CONNECTICUT HOSPITAL ASSOCIATION

TESTIMONY OF
CONNECTICUT HOSPITAL ASSOCIATION
SUBMITTED TO THE
HUMAN SERVICES COMMITTEE
Thursday, March 9, 2023

SB 10, An Act Promoting Access To Affordable Prescription Drugs, Health Care Coverage, Transparency In Health Care Costs, Home And Community-Based Support For Vulnerable Persons And Rights Regarding Gender Identity And Expression

The Connecticut Hospital Association (CHA) appreciates this opportunity to submit testimony concerning **SB 10, An Act Promoting Access To Affordable Prescription Drugs, Health Care Coverage, Transparency In Health Care Costs, Home And Community-Based Support For Vulnerable Persons And Rights Regarding Gender Identity And Expression.**

Connecticut hospitals continue to meet the challenges posed by the COVID-19 pandemic and are now facing new challenges of treating sicker patients than they saw before the pandemic, with a dedicated but smaller workforce who are exemplary but exhausted. They are also experiencing significant financial hardships brought on by record inflation. Through it all, hospitals have been steadfast, providing high-quality care for everyone who walks through their doors, regardless of ability to pay.

SB 10, among other things, requires hospitals to report certain information related to the federal 340B program, prohibits certain contract clauses between providers and health insurers, provides for Medicaid reimbursement for community health workers, and expands the Covered CT program

<u>340B Reporting and Restrictions</u>

CHA opposes Sections 5 and 6 of the legislation.

Section 5 of the legislation requires extensive reporting to the state on the federal 340B Drug Pricing Program. The reporting includes (1) a list of all prescription drugs purchased through the federal 340B drug pricing program, (2) the actual purchase price of each prescription drug, (3) the actual payment received for each 340B drug by a covered entity, (4) the average percentage savings realized by each covered entity on the cost of prescription drugs under the 340B program, and (5) how the 340B covered entity used cost savings generated through the program.

The assistance made possible by the 340B program is felt by communities across our state, but is especially important to some of our largest urban centers like Bridgeport, Hartford, New Haven, Stamford, and Waterbury. The health inequity across our country, laid bare by the uneven impact COVID-19 has had on our communities, reinforces the ongoing need for the investments 340B savings allow.

The 340B program was established 30 years ago to allow hospitals and other covered entities to stretch scarce federal resources as far as possible, reaching more eligible patients and providing more comprehensive services. Access to drug discounts provided through the program assists hospitals in meeting the needs of their patients in vulnerable communities. In many instances, the availability of 340B pricing is what allows a hospital to provide certain services at all. Without the program, many patients would need to seek care elsewhere.

Today, the 340B program is being undermined, on the federal level, by pharmaceutical manufacturers that seek to protect their profit margins. Unfortunately, this legislation doesn't address the issues harming the program and instead seeks costly and impractical reporting on a federally regulated program to the state government by covered entities. This reporting is unnecessary and unworkable. It creates a significant risk that hospitals will use the program less because the administrative burdens will outweigh the benefits of participation.

As an example of the reporting's unworkability, reporting requirement (3) misunderstands how services are provided and reimbursed. In many instances, outpatient services include and are billed with the drug costs as part of the overall service. Segregating the payment for the drug component of the overall outpatient payment is out-of-step with how these services are packaged and paid for.

The savings derived from the 340B program — meaning the difference between the discounted price at which covered entities are able to purchase 340B drugs rather than the non-discounted price they would otherwise be required to pay — supports the nearly $1 billion in unreimbursed care for low-income Medicaid beneficiaries provided each year, the nearly $250 million in uncompensated care (charity care/bad debt) provided each year, and the millions in community investments provided each year by hospitals across the state.

Section 6 of the legislation would prevent a 340B covered entity from attempting to collect payment for medical debt associated with a 340B-acquired drug that was billed to the individual for more than its acquisition cost. This section is unworkable. The purpose of the 340B program is for covered entities to use the program broadly to reach more eligible patients and offer more comprehensive services. It is not designed as a patient-level discount. The extraordinary administrative complications and burden of compliance with the bill will quickly outstrip the benefits of participation in the program.

