



STATE OF CONNECTICUT
ATTORNEY GENERAL GEORGE JEPSEN

Report of the Connecticut Attorney General Concerning Hospital Physician Practice Acquisitions and Hospital-Based Facility Fees

April 16, 2014

I. Introduction

The United States' health care market is buffeted by myriad economic forces that are changing health care pricing, delivery and access. Among those economic forces is a dramatic increase in consolidation among health care providers. According to the *New York Times*, between 2007 and 2012 there were close to 600 hospital mergers nationally, with 247 of those occurring in 2012. Large health systems have acquired competitors and then moved to vertically integrate – purchase – physician groups and freestanding clinic and surgery centers.¹ Connecticut is not immune to this trend, as demonstrated by several well-known hospital system mergers in recent years, as well as many less well known acquisitions by hospitals of physician practices and mergers between large physician groups.

One factor motivating hospitals to acquire physician practices is the Affordable Care Act (“ACA”), which incentivizes the creation of integrated health care delivery networks that take capitated risk – known as Accountable Care Organizations (“ACOs”). The ACA offers financial incentives to ACOs, which get a bundled payment to keep a patient in good health rather than charge for individual procedures. The expectation is that over the medium and long term this will result in better health outcomes and thus lower overall health care expense. For their part, physicians are more likely than ever before to sell their practices to hospitals and become salaried staff, in part due to the uncertainties about how health care reform will evolve over time, but also to avoid the burdens imposed by implementing electronic health records,

¹ Julie Creswell and Reed Abelson, *New Laws and Rising Costs Create a Surge of Supersizing Hospitals and A Wave of Hospital Mergers*, *The New York Times* (Aug 12, 2013), viewed Feb. 4, 2014 at http://www.nytimes.com/interactive/2013/08/13/business/A-Wave-of-Hospital-Mergers.html?_r=0

higher malpractice premiums and the cost of health insurance for staff.² According to the American Medical Association, 60 percent of family doctors and pediatricians, 50 percent of surgeons and 25 percent of surgical subspecialists – such as ophthalmologists and ear, nose and throat physicians -- are employees of hospitals.³

One significant manifestation of this consolidation in the marketplace is the hospitals' ability to engage in provider-based billing. "Provider-based billing," or as it is also known, "hospital-based billing," enables hospitals that own physician practices and outpatient clinics to bill separately for the use of the office or facility as well as for the physician's "professional fee". The "facility fee," also referred to as an "outpatient hospital charge" therefore, is a separate overhead charge assessed by a hospital that is increasingly being billed for services rendered in an office setting. When billed by previously independent physicians' practices, these charges – which can be hundreds of dollars or higher – are often surprising, confusing and financially burdensome to patients. This is particularly the case for patients who received regular care from a provider over long periods of time at roughly consistent cost, and who had no notice that the provider at some point in time had become hospital-based.

II. Our Investigation

In the face of this wave of horizontal mergers (*i.e.*, hospital to hospital) and vertical provider acquisitions (*i.e.*, hospitals buying up physician practices), in early 2013 the Connecticut Attorney General formed a Health Care Competition Working Group within his office to examine the potential impacts these consolidations may have on the pricing, quality, and access to health care for Connecticut's consumers and to propose recommendations for potential investigative or legislative initiatives to address them. The Health Care Competition Work Group includes Assistant Attorneys General from the Government Program Fraud and Antitrust Department, as well as members of office's Health Care Advocacy Unit, which provides advisory assistance to Connecticut consumers experiencing difficulties in obtaining health care coverage from their insurer or managed care organization.

² Elisabeth Rosenthal, *Apprehensive, Many Doctors Shift to Jobs With Salaries*, *New York Times*, (February 13, 2014) viewed at <http://www.nytimes.com/2014/02/14/us/salaried-doctors-may-not-lead-to-cheaper-health-care.html?ref=health>.

