TESTIMONY OF
CONNECTICUT HOSPITAL ASSOCIATION
SUBMITTED TO THE
HUMAN SERVICES COMMITTEE
Tuesday, March 14, 2023

SB 1203, An Act Concerning Medical Debt

The Connecticut Hospital Association (CHA) appreciates this opportunity to submit testimony concerning **SB 1203, An Act Concerning Medical Debt.** CHA opposes the legislation.

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.

Connecticut hospitals strive to ensure that inability to pay for services does not deter anyone from seeking needed medical care. It is why they work hard to ensure that their financial assistance policies are applied to all those who are eligible and to connect eligible, uninsured patients with a regular source of health insurance coverage.

Our objections to this bill, as further detailed below, include the following:

- Nearly all Connecticut hospitals already provide discounted care to individuals who are underinsured, so the intent of this bill is largely duplicative
- By asking hospitals to subsidize high deductible health insurance products (one of the key issues this bill is really trying to address), the bill creates an incentive for health insurance companies to expand their use
- Unlike hospitals' existing financial assistance policies, hospitals are being asked to bear these costs for any insured individual, regardless of income
- There are serious practical barriers to the administration of this policy, requiring the tracking of household income and medical liability for all insured individuals, both of which are subject to change over time, and use of a yet to be created uniform application for financial assistance

Nearly all Connecticut hospitals go well beyond statutory obligations by extending their financial assistance policies to those who are underinsured, consistent with the intent of the proposed bill. However, these policies are based directly on the federal poverty level (FPL) thresholds; in all cases extending discounts to individuals in households at 400% of FPL, in some cases as much as 550% of FPL. All individuals enrolled in the Supplemental Nutrition Assistance Program or Special Supplemental Food Program for Women, Infants and Children would qualify at these income levels. It is important to recognize that, regardless of income, underinsured patients are not subject to charges, but to the payer negotiated allowed amounts, which are already substantially discounted relative to charges.

SB 1203 amends the statute to extend protections for uninsured individuals to individuals who are underinsured, defined as "any person who is liable for one or more hospital charges that exceed two percent of the person's annual household income after coverage for hospital services was provided by a health carrier, as defined in section 38a-591a." The bill limits what hospitals are permitted to collect from such underinsured patients to "the cost of providing such health care." **This provision undermines the basic expectation of health insurance products that are the foundation for individual and employer-sponsored coverage and encourages the sale of flawed insurance plans that don't cover basic medical need and that promote medical debt**.

If insurance products are routinely offered by health carriers that, by design, include *annual* deductible and out-of-pocket maximums that exceed 2% of household income, the products themselves should be adjusted to fall within the parameters proposed in this legislation. Any attempt to shift those financial obligations to another party will undermine the health insurance market and actuarial principles on which such products are based. It is worth considering some examples. The average Affordable Care Act (ACA) marketplace plan has an annual out-of-pocket maximum of about $8,000, yet the proposed policy would limit the annual out-of-pocket obligation for an individual with a household income of $110,000 (family of four) to $2,200, and for that same individual with a household income of $277,500 to $5,550.

Under SB 1203, the hospital sector, which in 2022 lost $164 million, would subsidize the insurance products sold by an industry in which, in 2022, the four national carriers operating in Connecticut made between $4.1 billion and $20.1 billion in profit.

Aside from the above-noted concerns about the policies proposed in SB 1203, there are formidable practical barriers to implementation. **Hospitals would be required to collect household income information from *every insured patient* whenever that patient presents for care.** Household income is subject to change, as is the liability to which a patient is subject at any given point in time requiring an ongoing reassessment of liability against household income. It is not realistic to expect hospitals to track changes in income and medical liability for insured patients on an ongoing basis and reconcile accruing liabilities adjusted to cost *and* allowed amounts, at intervals throughout a course of treatment.

If the bill's focus is on the burden of medical debt, one must consider the combined costs across multiple categories of service including pharmacy, physician services, home care, ambulance, and ambulatory surgery. This is what insurance is designed to do — to take into account patients' total medical liability, across all benefit categories, ensuring that a patient's total annual liability does not exceed deductible and out-of-pocket maximums. The proposed bill's focus on hospital liability is overly narrow and unfairly misdirected at hospitals.

Finally, SB 1203 requires that hospitals use a uniform application for financial assistance and accept such completed uniform application by patients applying for financial assistance. We oppose this provision because it disregards the differences among hospitals in their financial assistance policies and the unique targeted programs that may be available in some hospitals but not others. Hospitals need the flexibility to tailor their applications to the financial assistance programs they administer. We also oppose related provisions that add burdensome and costly new reporting requirements.

We will continue to focus on making our hospitals' financial assistance programs as easy to access and navigate as possible, raise awareness about these programs with our patients, and ensure that our staff remain well prepared and trained to articulate these policies to our patients.

Additionally, we oppose Sections 6 and 7 of the legislation.

Section 6 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 this provision 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. As noted, 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.

Section 7 would prevent a hospital from seeking payment for a medical debt for an item or service if the hospital has failed to publicly disclose the cost of such item or service in compliance with federal price transparency requirements. This section, too, is unworkable. We support providing patients with the information they need to make choices about their healthcare. Compliance with the federal price transparency requirements is regulated by the federal government and not the state of Connecticut or other groups that purport to measure compliance with the rules. Noncompliance with the federal rules carry stiff monetary policies and hospitals work to ensure compliance with these and other federal regulatory requirements. Measuring and ensuring compliance with federal regulations is best left to the regulatory body that developed, promulgated, and enforces the rules; in this case, the federal Centers for Medicare and Medicaid Services, not the state of Connecticut.

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