**Testimony of Victoria Veltri**

**State Healthcare Advocate**

**Bipartisan Round Table on Hospitals and Health Care**

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Good morning, Senator Looney, Senator Fasano and members of the Roundtable on Hospitals and Healthcare. 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 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.

I would like to thank you for convening this work group to continue the important discussion about healthcare in our state. Connecticut has long been a national leader in promoting health and healthcare access for its citizens, and the legislature is to be commended for its foresight and work in this area. However, there remains much work to do in order to ensure that the vision of equitable and appropriate access to care becomes a reality for all stakeholders engaged in Connecticut's healthcare system.

As healthcare reform efforts continue to impact the consumer's experience, issues of transparency and timely access to appropriate care remain paramount to this ongoing discussion. The concept of transparency might seem fairly simple, but in practice has broad ramifications for our evolving healthcare system, with implications for stakeholder openness, communication, and accountability. The General Assembly recently reaffirmed the importance of transparency in healthcare by passing legislation requiring notice to consumers relating to facility fees (PA 14-145), notice of observation vs. inpatient status (PA 14-180), notice concerning the use of step therapy (PA 14-118), hospital acquisitions and the certificate of need ("CON") process (PA 14-168) and more. These acts begin to enhance the consumer's role in this complex relationship that exists between them, the provider and the insurer, but we need to go farther to promote total and actionable transparency.

As the cost of healthcare continues to outpace the average person's income growth, it becomes increasingly crucial that consumers understand all of the available options. If a person needs to buy a new TV or car, they can do thorough reviews of the options and compare costs across multiple vendors to get the best deal. If I bring my car to the mechanic for repairs or have a plumber look at a leaky water heater, I receive a good faith estimate that's based on the work involved, the quality of the materials that will be used for the repair, and a mark up for profit. After the service is complete, unless I've been informed of additional, complicating factors that resulted in an increased cost, I pay what the initial quote was for.

However, the average person cannot find out what a medical service will cost until after the service has been rendered, and in many cases, the cost of that service is not what a reasonable person would expect. Currently, there is no clear basis for what consumers are charged for medical services. The Office of Healthcare Access noted that, for 2013, hospitals' statewide average cost to charge ratio was 36%.[i] That means that, on average, in 2013 Connecticut's hospitals charged nearly 3 times more for the services that they delivered than it cost them to deliver that care, and the lack of advance notice of these charges coupled with the lack of a clear basis for understanding these charges results in

barriers to effective care. The recent increase in high deductible plans and consumer cost sharing has only exacerbated the impact of these charges on consumers.

The trend towards increasing consolidation of provider practices and hospitals, which predates the ACA, further complicates matters, because established patients will often experience significant changes in liability for services that they may have already been receiving, but without adequate notice or explanation. One important impact of the increase of hospital systems opting to consolidate is that these systems, as they become larger and merge with regional competitors, gain significant leverage in their negotiations with insurers. Merging with a larger institution, can help strengthen and preserve smaller, less financially viable institutions, potentially preserving the healthcare delivery system in these areas However, the increased bargaining power of these large systems may also result in higher healthcare costs as hospitals demand increased reimbursement for their services from insurers.

Although hospital consolidation and the acquisition of provider practices may have the potential to enhance the system's capacity to maintain access and quality by implementing consistency in policies and practice, evidence of increased quality, as noted in the Attorney General's testimony of November 6th, is not yet available. While there is evidence of movement toward value and integration of behavioral health in some systems, as noted by the Attorney General, higher healthcare costs are evident in these environments. The ongoing consolidations have created perverse incentives resulting in systems competing for cancer patients in an era where healthcare is moving toward paying for value and incentivizing cost containment.

