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**Testimony of State Comptroller Kevin Lembo
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I would like to thank our legislative leaders and all the members of the Bi-Partisan Roundtable on Hospitals and Healthcare for inviting me to speak to you today. As the State Comptroller, I am charged with administering the Connecticut state employee health plan. The plan covers approximately 210,000 lives and spent more than \$1.4 billion on health care coverage for state employees, retirees and their dependents in 2014. As the administrator of the plan I am always looking to identify opportunities to increase efficiencies, lower costs and improve health outcomes for members. Today I would like to discuss two such efforts that relate directly to hospitals; an investigation my office is conducting regarding provider consolidation and facility fees, as well as an ongoing investigation into Emergency Room (ER) charges.

Facility Fees

PA 14-217 charges my office with studying the impact of facility fees and total costs resulting from the consolidation of provider groups and independent facilities into hospital systems on the state employee health care plan. In recent years we have seen significant and rapid changes in the state's health-care delivery system, moving from a system that was dominated by small independent practices to one now dominated by large integrated hospital systems. The hospital systems stated goal for consolidation is to develop integrated care networks capable of managing patient health with the goal of improving outcomes and reducing long-term costs. At the same time there is legitimate concern that the consolidation of private providers and facilities into hospital systems will increase prices and total costs, in part due to the imposition of facility fees at new locations and the dramatically increased market strength of these entities.

Background

National trends indicate that provider consolidation with hospitals may result in increased health care prices and total costs. The impact is measurable both in hospital prices and in per-patient expenditures of hospital-owned physician practices. For example: A recent article in *Health Affairs* found that "an increase in the market share of hospitals with ownership of physician practices was associated with

higher hospital prices and spending.”¹ Another study in the *Journal of the American Medical Association* found that hospital-owned physician organizations, in California, incurred higher total expenditures per patient than physician-owned organizations with large hospital systems incurring 20% higher expenditures on average and local hospital groups incurring 10% higher expenditures.²

One symptom of the ongoing consolidation, and a component of potential additional costs, has been the proliferation of facility fees at locations that previously never charged such fees. Facility fees are charges submitted by a facility to cover the overhead costs and materials associated with providing care. Facility fee charges are in addition to professional fees which cover the cost of the professional services provided. Independent physician offices generally do not charge facility fees; instead they receive one professional fee for the total cost of the visit: overhead, materials and professional services. Over the last year the imposition of new facility fees has drawn a lot of attention. Many patients were surprised to see a significant bill from the associated hospital in addition to the professional fees paid. Members of the state employee plan have generally been shielded from unexpected facility fees because the plan does not have a deductible for members compliant with the Health Enhancement Program. Still, any new facility fees have the potential to increase the costs to the plan, which is unfortunately reflected in employee premiums.

The Study

PA 14-217 requires my office to use the state’s claims data to analyze the impact of facility fees and any increase in total fees charged or billed by a hospital or health system for outpatient hospital services on the state employee health plan.

In order to determine if consolidation and facility fees is resulting in higher costs to the state plan we will seek to answer two questions:

- 1) How do total charges differ between hospital-owned outpatient facilities and independent facilities, for services commonly performed at each?
- 2) What is the impact of new facility fees on the state employee plan as a result of hospital consolidations?

In our preliminary investigation we have found that the analysis of these seemingly simple questions is actually quite complex. For instance, determining the cost differential between hospital-owned outpatient facilities and independent outpatient facilities requires determining the ownership status of each facility and associated federal tax id numbers through which the facilities bill. Moreover, outpatient facilities, especially those associated with a hospital, generally bill facility fees and technical fees separately from professional fees which are billed by the physician under a separate tax ID number. The separate charges must be matched and aggregated to determine the total cost of a given service. Finally, in order to determine the impact of new facility fee charges or other associated charges that result from facilities consolidating with hospitals, the facilities that have been acquired and the date of acquisition must be determined.

My office is working with our medical carriers, Anthem and United, as well as the Connecticut Hospital Association to acquire all of the components needed for analysis. We plan to complete the analysis by March 1st.

¹ Baker LC, Bundorf MK, Kessler DP. “Vertical integration: hospital ownership of physician practices is associated with higher prices and spending.” *Health Affairs (Millwood)*. 2014;33(5):756-763;

² James C. Robinson and Kelly Miller. “Total Expenditures per Patient in Hospital-Owned and Physician-Owned Physician Organizations in California”, *JAMA* October 22/29, 2014 Volume 312, Number 16

Following the analysis, PA 14-217 requires my office to determine the appropriateness and reasonableness of higher total charges and/or new facility fees. The legislation does not provide guidance on how appropriateness and reasonableness should be defined, however recent analysis and recommendations by the Medicare Payment Advisory Commission (MedPAC) may provide some guidance. MedPAC recently recommended payment rates between hospital outpatient departments and free-standing clinics be equalized for 24 categories of services commonly performed in each setting based on 5 specific criteria.³ Following our analysis of Connecticut-specific data we will be looking to determine if the MedPAC criteria are an appropriate basis for our own evaluation of appropriateness and reasonableness. My office will also determine the remedies available to the state employee plan to limit any fees that are determined to be unreasonable or inappropriate. Consistent with the requirements of the Public Act summarizing the study's findings along with available options and actions taken to limit fees deemed inappropriate or unreasonable will be presented to the legislature and Governor by October 1, 2015.