³ *Id.*

A large component of the working group's investigation was directed at meeting with, and/or seeking information from, stakeholders throughout the health care system, including, *inter alia*, trade associations representing Connecticut's hospitals, physicians, and ambulatory surgery centers, Connecticut's leading health insurance companies, hospitals, large Connecticut employers, state officials and members of the National Association of Attorneys Generals' Antitrust Task Force.⁴

In November of 2013, the Attorney General sent letters to all of the state's acute care hospitals seeking broad information about their acquisition of previously independent physician practices, free-standing ambulatory surgical centers and urgent care centers and requesting detailed descriptions of their disclosure of hospital affiliation and any facility and professional fees charged to patients seeking care. The letter also sought information related to the extent to which hospitals ensured there was sufficient public awareness that hospital-based outpatient departments were affiliated with the hospital.

The information requests generally fell into the following categories:

- Identification of all "hospital-based" providers owned or controlled by the hospital that charge facility fees.
- The substance, manner, and timing of notice given to patients seeking treatment from off-campus providers informing patients that the provider is part of a hospital, and that patients are potentially liable for both a facility fee and a professional fee.
- Whether the provider discloses to patients the actual amount of any facility fee and the amount of any professional fee for which patients will be liable, or provides patients with estimates of facility and professional fees.

All 29 general hospitals provided written responses.

In addition, the Attorney General specifically requested that Connecticut residents contact his office and describe their experiences with facility fee charges. The office received approximately 70 responses from consumers.

⁴ Attorney General George Jepsen is a Co-chair of the Antitrust Task Force.

III. BACKGROUND

A decade ago, most Americans had comprehensive health insurance with low deductibles, coinsurance and co-pays. Their inpatient care was provided in the traditional hospital setting and specialty care and routine services were provided by primary care physicians and specialists unaffiliated with large hospital systems. *Those days are over.* In 2012 the annual family premium was 30% higher than in 2007 and 97% higher than in 2002.⁵ Likewise, in 2006 10% of employer health plans had a deductible of at least \$1,000; by 2009 that number rose to 22% and in 2011 it rose again to 31% of employer health plans.⁶ It is clear, therefore, that payers are reacting to the increased costs of health care by shifting more responsibility for these costs to consumers.

At the same time there is a risk that the acquisition trend will allow hospitals and health systems to secure market power – monopolies – that give them enhanced bargaining power over their reimbursement, which will likely lead to higher health care prices. Further, acquired physician practices and employed physicians give the hospitals a larger referral base, which in turn enhances the hospitals’ negotiating leverage with payers. A recent survey of such mergers and acquisitions concluded that “[h]ospital consolidation generally results in higher prices ,” with as much as a 20% increase in already concentrated markets.⁷

These market trends place ever greater financial burdens on consumers in the form of higher out-of-pocket expenses for health care, while consolidation in the healthcare industry and opaque pricing combine to leave them with dwindling ability to understand or avoid these escalating costs.

A. Connecticut Receives an “F” for its Health Care Price Transparency Laws

The inadequacy of patient notification of hospital facility fees must be considered within the much broader context of a health care industry that lacks general cost transparency.

⁵ <http://ehbs.kff.org/pdf/2012/8345.pdf><http://ehbs.kff.org/pdf/2012/8345.pdf>http://kff.org/report-section/ehbs-2013-section-1/#TB_inline?1=1&width=800&height=580&inlineId=exhibit-1_11

⁶ <http://kaiserfamilyfoundation.files.wordpress.com/2013/03/8346-employer-health-benefits-annual-survey-summary-of-findings-0912.pdf>

⁷ The Impact of Hospital Consolidation — June 2012 Update <http://www.rwjf.org/en/research-publications/find-rwjf-research/2012/06/the-impact-of-hospital-consolidation.html>

Consumers cannot make informed choices, and markets cannot function efficiently, when the prices of goods and services cannot be readily determined. The federal government defines “price transparency” as “the availability of provider-specific information on the price for a specific health care service or set of services to consumers and other interested parties.”⁸ In March 2013, two non-profit groups, the *Health Care Incentive Improvement Institute* and the *Catalyst for Payment Reform*, published a “*Report Card on State Price Transparency Laws*.”⁹ Because states play such a pivotal role in ensuring that consumers have access to both quality and price information by setting policies and implementing laws that advance transparency, the report was designed to determine how much pricing information each state makes available to its consumers.¹⁰ The report examined the existing transparency laws in all 50 states and graded them, according to carefully defined criteria, on how well each state supported the information needs of consumers.¹¹

Only Massachusetts and New Hampshire received “A” grades. Twenty-nine (29) states, including Connecticut, received an “F”. The authors noted that “[t]here is no public resource in Connecticut that makes (comparison) pricing information available to consumers. That means there’s no consumer protection against egregious pricing behaviors by providers.”^{12 13} Undisclosed or poorly disclosed hospital facility fees are a prime example of opaque pricing rampant in the health care sector, and an example that threatens to become much more common as vertical integration proliferates.