Hospitals are able to support their critical financial assistance policies, which provide free and reduced cost care, in part due to 340B program savings. Connecticut hospitals strive to ensure that inability to pay for services does not deter anyone from seeking needed medical care, and 340B program participation helps support the ability of hospitals to offer financial assistance policies beyond statutory requirements, helping to ensure more patients are able to avoid debt related to medical care.

A well-functioning 340B program is essential to hospitals that serve vulnerable communities and, as the statute describes, stretch scarce federal resources as far as possible to support essential services for their communities. Unfortunately, this legislation adds unnecessary burden to 340B covered entities and does nothing to stop pharmaceutical manufacturers' efforts to undermine and destabilize the program.

Prohibition of Certain Contract Clauses in Contracts Between Providers and Health Insurers

Section 9 would bar certain contract provisions between healthcare providers and payers. Hospitals and health systems are still facing the extreme aftershocks of a staggering once in a century public health crisis and this is not the time to consider the significant changes to the healthcare delivery system that are proposed in this bill. We are concerned about Section 9 because it would alter patient access at a time when deferred care and regular, community-based care are still recovering from the pandemic.

Connecticut hospitals strive to provide patients with the care they need, when they need it, in a location that is both accessible and convenient to them.

Section 9 prohibits the inclusion of an "all-or-nothing" clause in contracts between healthcare providers and health insurers. Continuity of care is so important to good outcomes, especially for those patients undergoing a course of treatment that may span months or even years. The opportunity to seek care through a network of providers at locations convenient and accessible to the patient is paramount to continuity and gives the best chance for clinical success. Prohibiting the inclusion of an "all-or-nothing" clause means that healthcare systems would not be permitted to negotiate with payers to ensure patients will have coverage for the full spectrum of services in a care network and to ensure patients can choose their doctors and care team. That prohibition would have a negative effect on patient access and continuity of care.

With respect to the provisions related to "anti-tiering," should the Committee continue to pursue this legislation, we ask that important safeguards be added to the "tiering" language. Specifically, the legislation should require payers to be transparent with the standards that they adopt when slotting providers into tiers. To the extent these standards are updated or changed, payers should be required to notify providers of those changes 90 days prior to the changes being made. The legislation should also provide for a process by which providers are able to contest the tiering decisions made by payers. Finally, the Department of Insurance should regularly audit payer compliance with those tiering standards and processes. We are attaching language that accomplishes this transparency.

Our members have experience with tiered networks and the opaque processes that insurers use to make determinations about placement in tiers. We also know from the experience of a neighboring state where similar legislation was implemented that payers' processes became even more opaque and seemingly more random when state law stripped providers of the ability to negotiate fairly.

Section 9 seeks to reach into existing contracts and make statutory changes. We respectfully ask that the legislature not interfere with existing contracts that have been negotiated between healthcare providers and health insurers. Changes in law that materially affect contractual rights should be prospective.

If the Committee decides to move forward with this section of the bill, in addition to our two recommendations above (adding transparency language to the tiering provisions of the bill and making the changes prospective), we ask the Committee to protect hospitals from health carriers' unilateral changes in contract provisions by policy. Health carriers should not be able to unilaterally change terms of a contract by policy.

Community Health Workers

Section 11 proposes to establish Medicaid reimbursement for certified Community Health Workers. The American Public Health Association defines Community Health Workers (CHWs) as "a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served" (APHA 2021). A hallmark feature of CHWs is their connection to their community and patients based on their shared socioeconomic and cultural background, often serving the communities in which they reside.

CHWs play an integral role in helping hospitals advance health equity and improving connections between hospitals and the communities they serve. CHWs help patients overcome barriers to care and address both the clinical and social care needs of patients.

