Thank you Senators Looney and Fasano for inviting me to the ***Bipartisan Roundtable on Hospitals and Healthcare*** to provide input on issues related to cost containment and fee transparency.

Connecticut has launched one of the country's most successful public health insurance exchanges, if not the most successful, and the insurance department has demonstrated very strict diligence over the commercial insurance rates charged by carriers (this year will witness many carriers with reductions in rates for the 2015 plan year) Fundamentally speaking, insurance is a financing vehicle for the cost of health care delivery. Its costs reflect the ever increasing costs of the health care delivery system. As such, it is imperative that this discussion is centered around overall policy development of provider regulation and health care delivery reform. In so doing, it is important we coordinate with the very thoughtful SIM plan which, as you know, just received its $45 million in federal funding, to avoid redundancy.

If we develop an oversight policy plan that changes the health care cost paradigm, we should enjoy cost savings, more transparency and erase disparities between commercial and government insurance and provide pathways to research, increased primary care and behavioral health workforce development and greater collaboration between academia, scientific research and health care delivery**.**
I am not here today to offer that design but I have been asked to share our perspective on some of the models in other states that have attempted headway in this regard.

Let me first note that the regulatory oversight of the insurance department does not reach to provider contract fee regulation. It is not within the Department's purview to address hospital consolidations, and provider acquisitions on contract negotiations and costs. Consolidation and facility fees oversight is within the purview of the Attorney General's office and Office of Health Care Access within Department of Public Health. I can, however, observe that the law of large numbers is double edged: consolidations give buying power to these entities for such items as medical devices, prosthetics and medical supplies in bulk and can be very positive for the health consumers in Connecticut. These large consolidations command very large portions of the market which lead to significant clout in negotiating with carriers for reimbursement rates with commercial insurers and self insured plans. By extension, one could imagine that the growing

costs to provide transparency and electronic health records could put significant pressure on the existence of solo or small practice groups.

I have been asked to address facility fees. Recent legislation requires advance disclosure to the patient/consumer. As of now, any of these fees are applied toward a policyowner's deductible.

As a quick refresher, recall that the Connecticut insurance market is comprised of three segments:

1. Commercial insurance which we regulate in CID
2. Self-insured plans such as the State of Connecticut employee plan, many municipalities and several large corporations. These are regulated by the U.S. Department of Labor under ERISA laws.
3. Government plans such as Medicare and Medicaid, which are regulated by the Secretary of Health and Human Services.

Each represent about one-third of Connecticut's market. As such, statutory oversight of commercial insurance impacts only one-third. Addressing health care delivery on a statewide basis would impact all three consistently.

So let's look very high level at some health reform activity in the other states you have asked us to reference. I offer a caveat that the insurance department is digging into these more substantially coincidentally and speaking with our colleagues across the country so my knowledge is not granular yet. I suspect I will have to come back to you on any detailed questions regarding other states' laws. Each of these appears to be a wholesale approach to reshaping its state's health care delivery models and the costs associated with them. Some are very thoughtful and others run the risk of extreme additional bureaucracy burdens. Let's have a look:

Price Transparency

As an aside, many carriers at their own initiative do currently provide pricing tools on their website.

The All Payer Claims Database may be a helpful tool to analyze billing practices by various entities, it is not relevant to what a consumer would be charged or reimbursed for medical services under their specific insurance plan. A consumer would need to know not only the general procedure, but also:

- What facility,
- Is there an assistant surgeon (if surgery)
- Is there an anesthesiologist (in network or out)
- Were there any complications
- What medicines and/or devices were used
- and so on….

So, while technically these price lists are in place, they do not reflect the negotiated rates of reimbursement for the covered members plan with their insurance company.

The Catalyst for Payment Reform, an independent non-profit comprised of employers and other purchasers, recently graded states on transparency. The organization acknowledged that many carriers offer such price lists and lauded that but noted that without legislation to mandate it, Connecticut received a failing grade. Its justification being that business policies and practices may change in the future and citizens may not be afforded such transparency. So, while CT may have received a failing grade for transparency, we should understand that while not codified into statute, there is transparency. We also note that the grade for Connecticut relied heavily on the establishment of the All Payer Claims Database, which is still in development.

Surprise billing protection

As you may know NY has just instituted new laws to protect consumers against surprise out-of-network billing, CT already has protections. Connecticut consumers who go to an *in-network* hospital are held harmless in Connecticut where ancillary services are provided by out-of-network providers without their knowledge (Emergency Room, Assistant Surgeon, Anesthesiologist). The Insurance Department does not approve an insurer's policy forms that contain balance billing provisions for these situations.

Insurers are left to pick-up the overcharges of out-of-network providers to keep members whole. This drives up claims costs resulting in premiums increases. Imagine that an out of network provider charges 20 times what the contracted rate is for an in network provider and a carrier is required to

cover this.

Insurers have no control over out-of-network providers, who are not under contract with them. The solutions belong with constraints on the out-of-network providers.

There are a range of responses:

- Hold hospitals and surgical centers accountable for using only in-network providers.
- Require hospital to cap the billed amounts that out-of-network providers can charge at their facility.
- Require that out-of-network providers at hospitals bill the hospital for services – and then have the hospital get the total reimbursement from the insurance carrier. This would also cap the reimbursement to negotiated rates.
- Prohibit providers from billing for services at a rate that is x% over Medicare/Fair Health for example.

California transparency law is new and doesn't go into effect until January 2015, but it is limited to preventing a medical provider from restricting a carrier from disclosing their negotiated fees to consumers. This does not appear to be an issue we see in Connecticut.