B. An Overview of Facility Fees

Hospitals contend that facility fees are used to cover their overhead costs for things like imaging equipment, electronic health records, and care for the uninsured. According to the American Hospital Association, the industry’s trade group, hospitals provide access to critical

⁸ U.S. Government Accountability Office (GAO). “*Meaningful Price Information Is Difficult for Consumers to Obtain Prior to Receiving Care*,” Sept. 23, 2011, viewed Feb. 14, 2014 at <http://www.gao.gov/products/GAO-11-791>

⁹ “*Report Card on State Price Transparency Laws*,” Mar. 18, 2013, viewed Feb. 14, 2014 at <http://www.catalyzepaymentreform.org/images/documents/reportcard.pdf>

¹⁰ *Id.* at 3.

¹¹ *Id.* at 4.

¹² *Report: Connecticut Fails Consumers Looking For Health Care Costs*, The Hartford Courant, July 25, 2013.

¹³ In 2012, Connecticut passed a law establishing an All-Payer Claims Database (“APCD”). The APCD is a database that will collect and aggregate medical, dental and pharmacy claims data. Once the APCD is implemented, Connecticut’s consumers will have access to information concerning cost and quality of health care services.

hospital-based services that are not otherwise available in the community and treat higher-severity patients for whom the hospital outpatient department is the appropriate setting. In addition, hospitals have higher cost structures than physician offices due to the need to have emergency stand-by capacity and are subject to more comprehensive licensing, accreditation and regulatory requirements than physician offices.¹⁴

On the other hand, critics contend that facility fees are a means to enable hospitals to earn more revenue for a simple office visit, which flows right to the hospital's bottom line. As the *Washington Post* reported in "*That'll Be \$418 For Use of the Examining Room,*"¹⁵ Alan Sager, a professor of health policy and management at the Boston University of Public Health, called facility fees "a tax on sick people" and nothing more than a "gimmick to generate revenue for hospitals" to make up for profit margins that sank during the recent recession.

Although hospitals have always charged patients facility fees for the use of the hospital itself, it is a relatively recent – but expanding – phenomenon that hospitals charge such fees for services rendered in the offices of formerly independent physician groups and clinics hospitals have acquired. Whether the physician's office is within the hospital, close-by or across town, all of these "provider-based" facilities are commonly deemed by hospitals to be part of their outpatient department for purposes of charging facility fees. Thus, the trend of vertical acquisition has a compounding effect for consumers: As more previously independent clinics and physicians are acquired by hospitals, more patients are charged hospital facility fees.

There is reason to question the assertion that the costs associated with acquiring and operating a hospital-based practice compel the charging of facility fees. Hospital-based physician practices have distinct economic advantages. Presumably, they may benefit from efficiencies in medical record keeping, centralized billing, procurement and other economies of scale. In addition, they can often charge payers and patients at the hospital's much higher reimbursement rates for professional services, leaving some doubt as to the financial necessity of also charging substantial facility fees. A *Wall Street Journal* article, *Same Doctor Visit, Double*

¹⁴ American Hospital Association FACT SHEET, Outpatient Evaluation & Management Services, January 10, 2014.

¹⁵ Sandra G. Boodman, *That'll Be \$418 for Use of the Examining Room*, *The Washington Post*, (Oct. 6, 2009), viewed Feb. 4, 2014 at <http://www.washingtonpost.com/wp-dyn/content/article/2009/10/05/AR2009100502910.html>

the Cost, noted that “[a]s physicians are subsumed into hospital systems, they can get paid for services at the system’s rates, which are typically more generous than what insurers pay independent doctors.”¹⁶ Moreover, the greater the market share of the hospital the more leverage it has in negotiating higher reimbursement rates for physician services from private insurers – much more leverage than that available to independent physicians.

