



Quality is Our Bottom Line

Connecticut Association of Health Plans

Judiciary Committee

March 24, 2006

Testimony in Opposition to SB 670 AAC Cooperative Health Care Arrangements and Standards in Contracts Between Health Insurers and Physicians.

The Connecticut Association of Health Plans opposes SB 670 AAC Cooperative Health Care Arrangements and Standards in Contracts Between Health Insurers and Physicians.

Sections of the bill dealing with Cooperative Health Care Arrangements, would establish an antitrust exemption, granted by the Attorney General, for providers to negotiate collectively with health plans on matters of reimbursement. We oppose this concept on the basis that it is anti-competitive and amounts to what some would say is price-fixing. Federal and state antitrust laws protect consumers by prohibiting this very type of behavior.

Under existing law, physicians can and do form legitimate joint ventures and multi-provider networks to gain leverage and negotiating strength with managed care organizations. The Connecticut State Medical Society operates one of the largest independent practice associations (IPAs) in the state and negotiates price and other contract terms routinely on behalf of its 8,000 members. The American Medical Association estimates that physicians have formed more than 4,000 IPAs nationwide. In addition, physicians also negotiate with managed care organizations through more than 19,000 group practices and more than 700 physician hospital organizations. In other words, an antitrust exemption is not needed to allow physicians and other health care professionals to form networks and other kinds of legitimate joint ventures to contract, or compete directly, with health plans.

In addition, antitrust exemptions risk permitting more powerful professions to negotiate for terms that effectively exclude or limit less powerful health care professionals. Physicians could, for example, demand terms that limit the ability of nurse midwives, advanced practice nurses, optometrists and other non-physician providers to treat patients in health plans and receive fair compensation. This, in turn, could deny consumers choice in the selection of their providers.

By permitting health care providers to collude in negotiating favorable contract provisions, and antitrust exemption would enable providers collectively to refuse to cooperate in reporting on health care quality measures or refuse to be held accountable for the health care services they deliver. Consider the havoc if a large group of providers chose to boycott a certain health plan.

The Federal Trade Commission and the Department of Justice have advised against these types of proposals time and again. We ask that you follow their lead and defeat SB 670.

With respect to the provisions in the bill related to Standards and Contracts, it's our understanding that in addition to the elements contained in previous versions, it is the intent of this legislation to codify portions of the legal settlements that several of the large health insurers have entered into on a national basis with medical societies from across the country – ***the Connecticut State Medical Society being one the most active and vocal organizations in the discussions***. These settlement policies apply to all practicing physicians including eye physicians and dermatologists.

While it is true that the settlements address some of the components under consideration here today, it is ***not*** true that the agreements are identical across the board. They differ by health plan in application, definition and timetable for phase-in purposes. Each health plan spent untold months and millions of dollars negotiating these settlements as they relate to their own specific business models and bargained with the medical societies in what they believed was “good faith” on both sides to address provider concerns. The ink is barely dry on some of these documents. It seems inconceivable to have to face legislation of this nature in Connecticut at this point in time given that some of the settlements were literally just finalized.

The benefit of national settlements – for both insurers and providers - is precisely the fact that they're national. It is enormously difficult and expensive for all parties involved to develop claims systems and contracting standards specific to one state. The costs would be exorbitant if Connecticut were to pass legislation that deviates from the negotiated agreements. Consider our testimony from year's past:

Health plans contract with providers in a variety of ways. Many plans enter into agreements with large physician groups called IPA's and/or PHO's. These are very sophisticated business entities that often employ staff, legal counsel and consultants to negotiate on the behalf of their providers. The market power that these entities bring to bear is significant and should not be discounted. Increased fees, dissolution of prior authorization requirements, coding and reporting standards have all been bargained at the table.

Other health plans still contract with independent practitioners. At least one plan in Connecticut contracts with over 8,000 independent providers in the state. Contracts entered into by these practitioners are generally referred to as “evergreen contracts” meaning that once the contract is signed, it is in effect until one of the parties decides to terminate. Under such contracts, health plans typically reserve the right to change the terms unilaterally in order to maintain the integrity of the network and avoid re-contracting with thousands of providers over and over again. If health plans have to seek provider approval before instituting any change in contract, it will be difficult to determine which providers are in or out of the network at any given time and the result will be chaos.

The negotiated settlements take into account these various distinctions in plan design.

Previous versions of the bill have aimed to prohibit health plans from using software systems designed to catch fraudulent billing. Such systems rely on statistically valid programs based upon the AMA's own coding standards and are recognized by CMS, most state departments of insurance and Medicaid and are important quality assurance mechanisms. ***To deviate in any way***

from the very individual, complex and painstakingly developed coding protocols determined in the legal settlements is to open up Connecticut insurers to costly and potentially fraudulent provider billing practices.

All of these distinctions are no small matters. Take, for instance, simply the disclosure of fee schedules. Proposals previously considered required health plans to make available all fee schedules on every CPT code to every provider. Such legislation would be enormously problematic in that it would consume significant resources at great expense to produce information that in all likelihood would prove irrelevant to the individual provider. Sending a cardiology fee schedule to a dermatologist makes little sense. Giving one dermatologist access to another's is simply anticompetitive. Furthermore, to provide this information in paper format, as some proposals suggest, is simply so cumbersome as to be impossible.

Again, the negotiated settlements make allowances for the practical considerations around fee schedule disclosure.

The legislature has been spending considerable time over the past year in trying to address the rising costs of health care. We would respectfully suggest that first you do no harm. Enacting legislation of a broad nature in this area would do considerable harm and stifle innovative approaches yet to come. We respectfully request that the committee take no action on SB 670.

Thank you for your consideration.