Advisory

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Connecticut Passes New Controversial Health Law Affecting Hospitals

A new law signed by the Governor on June 30, 2015, Public Act 15-146, "An Act Concerning Hospitals, Insurers and Health Care Consumers," will have a significant impact on hospitals in Connecticut. Provisions in the new law have been hotly contested, with hospitals protesting that its requirements are too onerous and burdensome. Many fear that the new law will make it even more difficult to engage in the types of affiliations and transactions that have become a survival tactic for providers in the current regulatory and reimbursement environment. Advocates supporting the law argue that it will increase transparency for health care consumers, enhance the health care marketplace, and address perceived concerns about the growth of large health systems that control multiple hospitals and physician practices.

The following are some highlights of the changes imposed by the Public Act:

CONSUMER HEALTH INFORMATION WEBSITE

The Connecticut Health Insurance Exchange is required to establish and maintain, by July 1, 2016, a consumer health information website to help consumers make informed decisions concerning their health care and informed choices among health care providers. The website is to be designed to allow comparisons between prices paid by various health carriers to health care providers and will contain:

- information comparing the quality, price and cost of health care services including, comparative price and cost information for certain primary diagnoses and procedures categorized by payer and listed by health care provider,
- links to the websites for The Joint Commission and Medicare hospital compare tool where consumers may obtain comparative quality information,
- definitions of common health insurance and medical terms so consumers may compare health coverage and understand the terms of their coverage,
- factors consumers should consider when choosing an insurance product or provider group, including provider network, premium, cost-sharing, covered services and tier information, and
- patient decision aids.

PATIENT NOTICES

There are several new types of notices that hospitals are required to provide to patients:

First, effective October 1, 2015, each health care provider that refers a patient to another health care provider who is not a member of the same partnership, professional corporation or limited liability company, but is affiliated with the referring health care provider, must notify the patient, in writing, that the health care providers are affiliated. The notice must inform the

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patient that the patient is not required to see the provider to whom he or she is referred and that the patient has a right to seek care from the health care provider chosen by the patient, and must provide the patient with the website and toll-free telephone number of the patient's health carrier to obtain information regarding in-network health care providers and estimated out-of-pocket costs for the referred service. Although health care providers that are members of the same partnership, professional corporation, or limited liability company are not required to comply with this notice requirement, medical foundations are not similarly exempted and must provide patients with this notice every time a referral is made to providers within the medical foundation.

Second, effective January 1, 2016, every health care provider must determine, prior to any scheduled admission, procedure or service for nonemergency care, whether the patient is covered under a health insurance policy. If the patient is determined not to have health insurance coverage or the patient's health care provider is out-of-network, the health care provider must notify the patient:

- of the charges for the admission, procedure or service,
- that the patient may be charged, and is responsible for payment for unforeseen services that may arise out of the proposed admission, procedure or service, and
- if the health care provider is out-of-network under the patient's health insurance policy, that the admission, service or procedure will likely be deemed out-of-network and that any out-of-network applicable rates under such policy may apply.

Third, on and after January 1, 2016, if a transaction materially changes the business or corporate structure of a physician group practice and results in the establishment of a hospital-based facility at which facility fees will likely be billed, the hospital or health system purchasing the practice must notify each patient the practice served over the previous three years, within 30 days after the transaction. The notice must include:

- a statement that the health care facility is now a hospital-based facility and is part of a hospital or health system.
- the name, business address and phone number of the hospital or health system that is the purchaser of the health care facility.
- a statement that the hospital-based facility bills, or is likely to bill, patients a facility fee that may be in addition to, and separate from, any professional fee billed by a health care provider at the hospital-based facility.
- a statement that the patient's actual financial liability will depend on the professional medical services actually provided to the patient, and an explanation that the patient may incur financial liability that is greater than the patient would incur if the hospital-based facility were not a hospital-based facility.
- the estimated amount or range of amounts the hospital-based facility may bill for a facility fee or an example of the average facility fee billed at such hospital-based facility for the most common services provided at such hospital-based facility.
- a statement that, prior to seeking services at such hospital-based facility, a patient covered by a health insurance policy should contact the patient's health insurer for additional information regarding the hospital-based facility fees, including the patient's potential financial liability, if any, for such fees.