Consider the example of the billing of physician-administered oncology drugs. One independent oncologist in southern Connecticut billed a commercial insurance company an average cost of \$87.31 per unit for a particular chemotherapy drug. After that same provider was acquired by a Connecticut hospital, the oncologist – now part of the hospital – was able to charge at the hospital’s higher fee schedule with that insurer, which averaged \$606.55 per unit, an increase of 595% over his prior charge. The same dynamic can be seen in the disparity in reimbursement Medicare pays for colonoscopies in freestanding ambulatory surgical centers and hospital-based outpatient departments. Medicare’s average reimbursement for the former is \$362, while reimbursement for the latter is \$643.¹⁷

C. The Medicare Model

The hospital practice of billing separately for facility and professional fees for outpatient services derives substantially from a long-standing Medicare reimbursement policy – a policy that incentivizes hospitals to purchase freestanding physicians’ offices and clinics and convert them to hospital outpatient departments (“OPDs”) without changing their location or patient mix.¹⁸

For care provided at an independent (i.e., unaffiliated) practice, Medicare pays a physician a single fee based on the Medicare physician fee schedule that includes some reimbursement for the physician’s services as well as the medical practice’s overhead expense. For an office visit in a hospital’s OPD, however, Medicare separately pays the facility fee to

¹⁶ Anna Wilde Matthews, *Same Doctor Visit, Double the Cost*, *Wall Street Journal*, (Aug. 27, 2012), viewed 2/4/2014 at <http://online.wsj.com/news/articles/SB10000872396390443713704577601113671007448>

¹⁷ *ASC to HOPD Conversion: Costly Consequences*, Ambulatory Surgery Center Association, viewed Feb. 14, 2014 at <http://www.wasca.net/wp-content/uploads/2007/03/ASC-to-HOPD-Conversion-Costly-Consequences.pdf>

¹⁸ Medicare Payment Advisory Commission, “*Report to the Congress: Medicare Payment Policy*,” at 48. http://medpac.gov/documents/mar12_entirereport.pdf. The Medicare Payment Advisory Commission (MedPAC) is an independent congressional agency established by the Balanced Budget Act of 1997 (P.L. 105–33) to advise the U.S. Congress on issues affecting the Medicare program.

cover the hospital's cost or overhead expense and the "professional" fee for the physician's services. As discussed above, the total of the two fees paid for visits to hospital OPDs can be considerably higher than the single fee paid to freestanding practices.¹⁹ For example, Medicare pays 80 percent more for a 15-minute office visit in an OPD than in a freestanding doctor's office.²⁰ In addition, Medicare beneficiary out of pocket cost is substantially higher when office visits are billed as OPD visits because beneficiaries have to pay a 20% coinsurance twice, once for the facility fee and once for the professional fee.²¹

For Medicare patients who receive their OPD treatment in the main hospital or on the hospital's campus (defined as within 250 yards of the main hospital), Medicare requires the hospital to notify patients that the medical provider is part of the hospital and bill accordingly. This "public awareness" requirement applies if the hospital-based provider is on campus or "off-campus" (*i.e.*, more than 250 yards from the hospital). Additional notice requirements apply to off-campus providers, including requirements for written notice of the amount of the beneficiary's potential financial liability (*e.g.*, coinsurance for an outpatient visit to the hospital and the physician service). If the exact type and extent of care needed is not known at the time the service is rendered, the off campus provider must give notice that the beneficiary will incur a coinsurance liability to the hospital that he or she would not incur if the facility were not provider-based, an estimate based on typical or average charges for visits to the facility, and a statement that the patient's actual liability will depend upon the actual services furnished by the hospital.²² "The notice must be one that the beneficiary can read and understand."²³ Although Medicare is not specific as to what constitutes sufficient "public awareness" that the OPD is part of a hospital, the American College of Physicians believes that hospitals and hospital-based providers can fulfill this requirement by ensuring that the "entity's signage, marketing materials, websites, stationery, etc. include the name of the main hospital and create the clear impression

¹⁹ *Id.* at 51.

²⁰ *Id.* at 48.

²¹ *Id.* at 73.

²² The Attorney General interprets this requirement to include notice of the actual or estimated facility fee, for which a beneficiary was liable.