The Massachusetts program enacted in 2012 is more detailed and is an overall policy implementation. Here's the summary (As found in Governor Patrick's 8/6/2012 press release) and as you may note, this model focuses broadly and is overseen by a separate commission.

- Establishes the Health Policy Commission as an independent agency which will have broad and aggressive oversight over health care delivery, providers, provider costs, medical technology, standard setting for ACOs and other innovative delivery models, etc
- Mass has established a form of rate review for medical providers; cost increases exceeding specified benchmarks must be justified to a new Health Policy Commission with potential for investigation by the Commonwealth's AG
- Revisions to Certificate Of Authority process – appears to have more stringent justification process

- Establishes requirements for the government plans to use alternative payment methods; innovative payment systems
- Establishes a Center for Health Information and Analysis – an independent agency to collect data and health information (owns the all payer claims database); used to develop health delivery standards, health benchmarks for pricing;
- Establishes a variety of funds for training healthcare workers; assisting hospitals (Distressed Hospitals Fund)
- There are some amendments to the insurance laws, but for the most part, this law does focus on how to manage delivery and costs of health care rather than simply trying to depress the insurance premiums. There might be some good lessons for us as a state.

Asserts it will Achieve Billions in Savings:

Sets a first-in-the-nation target for controlling the growth of health care costs. The law holds the annual increase in total health care spending to the rate of growth of the state's Gross State Product (GSP) for the first five years, through 2017, and then even lower for the next five years, to half a percentage point below the economy's growth rate, and then back to GSP.

- Strives to Result in nearly $200 billion in health care cost savings over the next 15 years, which will lead to up to $10,000 in additional take-home pay, per worker, over 15 years.
- The average family could see an estimated savings of $40,000 on their health care premiums over 15 years.

Move to Alternative Payments:

- To control costs and improve quality of care, the law requires government agencies like MassHealth, the GIC (Mass. Group Insurance Commissioner) and the Connector to a range of alternative payments to achieve savings for taxpayers.
- Encourages alternative delivery systems across health care fields to deliver additional savings for patients, business owners and working families.

Increase Transparency:

- The law also gives consumers better information about the price of procedures and health care services by requiring health insurers to provide a toll-free number and website that enables consumers to request and obtain price information.

Address Market Power:

- To monitor and address the market power and price disparities that can

lead to higher costs, the law allows a Health Policy Commission to conduct a cost and market impact review of any provider organization to ensure that they can justify price variations. The law identifies triggers for when a provider or provider organization will be referred to the attorney general for investigation. An independent Center for Health Information and Analysis will conduct data collection and reporting functions.

Promote Wellness:

- The law creates a Wellness Fund of $60 million administered by the Massachusetts Department of Public Health for competitive grants to community-based organizations, health care providers and regional planning organizations.

Enact Malpractice Reform:

- The law includes malpractice provisions proposed by Governor Patrick, requiring a "cooling-off" period before a party may initiate a suit, while making providers' apologies inadmissible as evidence. Many studies show that an apology can prevent a lawsuit but due to the threat of litigation, providers have oftentimes remained silent.

Support Health Information Technology

- Massachusetts is already a national leader in adopting electronic health records and health IT efforts. The law complements these efforts, by advancing several health information technology programs, including the Executive Office of Health and Human Services' work with the Obama Administration to build and operate the statewide health information exchange.

RHODE ISLAND– relatively recent – It has only been in place a couple of years and the state is currently amending it. The focus here is coupled with commercial insurance and is rate based with some back end quality incentives. It is not a comprehensive health policy. The focus is still primarily coupled with using this as a vehicle for reducing the insurance rates rather than reframing the health care delivery approach.

You have also asked us to comment on network designs:

We are into deep dive discussions on this now with our colleagues across the country at the NAIC (National Association of Insurance Commissioners) on

this subject.

Connecticut also hosted the Northeast Zone Commissioners this September and had presentations from the President of the America's Health Insurance Plans or AHIP, Karen Ignani, and senior officials from NCQA (National Committee for Quality Assurance). NCQA is a credentialing organization for network adequacy. I asked them to advise us on what they were seeing for network designs and models for the future and how they would expand their credentialing models to reflect new models.

An example of a point made by both is the need to move away from the old concept of time and access networks to understanding that there are many versions that support new medical delivery models such as telemedicine and going deeper into the health care provider chain to define adequacy. Tiered networks are only one element – we have system networks with companion products; ACO based networks; high value networks; telemed; etc. need to support innovation within context of overall policy – we can no longer limit our imaginations to old network definitions.

Finally, you asked that I comment on restrictions on hospital negotiating tactics in other states such as requiring them to negotiate separately for inpatient versus outpatient services, prohibit hospitals from requiring insurers to contract with all providers at all locations within their network, allow insurers to negotiate separately with hospitals within a health system, etc.

You probably won't find my response satisfying, Provider contracts with insurers – particularly between hospital systems and large medical practices – are commerce – contracts negotiated between sophisticated parties. While providers frequently claim they don't have equal bargaining power, they frequently have more power. I would caution against imposing too many restrictions for fear of unintended consequences.

I would like to thank you very much for having the insurance department at the table to give some input. With a new legislative session right around the corner, I would also ask you to consider supporting a bill the department has put forth a number of times. We are asking for approval authority over small group indemnity plans – another way to potentially control costs.

We are very much looking forward to working with you as you consider holistic approaches to considering the health care delivery model in Connecticut and its impact on prices. We will continue to do our very best to assure insurance rates reflect the true costs of health care provision. However, we can only work with the cost variables input to us. We will continue to study the models from the other states on behalf of all of us. In addition, I would be delighted to invite any of my colleagues from other states in to meet with you, if that would be useful.