CHWs have historically been employed by community-based organizations, and more recently, employed by hospitals and healthcare systems. When employed by hospitals, CHWs provide health education, support participation in follow-up care, and coordinate access to essential community support. CHWs may also help hospitals improve healthcare quality and strengthen relationships and trust within the communities for which they provide care.

CHWs are often trained to have basic knowledge of health conditions and to provide health coaching using techniques that include motivation and support. CHWs frequently possess expertise in the social drivers of health and can assist patients with economic, social, and environmental resources to help improve healthcare access and outcomes. CHWs augment patient engagement by strengthening patient connections to hospitals and identifying and helping to make connections between healthcare and social service systems.

Expansion of the Covered CT Program

Sections 13 and 14 build on the important investments that have already been made to expand access to health insurance coverage. As we have consistently argued in the past, as we consider legislation to expand state-operated and subsidized health insurance options, we should do so while avoiding policies that would undermine the commercial health insurance market.

We support the legislation's expansion of eligibility in the Covered Connecticut program to 200% of the federal poverty level (FPL). This modest expansion, from 175% FPL, would ensure that low-income Connecticut residents have access to no-cost commercial coverage that provides robust benefits.

We appreciate the interest in further expansion of the Covered Connecticut program for those making more than 200% FPL but less than 300% FPL. We support the requirement that the Department of Social Services (DSS) develop a plan for additional review by the legislature prior to moving forward with such expansion. As consideration is given to a broader expansion of the state-backed plan, it is important that a number of factors be considered:

- The impact on the individual health insurance market and consumer options
- The potential impact on employer-sponsored health insurance
- The benefits and cost-sharing associated with the plan

We support the legislature's continued commitment to ensuring Connecticut residents have access to robust, affordable health insurance and we are eager to continue to add our voice to that work.

Thank you for your consideration of our position. For additional information, contact CHA Government Relations at (203) 294-7310.

Proposed Amendment to HB 6620 and SB 983:

Add the following new subsection to each bill:

(New Subsection) Any contract involving a tiered network that is entered into, renewed or amended on or after January 1, 2023 between a health carrier and a participating provider shall include:
(1) a description of the standards used by such health carrier and its intermediaries for selecting and tiering, as applicable, participating providers and each health care provider specialty, including definitions and specifications of measures related to quality, cost, efficiency, satisfaction and any other factors that are used in developing such standards and measuring performance under such standards, with clear delineation of any inclusions or exclusions under each measure;
(2) a defined time period that is sufficient for measuring performance based on such standards, which shall be no shorter than one year;
(3) a requirement that the health carrier provide ninety (90) days written notice to tiered network participating providers before implementing any changes to such standards and measurements; and
(4) a description of the grievance process enabling a participating provider to appeal the results of tiering decisions and performance measurement.

Add a new section to each bill:

Subsection (f) of Section 38a-472f of the general statutes is repealed and the following is substituted in lieu thereof *(Effective January 1, 2023)*:
(f)(1) Each health carrier shall develop standards, to be used by such health carrier and its intermediaries, for selecting and tiering, as applicable, participating providers and each health care provider specialty. Such standards shall be set forth in the contract with each participating provider pursuant to Section 1 of this Act and shall remain in place for a defined time period that is sufficient for measuring performance based on such standards, which shall be no shorter than one year. The health carrier shall provide each participating provider with ninety (90) days written notice before implementing any changes to such standards and measurement and shall establish a grievance process enabling a participating provider to appeal the results of performance measurements and tiering decisions.

……

(4) Each health carrier shall make the standards required under subdivision (1) of this subsection available to the commissioner for review and shall post on its Internet web site and make available to the public a plain language description of such standards, including all measures and corresponding definitions and specifications used to tier participating providers and evaluate their performance within each tier. Each health carrier shall post on its Internet web site a description of the grievance process for providers wishing to appeal tiering and performance measure decisions and shall post a notice to inform health carrier members when a participating provider has appealed any such decision.