²³ 42 C.F.R. 413.65(g)(7)(ii).

that the facility is part of that hospital.”²⁴ Commercial health plans have largely acquiesced to the Medicare payment model for facility fee claims, but legal notice requirements, such as those that exist under Medicare, do not currently exist in the state of Connecticut for patients covered under these commercial plans or, for the uninsured.

IV. Our Findings

A. Common Consumer Complaints

The common threads running through the consumer complaints the Attorney General received demonstrate the following:

- Patients charged facility fees often believed that they were receiving non-hospital services.
- Patients believed they were given no effective notice that they would be charged an additional fee and no advanced information pertaining to the amount of the fee, their financial liability for the fee or what steps they might have taken to arrange comparable care at a lower cost from an alternative provider.
- Receptionists at OPDs typically only request payment of the professional copay on the date of service. When they paid their co-pay to receptionists at OPDs, patients claimed they reasonably believed that they had satisfied their full financial liability for the service. The receptionists’ request for and acceptance of a co-pay, without any disclosure that it did not constitute the full patient liability, led patients to believe that there were no additional charges.
- Patients were surprised, after their date(s) of service, to receive bills for either additional co-payments of facility fees, or the full cost of the facility fee.
- Patients described the facility fee as a financial hardship, and felt it bore no relationship to the care they were provided.
- The complaints regarding lack of notice and price transparency came from patients covered by Medicare, private insurance and those with no insurance.

B. Facility Fees Can be Expensive

²⁴ See *American College of Physicians Policy on Provider-Based Billing*, April 2013, viewed Feb. 14, 2014 at http://www.acponline.org/acp_policy/policies/provider_based_billing_2013.pdf, at 3.

Our findings indicate that facility fees for hospital-based outpatient services can range from \$100 to in excess of \$1,000. One patient's experience is illustrative. She went to her dermatologist's office for a fairly routine skin biopsy and was charged a total of \$390 for the office visit and the medical procedure. The office was several hundred yards from the closest hospital and appeared by all accounts to the patient to be unaffiliated with a hospital. After the dermatologist's practice was acquired by that hospital, however, the patient returned again to the same office for the same procedure and was charged the same amount plus a \$170 facility fee. Although this patient did not have health insurance, it should be noted that it is not uncommon for facility fees to be applied to an insurance plan's hospital deductible, which can often be thousands of dollars more than the deductible for a physician visit meaning, of course, more money out of the patient's pocket.

The Attorney General has received to date 70 complaints from Connecticut consumers who were surprised to find out that the medical services they received in an office setting triggered a hospital facility fee.

The complaint of Ms. S is another typical example. Ms. S is 75 years old and lives with her elderly husband in northwestern Connecticut. Her husband, Mr. S, needs treatment for a pre-cancerous skin condition every six months. Mr. S receives this care from a dermatologist with offices near a hospital. Until the fall of 2013, Mr. S, who is enrolled in a Medicare Advantage Plan, was required to pay only a \$50 co-payment for this care. In October 2013, however, Mr. S paid the \$50 co-pay after receiving the usual care from the same provider in the same office, but later received a bill for an additional \$128.28 directly from the hospital. Ms. S called the doctor's office and complained that she and her husband had received no prior notice of this hospital charge. An office staff person told her that the possibility of such a fee had been explained in a notice posted on the waiting room wall.

Ms. S then called the hospital to inquire further. She was told that the \$128.28 fee was an "outpatient charge" due because the dermatologist's practice was now "under the umbrella" of the hospital. Ms. S says she and her husband are on a fixed income and the facility fee is a real burden to them. She is fearful that visits to their other doctors will also trigger facility fees in the future.

Of the many complaints received by the Attorney General, some related to “off-campus” providers (those whose offices are not near the main hospital) whose practices were taken over by a hospital. These complainants alleged that they were each charged a facility fee that was never disclosed when the appointment was made. Other complaints pertained to consumers who received care in offices located on hospital campuses of the type that could typically be provided in a non-hospital office setting. The recurring theme from these complainants was that the services appeared to be provided in physician offices or clinics that seemed to be unaffiliated with a hospital. Some hospitals claim that they disclose to patients a provider’s affiliation on signs and/or paperwork. However, it is clear from the large number of complaints that these disclosures are often inadequate to convey to consumers that the provider is affiliated with the main hospital and patients will be charged both a professional and facility fee.

