Connecticut State Medical Society
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Connecticut State Medical Society testimony in Support of Senate Bill 670 An Act Concerning Cooperative Healthcare Arrangements and Standards in Contracts Between Health Insurers and Health Care Providers
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Senator MacDonald, Representative Lawlor and members of the Judiciary Committee, my name is Gregory Pepe and I am legal counsel to the Connecticut State Medical Society. I am here again this year to discuss the widening gap between the perception of the way the market works between physicians and managed care companies, and the reality of how it works.

Senate Bill 670 An Act Concerning Cooperative Healthcare Arrangements and Standards in Contracts Between Health Insurers and Health Care Providers contains two important sections to restore a balance between physicians and the entities with whom they contract: the ability to fairly negotiate and requirements for fair contracting. My written testimony addresses each individually

Cooperative Arrangements and stronger Negotiations

Despite what you will hear from managed care representatives, the vast majority of physicians have virtually no power to negotiate the terms of their provider agreements. This situation is in dire need of legislative solutions in order to address this unbalanced situation

We ask this committee to consider its support for this **S.B. 670** which provides relief for doctors, and is aimed at permitting balanced and fair negotiations with Managed Care Organizations. Such negotiations do not regularly occur in today's managed care environment, and are necessary to ensure that doctors and other health care providers can negotiate things such as: (i) the meaning of "Medically Necessary"; (ii) the language by which patients are informed about adverse claims decisions which implicate a physician's medical judgments; (iii) how disputes get resolved; and (iv) receive fair and adequate reimbursement of exceptional costs that they incur for the costs of malpractice insurance, for employee's salaries, for rent and other costs, all while providing access to all manner of medical procedures for their patients.

Similar legislation has passed in at least two other State legislatures in recent years as part of those State's comprehensive approach to reform.

Let me take a moment to outline what **S.B. 670** would do in one aspect of physician's practices, and the impact it can have on giving the physicians the ability to fairly and with

state oversight have bargaining parity to recoup the extreme costs of securing mandated coverage for medical liability coverage.

Federal law allows states to develop their own regulatory schemes in areas where the federal government has already developed a regulatory scheme, under a doctrine that is referred to as "state action. This bill applies that doctrine for the purpose of enabling collective negotiations by nominally competing physicians, of certain terms and conditions of a physician's provider contracts with health benefit plans.

The lack of meaningful bargaining power by non-integrated physicians has created a number of difficulties which threaten to curtail access to certain kinds of healthcare services, and compromise the quality of care received by Connecticut residents from their physicians. Some examples have been widely reported in medical journals ... radiologists are increasingly limiting annual mammograms, neurologists are restricting the types of high risk procedures they will undertake, and many OB/GYNs are restricting their practice to GYN and curtailing the delivery of babies ... all this in order to afford an adequate level of insurance coverage for some of the medical services they are trained to do, and want to provide to their patients.

Joint negotiation of the type being proposed in this bill will be permitted in instances where the state, acting through the office of the attorney general, either: (i) finds that a health plan has significant market power, enabling it to virtually dictate the terms of provider agreements to physicians or (ii) finds that negotiations on fee-related issues have been one-sided in favor of the health benefit plan or have not occurred due to the market power of the health benefit plan.

Definitions

For purposes of the Statute, a number of new statutory definitions are being proposed to both implement the purpose of the statute, and assist the State in the implementation of its purpose.

Role of the Attorney General

Any physicians or physician organizations seeking to negotiate the terms and conditions (including fees) with health benefit plans, in concert with or on behalf of more than one non-integrated physicians, shall need to comply with the following procedures;

(a) File an application with the Attorney General's office which provides:
(i) The name and address of the negotiator;
(ii) The names and addresses of the physicians represented by the negotiator;
(iii) The relationship of the represented physicians to the total population of physician in a geographic area;
(iv) The health benefit plan with whom the representative intends to negotiate;
(v) The subject matter of the negotiations;

(vi) The anticipated impact of the negotiations;
(vii) The benefits both to the physicians and to their patients of the anticipated impact of the negotiations

(b) Within 45 days of the filing of an application, the Attorney General shall either (i) approve the filing and permit the requested negotiation; (ii) disapprove the filing as incomplete or deficient, in which case the applicant shall be permitted to re-file an application which corrects such deficiencies; or; (iii) disapprove the filings as not authorized pursuant to the statute, in which case the applicant shall not be permitted to re-file an application for (180) days.

Prohibited Actions
Group actions to boycott or cease services to a health benefit plan shall not be an action authorized under the statute.

