

Insurance and Real Estate Committee

SENATE FAVORABLE REPORT

Bill No.: SB-333

AN ACT CONCERNING REIMBURSEMENTS FOR CERTAIN COVERED

Title: HEALTH BENEFITS.

Vote Date: 3/10/2020

Vote Action: Joint Favorable

PH Date: 3/5/2020

File No.:

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SPONSORS OF BILL:

Insurance and Real Estate Committee

REASONS FOR BILL:

This bill will require certain health insurers, preferred provider networks and other entities to include certain provisions in contracts with health care providers regarding reimbursement for certain covered health benefits.

RESPONSE FROM ADMINISTRATION/AGENCY:

Ted Doolittle, Healthcare Advocate for the State of CT feels this bill promotes greater pricing transparency and consistency for consumers by imposing realistic limitations on health care systems' use of facility fees, which are essentially an extra, separate fee charged when the same procedure is done in a hospital or a hospital-based clinic or office, rather than in a non-hospital setting. The facility fee is most commonly justified as being needed to help the hospital afford all of the extra equipment and capabilities that hospitals are required to have, but that physicians' offices or other non-hospital settings need not have in place. Facility fees can result in increased charges that are particularly frustrating and incomprehensible to consumers, since the same doctor performing the same procedure in two different office locations that look and feel identical can result in dramatically different total bills, based merely on whether one of the locations is classified as a hospital-based while the other is not.

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.

NATURE AND SOURCES OF SUPPORT:

UCONN Health stated the bill requires that health carriers contracting with health care providers on or after July 1, 2021 must (1) reimburse outpatient CPT evaluation and management and drug infusion codes at the same amount, regardless of the facility in which the service is being provided and (2) use equal reimbursement rates for such codes for health care providers in the same region, regardless of the employer or affiliation of the health care provider. In order to fully analyze the impact of this bill on UConn Health, we would like to work with the proponent to understand the underlying intent. As written, we are not sure if the goal is to set standard rates across all facilities in the state or to address differences in rates across site of services (e.g. outpatient hospital visits vs. freestanding infusion centers). More context will allow us to complete a more accurate financial assessment of how these proposed rate changes will affect our clinical enterprise.

NATURE AND SOURCES OF OPPOSITION:

CT Association Health Plans believes SB 333 will instead result in increased rates for all facilities to the detriment of consumers. It could drive higher services out of not-for-profit hospitals and deliver them instead to the for-profit private physicians office in the suburbs.

CT Hospital Association feels SB 333 site-neutral proposal would either: (1) increase the cost of healthcare by requiring health insurers to pay nonhospital-based providers the hospital rate, but not require them to comply with all the hospital regulatory requirements, including the requirements set forth in the Emergency Medical Treatment and Labor Act (EMTALA), which requires hospitals to provide screening and stabilization treatment to all individuals regardless of ability to pay; or (2) result in an inappropriate reduction in reimbursement to hospitals, as health insurers reduce payments arbitrarily, which would be backed by the new state law. SB 333 would move Connecticut in the direction of a government dictated rate-setting system. Health insurers know and understand the differences between provider types; the appropriate level of funding is properly determined by contract, not by state statute.

Hartford HealthCare stated the greater complexity and higher fixed costs of hospital based services have been recognized by Medicare, which established criteria by which to determine whether a service is hospital based vs. a physician office service. If a service is found to be hospital based, it receives a higher reimbursement rate. In commercial health insurance, these rates are determined as part of the negotiations between providers and health plans. SB 333 would limit our ability to negotiate rates that reflect the underlying costs of providing a service. We are concerned that this bill would lead to an inappropriate reduction in reimbursement rates for hospital based infusion services. Needing to fund fixed services, this will simply shift costs to a different service.

Reported by: Diane Kubeck

Date: March 26, 2020