The Attorney General also received a number of complaints from Medicare Advantage Plan members surprised that specialist visits, which at one time only included an office based co-pay under \$50, suddenly became hospital outpatient services with additional high coinsurance charges linked to facility fees. These complainants consistently stated that they had not received an estimate of charges, as required by Medicare and were not informed that a hospital would bill a separate fee for the facility component of the visit.

Significantly, complainants nearly universally stated that they each paid a single co-pay that was requested at the time of service. According to these complainants, receptionists did not inform them they would later be charged an additional copay, coinsurance or deductible for a facility fees. As a result, patients were effectively denied the opportunity to seek lower cost care alternatives from providers who did not charge facility fees.

Some complainants told us they were confused by hospital based systems that charged facility fees for some medical services but not others. In these instances, it had not been clear to patients when a service triggered a facility charge and when it did not; in large part because the service itself determined whether the fee applied, not the location of the service. For example, one complainant paid her \$25.00 co-pay at the receptionist counter of her physician’s office for a standard office visit. During the visit, which did not itself require a facility fee, she discussed with her doctor the need for a pulmonary function test. She agreed to have the test during the visit and followed the doctor to a different room in the same office suite. She was later surprised

to receive a bill for a facility fee co-pay of \$200 associated with the pulmonary function test. She was not informed that the test would trigger an additional charge and had never paid a facility fee copay in connection with any prior prior pulmonary tests.

In yet other instances, in-network providers affiliated with hospital systems referred patients to other in-network hospital-based providers for specialty services that could have been provided at a lower cost in an in-network office-based provider. One complainant identified a situation in which he was referred by a primary care physician who was affiliated with a hospital, to a hospital-based cardiology practice in an office that was not located on the main campus of the hospital. He was referred in order to receive a temporary cardiac “Holter monitor.”²⁵ The complainant was not informed that the practice was owned by the hospital and thus considered to be part of the hospital’s outpatient department. On the date he received the monitor, the receptionist requested the patient’s standard \$45 specialist co-pay, which the patient paid at the front desk. No mention was made of any additional patient financial liability. A few weeks after the initial service date, he received a facility fee of \$1,212.47 for the Holter monitor service. This amount was deemed his financial responsibility by his health insurance company because it fell within his unsatisfied annual deductible.

Complaints to the Attorney General have been consistent with media accounts. Articles published in recent years show that the imposition of new facility fee charges has become common in the health care industry. In 2012, for example, the *Wall Street Journal* described the case of one patient – a doctor – who was surprised to learn that the heart scan he had received cost his insurer \$1,605; more than four times the \$373 the insurer paid for the same procedure six months earlier.²⁶ The increased charges were the result of provider consolidation: “[the patient] was caught up in a structural shift that is sweeping through health care in the U.S. – hospitals are increasingly acquiring private physician practices.”²⁷

In July 2013, the *Connecticut Mirror* ran an article entitled “*As hospitals buy medical practices, patients face thousands of dollars in new charges,*” describing the plight of a patient required to pay an expensive facility fee after her radiologist’s practice was purchased by a

²⁵ A Holter monitor's most common use is for monitoring heart activity (i.e., electrocardiography or ECG).

²⁶ Anna Wilde Matthews, *Same Doctor Visit, Double the Cost*, *Wall Street Journal*, (Aug. 27, 2012), at 1, viewed 2/4/2014 at <http://online.wsj.com/news/articles/SB10000872396390443713704577601113671007448>.

²⁷ *Id.* at 2.

Connecticut hospital.²⁸ The article provides yet another example of a Connecticut patient's encounter with a bill for a facility fee:

[The patient's] situation is the result of something known as a facility fee, a charge that's likely to become increasingly common as hospitals acquire physician practices or take ownership of the equipment doctors use.

Patients or their insurance typically get one bill from a physician who performs an in-office procedure. But if a hospital owns the practice or the equipment used, it can charge a fee in addition to the bill for the doctor's service.

Hospital officials say the second fee reflects the overhead costs of the practice and hospital as well as higher standards that hospital-owned practices meet.

That second charge can amount to thousands of dollars.²⁹

C. The Extent of Hospital Disclosure of Facility and Professional Fees Varies Greatly Across the State.

The information requests the Attorney General sent to Connecticut's general hospitals yielded information demonstrating wide variation in the charging of facility fees and notice practices of Connecticut's hospitals.

