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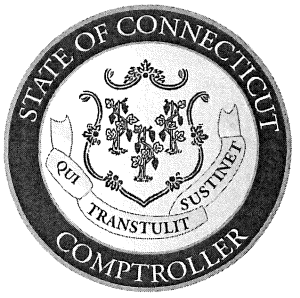

STATE OF CONNECTICUT
OFFICE *of the* STATE COMPTROLLER
55 Elm Street
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Written Testimony
Comptroller Kevin Lembo
March 17, 2014

Concerning
SB 807 An Act Concerning Fairness and Efficiency in Health Insurance Contracting

Senator Crisco, Representative Megna, Senator Kelly, Representative Sampson, and Members of the Committee:

Thank you for raising this legislation and giving me an opportunity to express my support.

I would also like to thank Senate President Pro Tempore Martin Looney and Senate Minority Leader Leonard Fasano for the leadership they have shown in working to tackle the incredibly complex issues surrounding the state's health care delivery system. I would like to address two policy proposals before you today that are included in SB 807 AAC Fairness and Efficiency in Health Insurance Contracting: 1) A requirement that multi-hospital health systems negotiate hospital contracts separately and other limitations on contract conditions; and 2) a requirement for site neutral reimbursement policies for evaluation and management visits and other common procedures.

Addressing the Market Power of Large Health Systems

Historically, both the state and federal governments have relied on anti-trust law to prevent hospital mergers and acquisitions that would result in a significant concentration

of the market under a single hospital system. However, recent studies have noted large hospital systems can leverage larger price increases from commercial health plans even when the systems do not have an excessive concentration of the market. [1] The increased leverage available to hospital systems -- even when anti-trust law does not apply -- indicates that the state may require new regulatory options to manage the potential for higher health-care costs as a result of ongoing consolidations.

The consequences of inaction could be severe. Higher prices have the potential to undermine the positive effects of moving from the current fee-for-service reimbursement model to one based on quality and outcomes. My office has heard of this already happening. At an informational forum I held on facility fees in December, Pro-Health Physicians, one of the state's largest independent physician groups, testified that higher prices at hospital and out-patient facilities had undermined their ability to achieve shared savings for their Medicare population despite successfully reducing emergency room visits and inpatient hospital stays.[2]

As we continue to pursue better patient outcomes through better care coordination driven by provider integration and an increased focus on quality metrics, we need to ensure that the cost savings achieved through lower utilization are not negated by higher prices. In order to mitigate the growing bargaining power of large hospital systems, I would like to express support for requiring each individually licensed hospital in a hospital system to independently negotiate contracts with insurance carriers. This strategy has been incorporated into anti-trust settlements by both the FTC and state Attorneys General. The specter of several hospitals simultaneously going out of network greatly increases the bargaining power of hospital systems in their negotiations with insurance carriers. The leverage of large hospital systems would be reduced if the

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[1] Matthew S. Lewis & Kevin E. Pflum, Hospital Systems and Bargaining Power: Evidence from Out-of-Market Acquisitions (Working Paper, 2013); Robert A. Berenson et al., "The Growing Power of Some Providers to Win Steep Payment Increases Insurers Suggests Policy Remedies May Be Needed", 31 Health Affairs. 973, 976 (2012)

[2] Statement of John Lynch, Executive Director, Pro-Health Physicians, Comptroller's Informational Forum on Facility Fees, December 3, 2014.

threat of contract termination applied to only one hospital in any given negotiation rather than all hospitals in the health system.

I also support placing additional limits on the negotiating power of large health systems by prohibiting them from requiring insurers to contract with all health care provider locations or facilities within the system for all services the system offers, or paying the hospital rate for covered services provided in outpatient facilities or health care providers' offices.

Historically, prices for similar procedures and services provided in the out-patient setting or in provider offices have been significantly lower than hospital-based care. The price differential is in part a recognition that hospitals incur greater overhead costs than free standing out-patient facilities or provider offices. However, when hospitals acquire free standing out-patient facilities or provider offices higher prices are not similarly justified.

The carriers that administer the state employee plan have begun to take actions that seek to prevent facilities and provider practices from automatically increasing their rates when they are acquired by a health system. However, upon contract renewal, a large health system has considerably more market power to negotiate higher rates than the previously independent facility or office. This bill takes reasonable steps to limit additional market leverage for large health systems in an effort to moderate price increases associated with market consolidation.

Addressing Variation in Reimbursement Rates for Common Medical Services

Across hospitals and care settings there is extreme variation in reimbursement rates for common procedures in Connecticut. The variation in rates is a significant contributor to unnecessary health care spending in our state, with many patients receiving procedures and services at high cost facilities and no documentation of higher quality or better outcomes. Reducing the variation in reimbursement rates for the most common

procedures and services that can be safely provided across care settings would have a significant impact on total health care costs.

The Medicare Payment Advisory Committee (MedPAC) recently recommended to Congress that reimbursement rates between hospital out-patient departments and free-standing clinics be equalized for evaluation and management visits, and certain procedures commonly performed in each setting.[3] MedPAC noted that the payment differential is, in some cases, contributing to the migration of care from lower cost free-standing physician offices to more expensive hospital out-patient departments, resulting in higher costs for Medicare without a corresponding improvement in patient care.

According to MedPAC, the higher payments received by hospital out-patient departments encourages providers to join hospital systems to gain higher reimbursements. The result is fewer services provided at low cost free-standing provider offices and more care provided at high cost hospital out-patient facilities, significantly increasing costs for Medicare. To reverse the trend MedPAC is recommending that hospitals be reimbursed for all evaluation and management visits, and for certain procedures at the rates currently paid to provider offices. The change in reimbursement policy for evaluation and management visits alone would save Medicare between $250 million and $750 million annually.[4]

The phenomenon is not limited to Medicare; it is similarly impacting the commercial insurance market. This legislation seeks to address the issue of reimbursement differentials in the commercial market by requiring health insurers to reimburse all contracted health care providers equally for certain common services and procedures. I

[3] Statement of Mark E. Miller, PhD., Executive Director, Medicare Payment Advisory Commission, before the Subcommittee on Health, Committee on Energy and Commerce, US House of Representatives, May 21, 2014.
[4] Report to the Congress: Medicare Payment Policy. Chapter 3: Hospital Inpatient and Outpatient Services March 2012. http://www.medpac.gov/documents/reports/march-2012-report-chapter-3-hospital-inpatient-and-outpatient-services.pdf?sfvrsn=0

support the intent of the bill, but respectfully recommend the committee amend the language to place a reimbursement cap on each identified procedure to ensure that the equalized payments migrate toward the lower rather than higher reimbursements. I am concerned that as written, large health systems with significant market power may resist significantly lowering their rate, which will force insurers to increase reimbursement to other providers. This would result in higher rather than lower total costs. MedPAC has recommended reducing hospital reimbursements, which are currently higher, to those paid to provider offices and free-standing clinics. A cap on reimbursements based on the Medicare rates for non-hospitals would ensure reimbursements would trend toward those currently received by lower cost providers; reducing total health care costs.

Conclusion

In order for our state to get a handle on health care costs we must ensure that savings associated with efforts to improve patient outcomes and reduce utilization are not swept away by rising reimbursement rates. This bill seeks to do that by placing reasonable limitations on the negotiating power of large health systems and limiting reimbursements for common procedures.

I urge your support. Thank you.