Hospital consolidations also have the potential to limit provider autonomy and consumer choice. Although there was testimony at the last task force meeting about steps that systems have taken to prevent the loss of autonomy, it is something that we must be ever-vigilant to safeguard. This potential risk is even more prevalent when non-profit hospitals convert to or are purchased by for-profit entities. While these profit-driven models have an interest in maintaining consistency in services and promoting quality of care, they also

have a fiduciary responsibility to maximize profits, which could easily mean the limitation or elimination of critical, but low revenue producing services that may not be easily replaced, especially as more and more providers affiliate with hospitals and lose the flexibility to respond to the needs of the community. At a time when the strength and stability of our healthcare infrastructure is more important than ever, the potential that these profit-driven systems could close, eliminate jobs and services or move operations if a facility ceases to be as profitable as desired is a cause for concern.

Consolidation is also an issue for consumers because as more providers become affiliated with hospital systems, and hospitals merge, there is greater potential for significant disruption in the individual provider practices, as seen above, and also to provider networks generally. Accurate listing and consistency of health plan networks is important not only for those already insured, but also for those seeking alternate coverage, so that consumers can make reasonably informed decisions concerning their healthcare choices based on transparent, accurate and intuitive information. An adequate network is fundamental to the purchase and utilization of insurance. Since it is part of the bargain in purchasing insurance, it should be transparent to all and enforceable, but current law does not require transparency of network adequacy standards, only the submission of verification of URAC or NCQA accreditation. SB 392 was considered by the legislature last year, and would have required enhanced reporting and analysis of these networks, but ultimately was not enacted.

This is particularly important because we are seeing an increase in occurrences of consumers receiving care at an in-network facility, but receiving treatment by out-of-network providers without notice. Most commonly, this is happening in Emergency Departments and in surgery. Consumers do their due diligence and use network providers so as to limit their out of pocket liability under their plan, but then are subjected to liability for significant charges for services performed by an out-of-network provider that they did not consent to, received no notice of and proactively sought to avoid by going to a network facility in the first place. It seems counterintuitive that a person receiving emergency care

or having surgery with a network provider in a network facility should have to question each person who becomes involved in their care.

Provider consolidation impacts this issue of networks when hospital systems become large enough to represent a significant percentage of the insured in the state. We saw the potential of this recently during the contract dispute between Anthem and Hartford Hospital. When Hartford Hospital's contract with Anthem lapsed, five of the primary hospitals in central Connecticut were no longer in Anthem's network. Given that Anthem has the largest percentage of insured in the state, it was demonstrative of the impact that this tendency towards consolidation can have on the consumers' ability to be able to access care. Another example of the impact of the lack of adequate network transparency reached a tipping point this year with the cuts to United Healthcare's Medicare Advantage network. Though a federal program, the lessons there are relevant to state regulated plans. Given the landscape today with changing networks, transparency of network adequacy not just in number, but also in quality, of providers is critical. The state should not be in a position of endorsing plans to provide virtually no notice or demonstration to consumers of network adequacy when plans decide to trim networks or when they offer their plans for sale. As we learned previously, it's not the number of providers in a network that is paramount, it is accessibility that matters most. Transparency to providers as to expectations of participation is also a critical component of trust in the network and value to consumers.

As in other states that have adopted network adequacy standards, statutory standards create an expectation that all plans will be operating under transparent and uniform standards that do not leave consumers at a disadvantage when purchasing a product.

Another impact of this practice involves the dramatic increase in the prevalence of facility fees charged, but of which consumers were often unaware. PA 14-145 represents a first step in protecting consumers against the unanticipated costs of facility fees associated with hospital based outpatient clinics (HBOC), requiring disclosure of the anticipated costs as well as the option to seek the service at a non-HBOC to avoid the additional cost of the

facility fee, but doesn't require the same level of disclosure for the cost of services unrelated to facility fees, nor does it impose a disincentive for non-compliance. These charges allegedly enables the hospital that now owns the provider practice to be reimbursed for the general costs of running an HBOC, with a separate fee for the provider's services. However, there appears to be no tangible relationship between the overhead costs that facility fees were intended to offset, with many instead being based on the reimbursement rate for the service delivered. One hospital's 2013 chargemaster listed facility fee rates for Anesthesia services. These facility fees went from $97 for 15 minutes up to $4240 for 12 hours. One would normally expect an increase in overhead the longer a service lasts, but that trend didn't hold true. Facility fees for 11 ½ hours of anesthesia services cost $3,140, but the charge for 11 ¼ hours, less time, cost $4,339, 1.38 times more than the longer procedure.[ii]