1. Most hospitals in Connecticut charge facility fees in their out patient departments.

Twenty-two (22) of the twenty-nine (29) hospitals contacted reported that they have OPDs and charge separate facility and professional fees. One hospital replied that it had stopped billing facility fees in its OPDs because multiple bills from different providers caused and contributed to patient confusion and dissatisfaction.

2. Many Connecticut hospitals fail to provide any notice of the charging of facility fees.

²⁸ Arielle Levin Becker, *As hospitals buy medical practices, patients face thousands of dollars in new charges*, *Connecticut Mirror*, <http://ctmirror.org/hospitals-buy-medical-practices-patients-face-thousands-dollars-new-charges>, July 22, 2013.

²⁹ *Id.*

Only twelve (12) hospitals responded that they notify all of their OPD patients to expect two separate fees applied to the medical service. Thirteen (13) of the responding hospitals stated that they only provided the notice of facility fees to patients covered by Medicare. Four (4) hospitals stated that they notify uninsured or “self-pay” patients of the separate facility and professional fees in writing, and provide an estimate of the amounts with a disclaimer that actual amounts may differ. Seven (7) hospitals do not provide notice of the facility fee component to any of their OPD patients.

3. *The timing of notice to patients concerning facility fees varies among hospitals.*

Of the hospitals that do provided a notice of facility fees, most provide the notice at the time the patient arrives at the OPD for their scheduled medical service. A few hospitals told us that they notify patients prior to the date of their scheduled appointment of separate facility fees, but only if the appointment is made – in their judgment – far enough in advance to permit them to do so.

4. *There are significant differences in the content of facility fee notices.*

One hospital fee disclosure in a letter mailed in advance to confirm a physician office appointment reads as follows:

BILLING POLICY As a hospital outpatient department, the hospital portion of your bill will be submitted to your insurance company through [the] Medical Center. The physician that treats you will bill your insurance separately through his/her medical office. Both [the] Medical Center and your Physician's bill are subject to co-pays.

Few of the notices provided by the hospitals described the fact that there were separate fees in plain language using easily readable type, bullet points, or colored paper.

However, none of the hospitals that were willing to provide patients with notice of the precise amount of potential liability for separate facility and professional fees, or even a best estimate, would do so unless specifically requested by the patient.

One hospital did state that it intends to provide an estimate of facility and professional fees as part of a recently rewritten patient notice letter. Another hospital is studying the feasibility of implementing a financial counseling call center so as to provide patients with more detailed information on pricing. Others, however, claimed that it is difficult and time-consuming to provide such pricing information due to the wide variability in patients' insurance coverage, including variations in copays, coinsurance and deductibles. Hospitals expressed a concern that requiring the provision of such information to the patient/consumer may necessitate the hiring of additional staff. One hospital complained that private health insurance companies do not provide detailed enough insurance information to permit hospital billing specialists to calculate patients' out-of-pocket charges, such as amounts applicable to the remainder of patients' deductibles.

5. *Hospitals often use ineffective mechanisms for giving notice of facility fees.*

Of the 29 hospitals, only one notifies patients of the existence of separate billing for the hospital and physician fee in a patient brochure, provided at the registration desk, and on a poster shown on an interior door. A second hospital uses multi-purpose written notices with a section captioned “Separate Hospital and Physician Services” that clearly describes possible patient liability for facility and professional fees, which is provided at registration. A third hospital provides patients with a letter mailed to the patient in advance of the service date, if feasible, which focuses only on professional and facility fees, and describes in detail how the fees differ, and why the patient may receive separate bills.

By contrast, however, a number of hospitals pointed to their “Treatment Agreement” as the notice that informed the patient of the hospital’s OPD billing practice. A Treatment Agreement or “Consent for Treatment” is primarily a contract between a patient and a hospital intended to, among other things, ensure “informed consent” for medical treatment. Treatment Agreements often include a number of other terms and conditions, including some related to use of protected health information, health insurance, assignment of insurance benefits, guarantees of prompt payment, and responsibility for valuables brought into the hospital. Given the multiple purposes of the Treatment Agreement, such contracts are not an effective means to communicate notice of the billing of separate facility and professional fees. None of the treatment forms provided to the Attorney General included the exact amount or an estimate of the patient’s financial liability. Moreover, the treatment agreement is invariably provided to the patient when they arrive at the OPD just prior to the medical service and far too late in the process for the patient to have a viable alternative should they choose to search for a provider that may not impose a facility fee. At such time, patients are often asked to fill out other paper work as well, such as medical history reports, which further obscure any communication regarding facility fees that might be contained in a Treatment Agreement.

