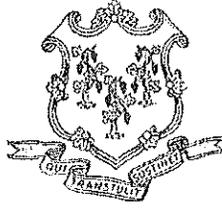


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Eleventh District  
*New Haven, Hamden & North Haven*

March 2, 2016



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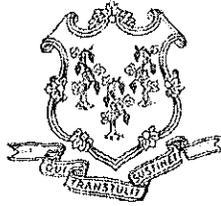
Good afternoon Sen. Gerratana, Rep. Ritter and members of the Public Health Committee. I am here to testify in regard to SB 289 AN ACT CONCERNING HEALTH CARE SERVICES, HB 5455 AN ACT ESTABLISHING A TASK FORCE ON PATIENTS' MEDICAL RECORDS, HB 5451 AN ACT CONCERNING THE DEPARTMENT OF PUBLIC HEALTH'S RECOMMENDATIONS FOR VARIOUS REVISIONS TO THE OFFICE OF HEALTH CARE ACCESS STATUTES, and SB 298 AN ACT CONCERNING TELEHEALTH SERVICES FOR MEDICAID RECIPIENTS

There are several provisions in SB 289 that are of grave concern to me in that they would roll back some of the important strides toward transparency made in SB 811 (PA 15-146) last year. I understand that this language was requested by the Connecticut Hospital Association (CHA) and that the Committee agreed to give these concepts a hearing; I believe that this hearing will prove to be useful. I am disappointed, however, in CHA's proposals. I had been assured by CHA representatives that they would request only technical fixes and had no plans to attempt to roll back any of the provisions in SB 811; unfortunately, CHA's requested language does exactly that.

Beginning January 1, 2017, SB 811 bans facility fees for a limited number of services, specifically evaluation and management services. For all other facility fees, it requires that hospital billing statements clearly identify all facility fees charged at hospital owned physician

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offices that are not on the hospital campus. Section 3 of this bill would effectively eliminate this important patient notice and transparency requirement by only requiring notice of facility fees for **evaluation and management services**. This would eviscerate the legislation AND it doesn't make a lot of sense; by the time that reporting would be required, those fees will no longer be charged. Hospitals would then be free to charge facility fees for all other outpatient community based services with no billing notice as required by SB 811. This directly undermines and the intent of the patient notice requirement which is to increase transparency and patient awareness regarding facility fees and hospital billing practices.

Section 1 of SB 289 would circumvent the price disclosure requirements that hospitals are required to give patients under SB 811 when scheduling a non-emergency procedure. SB 811 requires hospitals to notify patients, upon request and within three days of scheduling a non-emergency procedure, of the charge or allowed amount for the procedure, the comparative Medicare rate for such procedure, and certain care quality information. Price transparency is perhaps the single most important thing we can do to promote competition and enable consumers to make smart value based decisions about where they go for care. This language was modeled after legislation in Massachusetts and other states. No other industry would expect to be able to bill a customer for a service costing thousands or even tens of thousands of dollars without first providing an estimate. If they can do this in other states and if it is good for almost every other industry, hospitals can do it here in Connecticut.

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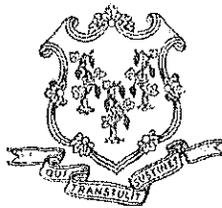
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It is absurd to think that posting this information on the hospital website or internet portal, as section 1 of this bill proposes, is sufficient. If a hospital can mail a bill to a patient, it can mail a notice. SB 811 even allows for electronic delivery. However, it must be delivered to the patient and not simply posted passively on a website where a consumer must search to find it. Section 1 also extends the already generous effective date for the requirement that hospitals inform patients regarding cost and quality data.

In addition, the language in section 4 that would exclude medical foundations from the notice of affiliation requirements is completely inappropriate. Patients are often unaware of the business relationships or affiliations between providers. For example, hospitals now employ hundreds of community based physicians through their affiliated medical foundations who then refer patients to each other and to their affiliated hospital. Providing increased notice and transparency regarding these affiliations as well as informing patients that they have a choice of provider is critical. We know that services at hospital affiliated physicians often cost more due to both facility fees and the increased reimbursement that large integrated health systems leverage. Patients cannot seek out value based care if they are unaware of these affiliations and don't know they have a choice. Excluding medical foundations would eviscerate the effectiveness of this

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section of SB 811. The medical foundations were specifically and intentionally included in the notice requirement.

I am also concerned that section 8's effective date is changed from July 2016 to January 2018. And in the final section of the bill it is also unclear to me why a hospital would want to allow an unlicensed or uncertified person to connect and disconnect oxygen supplies as this bill would do. Some of the other language changes in other sections would seem unnecessary and appear to make the legislation less clear.

Although I support the provision in section 6 that ensures that the notice of changes in the corporate structure of group practices are reported when the acquiring entity is an insurer or other business, I would prefer to expand the definition of captive professional entity to include these business organizations.

I would encourage you not to pass SB 289 but rather to add the few suggestions that are in fact technical to the bill on hospitals and physicians that I hope will be heard next week