The imposition of these additional charges on consumers, with no clear basis to understand or anticipate them, represents a significant barrier to care for many people. PA 14-145 requires as a part of the notice provided that the patient could receive the same services at a non-HBOC and no be subjected to these additional fees, but if the current rate of merger, privatization and consolidation continues, consumers may be less likely to find such a facility for treatment, and instead be forced to pay these additional costs. Connecticut's Comptroller recognized the burden that this practice placed on consumers and fought against these fees, utilizing the bargaining power of the state to eliminate these charges for the state employee plan enrollees. Further, the Medicare Payment Advisory Committee has recommended that facility fees no longer be valid charges for certain services performed at Ambulatory Surgery Centers, acknowledging the unintended impact that this billing practice has had on consumers.

All of these practices have an impact on consumers' ability to clearly understand their liability for services for which they have no clear basis to anticipate costs and that, in most cases, they need to have. Lack of transparency in costs, charges and patient cost sharing become significantly more relevant as we consider the increase in the

An example of the lack of transparency that is endemic in healthcare came from a young mother that recently attended one of our outreach events. She had scheduled routine wellness checks for her twin toddlers with the pediatrician. These visits were considered preventative under the ACA and would be covered without cost sharing. However, during the exam, the doctor asked her if she had any questions. She did, asking about a small rough patch of skin on her daughter's neck. The doctor looked at it and recommended an over-the-counter remedy, writing the name down on a slip of paper for her. A month later, this woman was shocked to get a bill for $350 for an office visit for her child that, because she asked a question, was no longer considered to be preventative and screening, but diagnostic, and subject to her full deductible and cost sharing. Had she been informed of this, she would never have asked the question. Although this practice is allowed, consumers are unaware of this and it undercuts the intent of securing preventive services for people. The practice of informing consumer of charges for their healthcare as a part of the medical decision-making process rarely occurs.

Another example of the impact on cost trend comes from one of our clients who contacted OHA about a bill for routine chemotherapy injections that he had been receiving in his provider's office for nearly a year. His injection was done in a normal exam room, and the total charge for the medication was about $2,500, of which his plan paid the provider the negotiated amount of $400, minus his cost sharing. During the course of the client's treatment, the practice was acquired by a large hospital system. This patient was aware of this change, but never received information that the charges for his treatment would change, and was shocked when he received a bill for his first injection following the transition. The charge for the same medication, delivered in the same office, by the same staff, had gone from about $2,500 to nearly $12,000, and the negotiated amount was over $2,100, which had resulted in a significantly higher cost share for him than he ever imagined, or would have agreed to.

As Connecticut continues to refine its health reform initiatives, the All-Payer Claims Database ("APCD") remains a crucial element in achieving the goal of transparency in our health care delivery system. It will enable us to identify and understand healthcare trends

concerning safety, quality, cost-effectiveness, access and efficiency in much greater detail than ever before, providing information essential to the continuing evolution of Connecticut's healthcare system.

As you have heard from stakeholders and your constituents, Connecticut's healthcare system still needs work. Although we are on a path to reform our system, network adequacy, costs and billing practices, access to providers, hospital and provider consolidation, and the technological evolution of healthcare all share a common, fundamental principle – transparency and accountability. Only through increased transparency in the way that all of these elements of Connecticut's healthcare system function and interact can stakeholders and consumers maximize their effective use of the system.

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.

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[i] http://www.ct.gov/dph/lib/dph/ohca/hospitalfillings/2013/fsreport_fy2013_final.pdf

[ii] "2013 John Dempsey Hospital Chargemaster." *Hospital Pricemaster Filings*. Office of Healthcare Access, 18 Nov. 2013. Web. 19 Nov. 2014. <http://www.ct.gov/dph/lib/dph/ohca/customer_assistance/pricemasters/dmpsy_pm.pdf>.