Many of the hospitals provided photographs of outdoor and indoor signs and websites identifying that the OPD was part of a hospital. Of course, the extent to which consumers understand the signage is determined by its content and placement. It bears noting that most complainants were unaware of information about facility fees in either a Treatment Agreement or signage at the OPD.

V. CONCLUSION AND NEXT STEPS

Clearly the extent of the disclosure that a provider is affiliated with a hospital and that the patient will be charged a separate facility fee varies greatly among Connecticut's hospitals. The level of variation is equally applicable to disclosure of specific and estimated facility and professional charges and the timing of notice by those hospitals that provide it.

To their credit, several hospitals acknowledged in their responses an understanding of the problem and indicated a willingness to reexamine and improve their current fee disclosure policies for OPDs. We furthermore appreciate the cooperation demonstrated by all Connecticut hospitals in engaging in a voluntary and productive exchange of information with this Office.

Our conclusion, however, is that Connecticut residents need and deserve far greater notification and transparency in the charging of facility fees in order to facilitate real choice, and that hospitals should be required, under a uniform legal standard, to provide it. In addition, the ability of the Attorney General to better ensure a competitive health care marketplace in Connecticut necessitates the disclosure of smaller scale provider acquisitions that are not currently legally mandated.

For that reason, the Attorney General has proposed that the Connecticut General Assembly consider enacting the following bills:

AN ACT CONCERNING HOSPITAL FACILITY FEES. In essence, the proposed bill will ensure that all Connecticut consumers who are not covered by Medicare, Medicaid or health care through a worker's compensation plan will receive clear and easily understood notice when they will be charged a facility fee and a separate professional fee and, in certain instances they will also receive their actual financial liability for both or an estimate. In addition, for non-emergency care scheduled ten (10) days or more in advance of the medical service, consumers will receive the notice in writing. This will give the consumer the option of seeking potentially lower cost alternative services, *i.e.*, providers who do not impose a facility fee or can provide the service at a lower cost. Finally, the bill will require OPDs to clearly hold themselves out to the public and payers as being hospital-based, including at a minimum by stating the name of the hospital or health system in its signage, marketing materials, websites, and stationery.

AN ACT CONCERNING NOTICES OF ACQUISITIONS, JOINT VENTURES AND AFFILIATIONS OF GROUP MEDICAL PRACTICES. While most hospital mergers are well known to the public and reported in the news media, a large majority of the hospital acquisitions of medical groups, clinics and ambulatory surgical centers are not. In a similar vein, large physician group acquisitions of competing physician groups are also generally not reported. The purpose of the bill is to provide the Attorney General with notice of such acquisitions, mergers and joint ventures and thereby enable his office to better monitor these transactions in order to fulfill his legislative mandate to ensure that competitive health care markets are maintained in Connecticut. Thus, the proposed bill requires that the Office of the Attorney General be notified of changes in business relationships of physician practices. It also requires that all hospitals and hospital systems file with the Office of the Attorney General and the Commissioner of Public Health a written report regarding the group practices which the hospitals or hospital systems own or are affiliated with.

We are confident that the legislation described above would provide the Office of the Attorney General and others greater insight into the makeup of the evolving health care market in Connecticut and, where appropriate, assist the initiation of legal action to preserve competition when it is threatened. Of course, issues surrounding health care competition and transparency will persist far beyond the current legislative session. The Office of the Attorney General will remain engaged on these vital subjects, cognizant of their profound impacts on individuals, families, businesses and communities. We will also continue to urge policy makers to address these issues with thoughtful deliberation, and look forward to contributing to that process in collaboration with affected stakeholders.

In the meantime, our staff remains available to assist individuals requiring assistance with complaints concerning health care. Complaint forms, contact information and other consumer resources are available at <http://www.ct.gov/ag>.