**Testimony of Victoria Veltri**
**State Healthcare Advocate**
**Before the Public Health Committee**
**In support of SB 809 & SB 993**
**March 11, 2015**

Good afternoon, Representative Ritter, Senator Gerratana, Senator Markley, Representative Srinivasan and members of the Public Health Committee. For the record, I am Vicki Veltri, State Healthcare Advocate with the Office Healthcare Advocate ("OHA"). OHA is an independent state agency with a three-fold mission: assuring managed care 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 on SB 809 and SB 993, both of which are titled AAC Facility Fees. These bills strive to continue the efforts to enhance consumer protection by promoting greater transparency in health care system's use of facility fees. SB 993 adds to the consumer notice required by P.A. 14-145, requiring that hospitals add to their websites notice concerning the imposition of facility fees for consumers.

SB 809 brings Connecticut into alignment with the Medicare Payment Advisory Commission's (MedPAC) position concerning the imposition of these fees, limiting Medicare reimbursement for one group of services that meets specific criteria. MedPAC's test assesses several distinct criteria for a given service: if the service is 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. Services meeting these criteria are deemed to be clinically safe and appropriate to perform in a physician office setting, and the additional level of care that facility fees presume to compensate for is unnecessary. The services listed in Group 1 of the Medicare payment classification system are such services, and the elimination of facility fee charges for these services when delivered in hospital based settings is appropriate.

Although the intent of SB 809 promotes greater consumer protections against unnecessary and often unanticipated expenses, its limit of $100 is well intentioned, but may inadvertently bar hospitals from receiving reimbursement for the actual cost of care delivery when such a setting is medically indicated. Instead, it artificially sets a cap for the provision of services that is unrelated to the actual cost of that care. 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 victoria.veltri@ct.gov.