a hospital setting are necessary for the safe and effective delivery of a given service – which is the reason facility fees were originally permitted. MedPAC's test considers: if the service is performed at least 50% of the time in a physician office setting, an indicator of the safety of providing the service in a non-hospital setting, whether there are minimal differences across service locations in how the service is provided, if the typical patient acuity is no different across settings and whether the service does not have a 90-day surgical code. Services meeting these criteria are deemed to be clinically safe and

appropriate to perform in a physician office setting and the additional level of care that facility fees presume to compensate for is unnecessary. MedPAC's findings identified a series of services, listed as Group 1 of the Medicare payment classification system, as such services, and recommended the elimination of facility fee charges for these services when delivered in hospital based setting. The inclusion of this group of services, as amended from time to time, represents an important measure to promote effective, high quality healthcare while reducing unnecessary costs. These criteria should serve as a baseline for our continuing efforts to evaluate and improve the quality of care that consumers receive, while striving to control costs, but we should not stop there. SB 807 before the Insurance and Real Estate Committee promotes the inclusion of these site-neutral standards into provider participation agreements with health plans.

Although the intent of SB 809 promotes greater consumer protections against needless and often unanticipated expenses, facility fees, where they are appropriate, ought to be based on the actual costs of providing the higher level of care that may be indicated for some services. This promotes equity in billing and reimbursement for the delivery of necessary treatment, while bolstering transparency in healthcare costs so that consumers can make informed and thoughtful decisions concerning where to receive their care.

This issue lends itself to a discussion concerning the need for a single authority to monitor and evaluate healthcare cost, delivery and payment trends, as well as the healthcare market indicators. This is not a novel concept. Other states, including Massachusetts and Vermont, have established an entity that monitors the myriad factors influencing healthcare policy and delivery in their state. This coordination and integration of planning and policymaking promote maximum stakeholder participation, and must include consumers, so reforms may be responsive to all of Connecticut's residents. Such an entity could evaluate trends, including hospital and provider consolidation, and recommend policy changes that incorporate not only our state's experience, but successes elsewhere. Indeed, Connecticut's State Innovation Model (SIM) initiative promotes care coordination and resource integration as key components of its model. Active participation by payers, providers, consumer and the state is essential to the successful implementation of this

effort and maximizes available resources while minimizing redundancy and the associated costs. However, the development of an effective and responsive infrastructure with which to support and measure these efforts is critical to our success. The creation of a single entity to monitor healthcare trends and inform policy is one important step towards the realization of this goal, and the proposal to create a statewide health information exchange (HIE) is another. It is a key element in that infrastructure and promotes greater insight into population health needs, utilization and cost trends and facilitates greater care coordination across providers and payers. However, as we develop this model, we must be thoughtful and deliberate, understanding the limitations that have hampered our efforts to develop an effective HIE in the past, while ensuring that the model is dynamic and adaptive to the evolution of healthcare delivery, as well as congruent with complimentary regional and national efforts, whenever possible.

In order to realize the promise of affordable, quality healthcare, and to stem the unsustainable trends in healthcare costs that our state and nation has seen, each person needs to be empowered to actively and effectively participate in their own healthcare, but the current landscape makes that very difficult for even the most sophisticated consumer to achieve. Providing detailed information about the cost and quality of healthcare for consumers, offering consistent policy guidance that is based on a comprehensive understanding of market trends and streamlining expectations for providers all are important elements of an extensive and inclusive system of reform. Each by itself represents an important initiative, but each by itself cannot achieve these goals, but are integral pieces of a larger effort. These bills continue Connecticut's initiative to realize the effective integration of our healthcare delivery and payment system while promoting consistency and transparency for all stakeholders, and affordable, sustainable healthcare system for Connecticut.

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.