A copy of the written notice must be filed with the Office of Health Care Access, which will post a link to the notice on its Internet website. Also, no facility fees are allowed to be collected for services provided at the new hospital-based facility from the date of the transaction until at least 30 days after this required written notice is mailed to the patient or a copy of such notice is filed with the Office of Health Care Access, whichever is later.

Fourth, on and after January 1, 2017, every time a hospital schedules certain nonemergency diagnoses or procedures, the hospital must notify the patient of his/her right to make a request for cost and quality information. Within three business days after scheduling such a diagnosis or procedure, the hospital is also to provide the patient with written notice, including the following information:

- if the patient is uninsured, the amount that the patient will be charged for the procedure, including the amount of any facility fee, or if the hospital is unable to provide a specific amount, the estimated maximum allowed amount or charge for

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the admission or procedure, including the amount of any facility fee.

- the Medicare reimbursement amount.
- if the patient is insured, the allowed amount, toll-free telephone number, and Internet website address of the patient's health carrier where the patient can obtain information concerning charges and out-of-pocket costs. If the hospital is out-of-network under the patient's health insurance policy, a statement that the diagnosis or procedure will likely be deemed out-of-network and that any out-of-network applicable rates under such policy may apply.
- the Joint Commission's composite accountability rating and the Medicare hospital compare star rating for the hospital, as applicable, and the website addresses for The Joint Commission and the Medicare hospital compare tool where the patient may obtain information concerning the hospital.

FACILITY FEES

Hospitals are already required to provide patients with notifications regarding any charged facility fee, defined as, "any fee charged or billed by a hospital or health system for outpatient hospital services provided in a hospital-based facility that is intended to compensate the hospital or health system for the operational expenses of the hospital or health system, and separate and distinct from a professional fee."

The new law requires, effective January 1, 2016, that each billing statement that includes a facility fee also must:

- clearly identify the fee as a facility fee that is billed in addition to, or separately from, any professional fee billed by the provider;
- provide the Medicare facility fee reimbursement rate for the same service as a comparison;
- include a statement that the facility fee is intended to cover the hospital's or health system's operational expenses;
- inform the patient that the patient's financial liability may have been less if the services had been provided at a facility not owned or operated by the hospital or health system; and
- include written notice of the patient's right to request a reduction in the facility fee or any other portion of the bill and a telephone number that the patient may use to request such a reduction.

Moreover, the actual facility fees collected are now subject to certain limitations. As stated above, if a transaction materially changes the business or corporate structure of a physician group practice and results in the establishment of a hospital-based facility at which facility fees will likely be billed, the hospital, health system or hospital-based facility may not collect a facility fee for services provided at a hospital-based facility from the date of the transaction until at least 30 days after the required written notice to patients, as described above, is mailed to the patient or a copy of such notice is filed with the Office of Health Care Access, whichever is later.

In addition, on and after January 1, 2017, no hospital, health system or hospital-based facility is permitted to collect a facility fee for outpatient health care services provided off-site from a hospital campus, other than a hospital emergency department, if a current procedural terminology evaluation and management code is used. And, even when such a code is not used, if the services are provided to a patient who is uninsured, then the collected facility fee may not be more than the Medicare rate.

In circumstances when an insurance contract that is in effect on July 1, 2016, provides reimbursement for these types of facility fees, a hospital or health system is permitted to continue to collect reimbursement from the health insurer for the facility fees until the date of expiration of such contract.

Beginning on July 1, 2016, and annually thereafter, each hospital and health system must report to the Commissioner of Public Health concerning facility fees charged or billed during the preceding calendar year and the information reported will be published on the website of the Office of Health Care Access.

