



Office of the  
Healthcare  
Advocate  
STATE OF CONNECTICUT

Testimony of the Office of the Healthcare Advocate  
Before the Insurance and Real Estate Committee  
In Support of SB 281  
March 3, 2016

Good afternoon, Senator Crisco, Representative Megna, Senator Hartley, Representative Zoni, and members of the Insurance and Real Estate Committee. For the record, I am Demian Fontanella, General Counsel for the Office Healthcare Advocate ("OHA"). OHA is an independent state agency with a three-fold mission: assuring 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.

Thank you for the opportunity to comment in support of SB 281, An Act Requiring Site-Neutral Reimbursement Policies in Contracts Between Health Carriers and Health Care Providers. This bill promotes greater pricing transparency and consistency for consumers by imposing realistic limitations on health care system's use of facility fees.

This bill brings Connecticut into alignment with the Medicare Payment Advisory Commission's (MedPAC) recommendations concerning the imposition of these fees, which proposed limiting Medicare reimbursement for services that meet specific criteria. MedPAC reviewed the most common services and assessed several distinct criteria for each: whether the service was 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. MedPAC determined that services meeting these criteria were clinically safe, and

appropriate to perform in a physician office setting, and that the additional level of care that facility fees presume to compensate for was clinically unnecessary. The services listed in Group 1 of the Medicare payment classification system are such services, and the MedPAC's proposal to eliminate facility fee charges for these services when delivered in hospital based settings is appropriate. SB 281 merely acknowledges the MedPAC's recommendations concerning the merit and clinical justification for when additional fees may, and may not be, appropriate for the service delivered. This is reflected in the limited additional reimbursement MedPAC supports for those services classified as Group 2, for which it determined that some additional measures may be clinically appropriate, but that the fee should reflect only the additional components essential to delivering the service in an ambulatory or outpatient setting.

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.

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 [demian.fontanella@ct.gov](mailto:demian.fontanella@ct.gov).