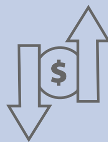
OUT-OF-NETWORK CAPS JEOPARDIZE HOSPITALS AND HEALTHCARE

Quick Facts

Could lead to more than **$700 million in reductions to hospitals**, at a time when Connecticut hospitals continue to struggle with negative operating margins

Jeopardizes hospitals' ability to maintain current levels of access to services for patients and **undermines hospital efforts to rebuild and recover** financially

Unfairly favors insurance companies in payer/hospital negotiations



Ignores the role of **Medicaid underpayment on commercial costs**

What's in the Bill: Insurer-Focused, NOT Patient-Focused

HB 6871 would cap out-of-network payment for hospital inpatient and outpatient services at 240% of Medicare or at a different amount determined by the Office of Health Strategy (OHS) through regulation.

As described in the governor's fact sheet accompanying the bill, the real intent of HB 6871 is not to protect patients — they are already protected by state and federal law.* **Instead, the intent of HB 6871 is to favor national health insurance companies over Connecticut's hospitals in commercial contract negotiations.**

* Patients are already protected from out-of-network surprise bills, through the state's nation-leading surprise billing legislation, which holds patients harmless for out-of-network emergency services and for non-emergency services provided by an out-of-network provider at an in-network facility, and, more recently, the federal No Surprises Act.

The legislation has everything to do with giving health insurance companies more leverage. **If insurers have no incentive to avoid going out of network, they are empowered to strong-arm hospitals into limiting reimbursements for in-network rates.** This is a bold attempt by the government to insert itself in rate negotiations in favor of one side — insurers that count profits in the billions. At a time when hospitals are already struggling, this would jeopardize the ability to provide high-quality care. This truly is not a patient-focused policy. It is an insurer-focused policy.

The Effect: Harm to Hospitals and Patients

Were such a cap in place, and in-network rates pushed closer to Medicare payments, **hospitals could lose more than $700 million annually in commercial revenue.** This is all while hospital operating expenses are increasing rapidly (a billion dollars in one year between 2022 and 2023). The consequences would be damaging to many Connecticut hospitals and health systems and would jeopardize their financial recovery and ability to maintain current levels of access to services for patients.

Better Solutions

The proposed caps do nothing to address the role that Medicaid underpayment plays in the cost of commercial insurance. Medicaid underpayment in Connecticut has increased sharply, rising to $1.4 billion in 2023. Because of the role commercial insurance plays in cross-subsidizing Medicaid underpayment, these losses put significant pressure on negotiations with commercial health insurance companies. **If the goal is to make care more affordable, this proposal fails, and Medicaid underpayment cannot be absent from the solution.**

CHA CONNECTICUT HOSPITAL ASSOCIATION

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