AFFILIATIONS AND ACQUISITIONS

In addition to notifying the Attorney General, parties to a transaction resulting in a material change to a group practice must now submit written notice to the Commissioner of Public Health, which notice will be posted on the Department of Public Health's website. Notice requirements to patients may also be required, as described above. Also, not less than 30 days prior to the effective date of any transaction that results in an affiliation between one hospital or hospital system and another hospital or hospital system, the parties to the affiliation must submit written notice to the Attorney General of such affiliation. In addition, not

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later than December 31, 2015, and annually thereafter, each hospital and hospital system must file with the Attorney General and the Commissioner of Public Health a written report describing each affiliation with another hospital or hospital system.

Many changes were also made to the Certificate of Need ("CON") process in regard to hospital affiliations. These changes apply to CON applications and certificate of need determination letters that are filed after December 1, 2015:

Three Year Plan: If a CON application involves the transfer of ownership of a hospital, the applicant must submit to the Office for Health Care Access ("OHCA") a plan demonstrating how health care services will be provided by the new hospital for the first three years following the transfer of ownership of the hospital, including (A) any consolidation, reduction, elimination or expansion of existing services or introduction of new services, and (B) the names of persons currently holding a position with the hospital to be purchased or the purchaser as an officer, director, board member or senior manager, whether or not such person is expected to hold a position with the hospital after completion of the transfer of ownership of the hospital and any salary, severance, stock offering or any financial gain, current or deferred, such person is expected to receive as a result of, or in relation to, the transfer of ownership of the hospital.

Considerations: In any deliberations involving a CON application that involves the transfer of ownership of a hospital, OHCA must take into consideration and make written findings concerning each of the following guidelines and principles:

- whether the applicant fairly considered alternative proposals or offers in light of the purpose of maintaining health care provider diversity and consumer choice in the health care market and access to affordable quality health care for the affected community; and
- whether the plan submitted demonstrates how health care services will be provided by the new hospital for the first three years following the transfer of ownership of the hospital, including any consolidation, reduction, elimination or expansion of existing services or introduction of new services.

OHCA must deny any CON application involving a transfer of ownership of a hospital unless OHCA finds that the affected community will be assured of continued access to high quality and affordable health care after accounting for any proposed change impacting hospital staffing. OHCA may deny any CON application involving a transfer of ownership of a hospital subject to a cost and market impact review if OHCA finds that (A) the affected community will not be assured of continued access to high quality and affordable health care after accounting for any consolidation in the hospital and health care market that may lessen health care provider diversity, consumer choice and access to care, and (B) any likely increases in the prices for health care services or total health care spending in the state may negatively impact the affordability of care.

Conditions: OHCA may place any conditions on the approval of a CON application involving a transfer of ownership of a hospital, but before placing any such conditions, OHCA must weigh the value of such conditions against the individual and cumulative burden of such conditions on the transacting parties and the new hospital. For each condition imposed, OHCA must include a concise statement of the legal and factual basis for such condition and each condition must be reasonably tailored in time and scope. The transacting parties or the new hospital will have the right to make a request to OHCA for an amendment to, or relief from, any condition based on changed circumstances, hardship or for other good cause.

Post-Transfer Independent Consultant: If a CON application is approved involving the transfer of ownership of a hospital, whether located within or outside the state, to a purchaser that had $1.5 billion net patient revenue for fiscal year 2013 or is organized or operated for profit, OHCA must hire an independent consultant to serve as a post-transfer compliance reporter for a period of three years after completion of the transfer of ownership of the hospital. The reporter will at a minimum:

- meet with representatives of the purchaser, the new hospital and members of the affected community served by the new hospital not less than quarterly; and
- report to OHCA not less than quarterly concerning (I) efforts the purchaser and representatives of the new hospital have taken to comply with any conditions OHCA placed on the approval of the

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certificate of need application and plans for future compliance, and (II) community benefits and uncompensated care provided by the new hospital.

If the reporter finds that the purchaser has breached a condition of the approval of the CON application, OHCA may, in consultation with the purchaser, the reporter and any other interested parties it deems appropriate, implement a performance improvement plan designed to remedy the conditions identified by the reporter and continue the reporting period for up to one year following a determination by OHCA that such conditions have been resolved. The purchaser must provide funds, in an amount determined by OHCA not to exceed $200,000 annually, for the hiring of the post-transfer compliance reporter.

