

**Testimony in Support of Senate Bill 670 AAC Cooperative Healthcare  
Arrangements and Standards in Contracts Between Health Insurers and Healthcare  
Providers  
March 24, 2006  
Before the Judiciary Committee**

Senator McDonald, Representative Lawlor and members of the Judiciary Committee, my name is Debbie Osborn, I am here as the Executive Director of the Connecticut Society of Eye Physicians and the Connecticut Dermatology and Dermatologic Surgery Society. I am here to respectfully ask for your support of **Senate Bill 670 AAC Cooperative Healthcare Arrangements and Standards in Contracts Between Health Insurers and Healthcare Providers**. The legislation before you today would prevent health insurers from unilaterally changing the provisions of a contract during the contracting period. These standards should be common sense in any contracting process. Unfortunately they are not prevalent in contracts between healthcare providers and HMOs.

For years now you have heard physicians from throughout the state repeatedly testify for “standards in contracting” before several committees of this General Assembly. At the same time the largest managed care companies have entered into settlement agreements in national class action lawsuits on these very issues. Through this proposed legislation we ask that this committee codify one important aspect of those agreements, the **prevention of unilateral changes to a contract once a contract has been signed by a healthcare provider**.

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. These four carriers have already admitted to changing the terms of their provider contracts unilaterally. Unfortunately, these settlements have various sunset provisions, which vary from settlement to settlement. The settlements also have no effect on the other carriers in the state who have not entered into settlements and are are also guilty of changing the terms of their contracts with providers at will.

SB670 provides an opportunity to take the most salient and fairest aspect of the settlements and turn it into statutory requirements applicable to all companies that offer health insurance products in Connecticut.

Following in my testimony I provide to you one feature of the class actions settlements that needs 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. Physicians have previously testified to many provisions before the Insurance and Real Estate Committee and in the Public Health Committee, today we are asking you to address only one the prevention of unilateral changes. We feel very strongly that this issue falls within the prevue of this committee which deals with contract law.

I would like to take the rest of my time to give examples of some of the unilateral changes which have been imposed on Connecticut Physicians. Please keep in mind that these unilateral changes were delivered on "take it or leave it" terms

On February 25<sup>th</sup> 2006, Connecticut physicians who participate with Aetna Health care were sent a letter which unilaterally amended their provider contracts. This amendment has been included with my testimony for your review. In an effort to save time I will highlight only a few of the egregious changes which were unilaterally made by Aetna. First, physicians who participate with Aetna now must provide services for Aetna's Medicare program. Aetna's letter states, " We are in the process of expanding our product offering to include Medicare plans in select counties/areas in the State of Connecticut, and we have designated your office to be part of our Medicare network." Providers will be paid beginning on Jan. 1, 2007 for the Aetna Medicare Plan based on Aetna's Standard Market Fee Schedule(AMFS). The (AMFS) will be based on 100% of the 2005 Medicare Schedule. In other words by the end of 2006, physicians who participate with Aetna must also participate with their medicare program, at rates which are based on **2005 medicare rates**. The only alternative is for the physician to terminate their contract with Aetna and walk away from their Aetna patients. Is this fair?

On March 28, 2005 United Healthcare delivered a jolting letter informing Connecticut Physicians that they had merged with Oxford Health Plans and that if they wanted to remain a United Healthcare provider they would have to service the Oxford contract as well. For many of the dermatologists in this state it was a serious blow, since many had opted out of the Oxford plan, due to administrative problems including an egregious appeals process, bundling of services which resulted in non-payment of services and of course reimbursement levels which fell far below industry standard levels.

Healthnet recently amended their fee schedules on their commercial plans after physicians had agreed to other rates, resulting in reimbursement levels on many codes far below Medicare reimbursement rates. The list of unilateral changes goes on and on.

Physicians in this state believe that these "take it or leave it contracts" have dramatically effected not only the patient physician relationship in a negative way but has also jeopardized the stability of the healthcare delivery system as a whole.

Connecticut physicians ask that you support SB670 which brings relief to the physician community and brings a level of fairness which should be self-evident in contracting arrangements. 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 SB 670 as an incremental first step to improving the balance of power in healthcare by bringing a level of fairness into contract arrangements between physicians and HMOs.

Thank-you for your time and consideration.