Rule Promulgation
The Attorney General shall be authorized by the statute to implement such rules and procedures as are necessary or convenient to implement the provisions of the statute, including the filing of application fees.

Certain Joint Negotiations Authorized Without Need for Application to the Attorney General – Negotiation by non-integrated physicians over certain terms and conditions of their provider agreements with health benefit plans are permitted under the statute, without the need to apply to the Attorney General; those terms include the following:

(a) Practices and Procedures relating to preventive health care services;
(b) Practices and Procedures related to Clinical Integration and disease management programs;
(c) Clinical referral procedures;
(d) Patient education programs;
(e) Administrative procedures, including methods of claims submissions, credentialing procedures, and coding procedures;
(f) Dispute resolution procedures;
(g) Utilization Review programs;
(h) Quality Programs;
(i) Physician selection criteria and de-certification procedures, including the terms for inclusion in so-called "tiered networks".

Thank you for your time and attention. On behalf of Connecticut's physicians, I urge you to recommend SB 28 and consider this unique opportunity to help Connecticut's physicians struggling under the weight of extreme increases in the costs they incur for medical liability coverage, and for the other costs in operating a practice in Connecticut in 2006.

Fair Contracting

The legislation before you today contains a few necessary components to create a fair system for contracting between physicians and health insurers. However, we ask that through this proposed legislation this committee codify a number of agreements that have been entered into between the largest managed care companies in the country, and all 700,000 physicians in the United States.

These agreements came about as a result of settlements in connection with national class action lawsuits by the doctors in about 40 percent of the states throughout the Country. Settlements were reached, and agreements entered into between doctors and Aetna, CIGNA, HealthNet and Anthem/Wellpoint.

This bill provides you an opportunity to take the most salient aspects of the settlements and turn them into statutory requirements applicable to all companies that offer health insurance products in Connecticut.

I want to call your attention to a few features of the class actions settlements that need to be codified into Connecticut law so that the environment in which doctors interact with patients can have a level of predictability and stability. The predictability and stability will allow physicians to devote more time to their patients and less time to contract harangues with managed care companies.

FIRST and foremost, any managed care company should only be permitted to change its fee schedules once per year ... we propose that such change occurs at the time that a provider contract is negotiated or renewed. Doctors are no different than other business people. They need to budget their office's expenses and revenues annually without the fear of being blindsided by reimbursement changes which sometimes happen two or three times a year with some plans.

In addition, doctors should be provided an opportunity to know, with certainty, how their bills for reimbursement will be treated by healthcare payors. To that end, managed care companies must be required to disclose their rationales and programs for bundling, down coding, global periods and other cost reduction programs which have the effect of reducing physician reimbursement. This provision does not dispute the payor's right to bundle or down code, but only seeks to require disclosure of these programs and their rationales in advance. Any business person has a right to know how they will be paid when they enter into a contract with someone purchasing their services.

SECOND, all managed care plans in Connecticut ought to operate under the same definition of medical necessity. It is irrational, and undermines the stability of the healthcare market, when Company A agrees that a certain procedure is medically necessary and Company B, on the same day decides that the same procedure is not

medically necessary. While you may think that such an event is unlikely, Connecticut physicians face this anomaly frequently when they receive denials for payment from Company B for a procedure which Company A routinely pays for. I think you will hear examples of this phenomenon from some of the speakers who follow me.

THIRD, when a physician has his or her medical decision for a patient overturned or declined for payment by a managed care company in Connecticut, the physician needs to consult the provider manual for that patient's plan, and advocate under that plan's process on behalf of the patient.

If a physician office has agreements with eight plans, that means eight different provider manuals, eight different appeals processes, and eight times the harangue. Why not agree on a single process to resolve these issues, and reduce administrative confusion, "hassle factor" and irrationality from Connecticut's healthcare system? The multiplicity of processes that exists today adds nothing to a particular plan's competitive advantage over its peers, but rather, it diverts valuable practice time and resources that can be better devoted to patient care.

FINALLY, the provisions that I have outlined in my testimony, have been agreed to by Aetna, Anthem, CIGNA and HealthNet in the context of the settlement of the class action litigation. If they make sense in that context, how could they not make sense when they are extended for all of Connecticut's managed care enrollees?

By making the contracting process easier, more rational, less time consuming and universal in these aspects, you will be improving the practice environment for physicians and their patients. That kind of change will be good for all of us.

. We respectfully urge you to support Senate Bill 670 and welcome the opportunity to work with members of this Committee craft the best possible legislation