Cost and Market Impact Review: OHCA must hire an independent consultant to conduct a cost and market impact review of CON applications proposing to transfer hospitals if the purchaser is an in- or out-of-state hospital or a hospital system that had net patient revenue exceeding $1.5 billion for fiscal year 2013 or organized or operated for profit. OHCA may conduct any inquiry, investigation, or hearing needed to complete this review, including issuing subpoenas; requiring the production of books, records or documents; administering oaths; and taking testimony under oath. The hospital purchaser must pay for the consultant's review, up to $200,000 per application.

UNFAIR TRADE PRACTICES

The Public Act expanded the practices that are considered unfair trade practices under the Connecticut Unfair Trade Practices Act ("CUTPA") to include:

- any health care provider requesting payment from a patient, other than a coinsurance or other out-of-pocket expense, for (1) health care services or a facility fee covered under a health care plan, (2) emergency services covered under a health care plan and rendered by an out-of-network health care provider, or (3) a surprise bill, defined as a bill for health care services, other than emergency services, received by an insured for services rendered by an out-of-network health care provider, where such services were rendered by such out-of-network provider at an in-network facility, during a service or procedure performed by an in-network provider or during a service or procedure previously approved or authorized by the health carrier and the insured did not knowingly elect to obtain such services from such out-of-network provider.
- any health care provider reporting to a credit reporting agency a patient's failure to pay a bill for the facility fee or surprise bill, when a health carrier has primary responsibility for payment of such services, fees or bills.
- a hospital, health system or hospital-based facility collecting a facility fee for services provided at a hospital-based facility from the date of the transaction that resulted in the change from a physician practice to a hospital-based facility, earlier than the thirty day time period after the required written notice to patients, as described above, is mailed to the patient or a copy of such notice is filed with the Office of Health Care Access.
- a hospital, health system, or hospital-based facility collecting a facility fee for outpatient services that use a current procedural terminology evaluation and management code and are provided at a facility, other than a hospital emergency department, that is not on a hospital campus.
- a hospital, health system, or hospital-based facility collecting a facility fee for outpatient services from uninsured patients, other than those provided in off-site emergency departments, that exceeds the Medicare facility fee rate.
- health information blocking, meaning (A) knowingly interfering with or knowingly engaging in business practices or other conduct that is reasonably likely to interfere with the ability of patients, health care providers or other authorized persons to access, exchange or use electronic health records, or (B) knowingly using an electronic health record system to both (i) steer patient referrals to affiliated providers, and (ii) prevent or unreasonably interfere with patient referrals to health care providers who are not affiliated providers.
- a seller making a false, misleading or deceptive representation that an electronic health record system is a certified electronic health record system.

The Connecticut Unfair Trade Practices Act generally permits enforcement by the Commissioner of Consumer Protection, the Attorney General and/or private litigants.

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Connecticut Passes Law Imposing New Burdens on Health Insurance Companies

The Attorney General may seek injunctive relief, restitution, and civil penalties of up to $5,000 for each willful violation in the Superior Court, while the Commissioner of Consumer Protection possesses investigative authority and may seek administrative relief in the form of a cease and desist order as well as restitution of up to $5,000. Private litigants may seek injunctive relief as well as compensatory and punitive damages in the Superior Court as well.

ELECTRONIC HEALTH RECORDS

Electronic health records must, to the fullest extent practicable, (1) follow the patient, (2) be made accessible to the patient, and (3) be shared and exchanged with the health care provider of the patient's choice in a timely manner.

Each hospital must, to the fullest extent practicable, use its electronic health records system to enable bidirectional connectivity and the secure exchange of patient electronic health records between the hospital and any other health care provider who (1) maintains an electronic health records system capable of exchanging such records, and (2) provides health care services to a patient whose records are the subject of the exchange. Each hospital must also implement the use of any hardware, software, bandwidth or program functions or settings already purchased or available to it to support the secure exchange of electronic health records and information.