

Testimony of Steve Levine
In Support of S.B. 670
**An Act Concerning Cooperative Healthcare Arrangements and Standards in
Contracts between Health Insurers and Healthcare Providers**

March 24, 2006

Good afternoon Senator McDonald, Representative Lawlor, and members of the Judiciary Committee. For the record, my name is Steve Levine, I am a board certified otolaryngologist practicing in Trumbull. I come before you today representing more than 250 members of the Connecticut ENT Society to ask for your support in passing **S.B. 670 An Act Concerning Cooperative Healthcare Arrangements and Standards in Contracts between Health Insurers and Healthcare Providers**

I am using my allotted time to talk primarily about the need to pass standards in contracting language for healthcare providers to prevent health insurance companies from making non-negotiable unilateral changes in provider contracts. Although cooperative healthcare language is equally important I feel confident that my colleagues and the representatives for the Connecticut State Medical Society will adequately address this issue.

As I come before you today, it is hard for me to believe that we are now in the second half of the first decade of the 21st century. It is even harder for me to believe that I - or one of my colleagues - have given testimony on the issue of unilateral changes to contracts every year since the year 2000. SB 581, SB 683, & SB 448; HB 5205 & 6135 – the list goes on. In 2004, a Fairness Bill was narrowly defeated in the Senate. In 2005, the Fairness Bill passed handily in the Senate but died when there was no House vote.

Physicians are carefully regulated with regard to billing practices, and we must adhere to the guidelines set forth in the American Medical Association's Current Procedural Terminology Manual, known as CPT codes. In addition, anti-trust

regulations prevent Physicians from working together to achieve more equitable treatment. Only health insurance companies and Major League Baseball are exempt from these anti-trust issues. As you all know, in recent years there has been tremendous consolidation of payors in the Healthcare field, a situation that gives enormous power to those that remain.

Although some Payors have worked with Physicians to improve the quality of health care in Connecticut, others have taken advantage of the imbalance of power to offer physicians “take-it-or-leave-it” contracts. Physicians are understandably reluctant to reject contracts when doing so would mean a loss of 15 to 40% of their patients.

As I mentioned before, these are not new issues. I have personally included a letter from United Healthcare which unilaterally changed the terms of my contract with them. This change forced me to take back a contract with Oxford Health Plan from a merger with United Health Care, which I had terminated 9 months previous. I terminated my contract with Oxford because I found that:

- Oxford onerously bundled CPT codes such that many of the services I provided were never reimbursed and the net reimbursement by Oxford (compared to other plans) remained untenable.
- Furthermore, Oxford had the most difficult and burdensome administrative requirements for me to order CT scans or MRI scans, such that I had to often suggest to my patients that even though Oxford was denying coverage for a CT, it was in their best interest to have the study done and pay for it out of pocket.

It should be no surprise that in the absence of legislation supporting Fairness in Contracting, many insurance companies continue past practices that place physicians in an unsustainable position. We sometimes have to sign a contract to get the full terms of the contact. But even those terms may change at the whim of the insurance company. Physicians frequently invest considerable money in the equipment and personnel necessary to provide state-of-the-art care

for their patients, but procedures and treatments previously approved suddenly become “experimental” – and therefore not reimbursed. Add to this list the practice of bundling services, arbitrary down-coding, and this recitation could go on & on. This combined with the other pressures on medical practices: the Personal Liability Insurance crisis, falling reimbursement, increasing practice and labor costs, and ever more complex regulatory issues. Thus far, most of the stresses on the health care system have been absorbed by physicians, but there are limits and patients will pay the ultimate price with less access and fewer choices. In the year 2005 I made the decision to drop a carrier which I believed provided a great disservice to the patients I serve, in 2006 I was forced to become a provider once again for this plan or walk away from a plan I had served for over 20 years and represented over 15% of my patient base.

The insurance companies, while denying that they do any of the things we are describing, fight tooth and nail against this legislation. Why? Why do they do that? Would are they fighting legislation against something they claim is not an issue? Furthermore, it is impossible to ignore that while Physicians, employers, and patients are being squeezed by these big insurance companies, they are reaping record profits, and some executives enjoy outrageous compensation packages. I have included supporting documentation for your review.

We therefore ask for your support for this legislation that will help establish a measure of equity and fairness in contracting between HMOs and physicians. This bill requires that contracts include restrictions on unilateral changes, a small incremental change which will bring relief and fairness to our contracting arrangements with HMOs. It is time to clear the air and correct this long-standing inequity. We want contracts to contain real information that cannot be changed unilaterally during the period of the contract. In short, we want – we need – fair standards in contracting.

Thank you for your time and attention.

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The Business Journal of Milwaukee - 4:22 PM CST Friday

UnitedHealth CEO sells \$137 million in stock

Minneapolis-St. Paul Business Journal

UnitedHealth CEO William McGuire sold roughly \$137 million worth of stock on Thursday, the company said Friday.

The sale of 2.3 million shares represents about 6 percent of McGuire's holdings in the Minnetonka-based company.

Many of those shares were presumably converted from McGuire's pool of stock options, which as of December 2004 had a value of more than \$1 billion. The exercise price on those options -- and, consequently, McGuire's net profit in Thursday's sale -- wasn't disclosed. UnitedHealth officials said they would file that information Monday.

The company (NYSE: UNH) also didn't disclose the share price; the \$137 million total assumes an average share price of \$59.625. UnitedHealth stock closed Thursday at \$59.45. On Friday, the stock finished at \$58.89, down 56 cents.

McGuire sold his stock to support "significant new and existing philanthropic commitments and as part of a periodic financial diversification program," the company said in a news release.

UnitedHealth is the parent company of UnitedHealthcare of Wisconsin Inc., a health maintenance organization based in Wauwatosa, and Appleton-based TouchPoint Health Plan.

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