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STATEMENT IN OPPOSITION TO SENATE BILL NO. 31

An Act Concerning Surprise Medical Bills for Laboratory Services

Health plans payers are engaged in systematic legal and policy efforts to drive down reimbursements by controlling the amounts paid for out-of-network services. The term 'surprise bill' applies to bills incurred by insured patients who receive services from an out-of-network provider at an in-network facility. This bill would expand the definition of 'surprise bill' to include nonemergency services rendered by out-of-network clinical labs. As a practical matter, health plan payers have complete control of rate-setting for the hospital-based specialties of Anesthesiology, Pathology, and Radiology under CT law which allows them to pay in-network rates for those services. If payers should decide to pay 50% of Medicare rates for these services, they are fully empowered to do so under CT law without facing bilateral negotiations, any legal relief for physicians, or market-based leverage from physicians to resist. The only exception is for Emergency Medicine services which are currently mandated to be paid at the 80th percentile of FAIR HEALTH INC. charges. We urge that Section 38a-477aa of the general statutes not be amended to expand the definition of 'surprise bill' to include bills for non-emergent health care services rendered by out-of-network clinical labs.

There are many highly valid medical reasons that referrals are made to out-of-network laboratories outside of the facility setting. If the medical reasons for such testing are explained to the patient by the ordering physician and the patient consents in writing to such testing the situation is not a 'surprise' and should not be subject to this law.

The proposed expansion of this bill to encompass all out-of-network referrals will be a great disincentive for health plan payers to contract with laboratories, especially if the provision for voluntary consent is not included, and would have the effect of denying patients access to specialized clinical laboratories, many out-of-state, who may not accept payment at the median in-network rate unilaterally controlled and dictated by plan payers in CT. If health plan payers can unilaterally dictate payment, physician services will

have no market value. The FAIR HEALTH 80th percentile reimbursement for Emergency Services enacted in CT several years ago is modeled after the NY statute which mandates such payment for all out-of -network providers. It is a fair practice for both physicians and consumers and is market-based. We therefore urge you to oppose SB 31. Thank you for the opportunity to address this committee.