Broader Concerns related to Changes in Connecticut's Health Care System

While my office develops hard data from our study, I have growing concerns with the ongoing vertical and horizontal consolidation of hospital systems. Despite recent statutory changes, our current regulatory system may not be equipped to manage the rapid changes in the health-care delivery system. Historically, both the state and federal government 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.⁴ 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. For example, at a recent informational forum I held on facility fees, 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.⁵

New payment models like shared savings programs are designed to encourage greater integration of care and better management of chronic disease. They are intended to give doctors incentive to manage the care of each patient and prevent rather than just treat disease, a payment model that creates a reimbursement mechanism for services which fee for service does not reimburse, like care coordination and chronic disease management. Integrated care networks consolidated under hospital systems may well be the most effective instrument for improving care coordination, but policy makers must ensure that the outcome of consolidations tilts toward better care and lower utilization rather than higher prices as a result of increased market power.

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 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)

⁵ Statement of John Lynch, Executive Director, Pro-Health Physicians, Comptroller's Informational Forum on Facility Fees, December 3, 2014.

Some potential options for managing the impact of provider consolidations, that I would like to work with the General Assembly on, include:

- Requiring each individually licensed hospital in a hospital system to negotiate contracts with insurance carriers independently. This strategy has been incorporated into anti-trust settlements by both the FTC and state Attorneys General. The specter of several hospitals going out of network simultaneously greatly increases the bargaining power of hospital systems in their negotiations with insurance carriers. This is especially true in a small state like Connecticut where consumers generally expect all or most of the state's acute care hospitals to be in their insurance network.
- Requiring a 30-day period of mandatory mediation after a contract expires. Increasingly, the negotiation of network contracts between the carriers and the hospitals has become an exercise in brinksmanship. Patients and large employers like the State are caught in the middle. As deadlines approach, hospitals customarily announce that they will soon go out of network; patients are urged to ask their employer to switch carriers or demand that the carrier reach a "fair deal" so that they can continue to receive care at their trusted, local hospital or hospital network. Mandatory mediation could help to rationalize this process by placing an independent party in the middle. Someone to call balls and strikes and help the parties reach an agreement that is truly in the best interest of consumers, one that balances the financial needs of the hospital with the consumer interest of keeping health care affordable and accessible.
- Requiring an extended period of time that hospitals must continue to accept patients and receive reimbursement at previously contracted rates after a contract expires and negotiations breakdown. Extending the period of time that a hospital remains in network will provide patients with additional time to find new providers and ensure continuity of their care, making the prospect of a hospital going out of network less daunting.

There are several other regulatory options in practice in other states that can limit the impact of increased provider leverage. Each should be evaluated with the goal of improving the quality of care, patient outcomes and retaining access to care while limiting costs.

Emergency Room Investigation

Recently, as part of an ongoing investigation, I ordered the state's administrative service organizations, Anthem and United, to audit claims at a hospital emergency room (ER) to determine if the state employee plan was being appropriately charged for the services that were provided. This ongoing review was initiated after several complaints by plan participants who were charged an ER co-pay for what they believed to be an urgent care visit. The audit has so far revealed several concerning practices related to hospital billing and claims oversight by Anthem and United on behalf of the state employee plan.

The ongoing investigation has already found that claims were coded differently than expected, based on diagnosis, in more than 50% of cases. Moreover it was discovered that the health plans did not have significant oversight procedures in place to systemically review ER charges and generally just paid claims as billed. Finally, it came to our attention that virtually all encounters at either free-standing or in-hospital ERs are billed at ER rates rather than lower urgent care rates, regardless of whether a patient saw an ER doctor for a real emergency or an APRN or PA for a non-emergent condition.

Anthem and United are negotiating with the hospital over the exact number of claims that require reprocessing due to over charges. In the meantime my office is taking several action items in response to these findings, including:

- Requesting our carriers negotiate stricter standards for ER billing and push to have hospitals use urgent care revenue codes when appropriate.
- Updating urgent care directories to remove ER locations that do not use urgent care revenue codes.
- Auditing additional hospitals beginning in January of 2015.

Moving forward we will expand our investigation into ER billing practices to identify other service areas where similar revenue maximization practices may be in place due to lax standards and oversight by the insurance carriers.

Closing

In closing, thank you for the opportunity to testify before the task force. I applaud the work the task force is undertaking. The landscape of health-care delivery is changing dramatically – so it's important that we identify these changes, and establish appropriate policies to manage these changes to deliver the best possible care to Connecticut consumers, while ensuring the stability of our health care delivery systems.