



Connecticut State Medical Society Testimony
Senate Bill 687 An Act Concerning Notice To Patients Of Costs For Routine Health Services
Public Health Committee
March 11, 2015

Senator Gerratana, Representative Ritter and Members of the Public Health Committee, on behalf of the physicians and physicians in training of the Connecticut State Medical Society (CSMS) and all the organizations listed above, thank you for the opportunity to provide this testimony on **Senate Bill 687 An Act Concerning Notice To Patients Of Costs For Routine Health Services**.

On behalf of this large group of dedicated physicians, we express our deep appreciation for the efforts of this committee in calling attention to the importance of transparency in health care and for trying to address this problem.

Transparency is not new to our organizations; we have been fighting for transparency in health care for many years. We applaud the effort to engage the patient in decision making by bringing clarity to the health insurance process, a system that has confounded many a doctor, not to mention our patients.

One of the most significant and repeatedly stated goals of the Accountable Care Act (ACA) is to bring affordable insurance coverage to each and every resident of the state. As of 2014 with 96% of our residents covered by insurance we have all but reached that goal. With 96% coverage, physician fees are no longer set by physicians; they are set by the insurance industry through the contractual process, typically very lopsided in favor of the large and powerful industry. A physician's fee schedule rarely has anything to do with what a physician gets paid or what a patient gets charged. Compelling physicians or any other providers to disclose their fee schedules certainly has the appearance of transparency, but it will not accomplish the true

purpose of transparency, and it will not accomplish the purpose stated in this bill, which is to help patients participate meaningfully in decision making processes that will help shape the health care landscape in a positive way.

Providing patients with information regarding “standard costs” would be very difficult and often misleading or inappropriate for a few reasons. As mentioned, physician reimbursement is mostly unrelated to patient charges. The actual cost to a patient for a service is dependent on whether or not there is insurance coverage, the insurer, the actual plan purchased by the patient and the contract between the physician and the insurer. Contract are often un-negotiated contracts in which physician reimbursement is set by the insurer. The actual cost to the patient would be different for services dependent on such items as coverage, copayment and deductible levels, in-network or out of network limits and other factors tied to the insurer plan benefit design and patient cost sharing.

Physicians often work with patients without insurance coverage and in most cases establish reimbursement agreements below their established fee schedule or what is usual and customary for the service. For patients with insurance, physicians are prohibited from sharing fee schedules considered propriety by the insurer.

With 96% of our citizens with some form of insurance coverage, what is missing in this discussion is the insurer is the entity responsible for the final cost to enrolled patients. While we support the need for transparency, we suggest to the committee that SB 687 be written in such a manner to require insurers to provide real time information on cost and payment obligations to enrolled patients regarding the services they seek from physicians and other health care professionals in Connecticut. We offer our resources to assist the committee in working through this very complicated issue to ensure that patients have the necessary information from their insurers to make informed decisions about their health care needs and the availability of physicians.