Quality is Our Bottom Line

Public Health Committee
Wednesday, February 21, 2007

Connecticut Association of Health Plans

Testimony in Opposition to

HB 5308 AA Establishing Standards for Contracts Between Health Insurers and Physicians; and

HB 6841 AAC Standards in Contracts Between Health Insurers and Physicians.

The Connecticut Association of Health Plans respectfully urges the Committee's rejection of both HB 5308 and HB 6841 that seek to establish standards in contracts between health insurers and physicians.

It is our understanding that in addition to the elements contained in these 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

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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 this bill include sections that prohibit health plans from using software systems that are 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.***

In closing, we'd like to draw the Committee's attention to Public Act 06-178 that was passed just last year and dealt with disclosure of fee information which is one of the main provisions of the bills under consideration today. That Act also contained language requiring that the Chairs and Ranking Members convene a meeting of physicians and managed care organizations at least two times annually to discuss issues related to contracting, including issues relative to any national settlement agreements, to the extent permitted under such agreements.

We respectfully suggest that Public Act 06-178 be allowed to stand unamended. A framework for an ongoing dialogue has already been established, and given that the public act just went into effect on October 1st, we believe it is premature to adopt further revisions. It was certainly our hope that after enactment of last year's bill, "standards in contracts" issues would be dealt with under the umbrella of the public act and not through additional legislation.

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 urge your opposition.

Thank you for your consideration.

House Bill No. 5189

Public Act No. 06-178

AN ACT REQUIRING THE DISCLOSURE OF FEE INFORMATION BY HEALTH INSURERS.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. (NEW) (*Effective October 1, 2006*) (a) As used in this section: (1) "Contracting health organization" means (A) a managed care organization, as defined in section 38a-478 of the 2006 supplement to the general statutes, or (B) a preferred provider network, as defined in section 38a-479aa of the general statutes; and (2) "physician" means a physician or surgeon, chiropractor, podiatrist, psychologist or optometrist.

(b) Not later than October 1, 2007, each contracting health organization shall establish and implement a procedure reasonably designed to permit a physician, physician group or physician organization under contract with such contracting health organization to view, on a confidential basis, in a digital format or by electronic means, at the option of such organization, the fee-for-service dollar amount such organization reimburses pursuant to the organization's contract with the physician, physician group or physician organization for the fifty current procedural terminology codes most commonly performed by the physician, physician group or physician organization.

(c) The procedure established by a contracting health organization shall also permit a physician, physician group or physician organization to request and view fee-for-service dollar amounts the contracting health organization reimburses for current procedural terminology codes for which a physician, physician group or physician organization actually bills or intends to bill the contracting health organization, provided such codes are within the physician's specialty or subspecialty.

(d) The provisions of subsections (b) and (c) of this section shall not apply to any physician, physician group or physician organization whose services are reimbursed in a manner that does not utilize current procedural terminology codes.

(e) The fee information received by a physician, physician group or physician organization is proprietary and shall be confidential, and the procedure adopted pursuant to this section may contain penalties for the unauthorized distribution of fee information, which may include termination from the contracting health organization network.

Sec. 2. (NEW) (*Effective October 1, 2006*) The chairpersons and ranking members of the joint standing committee of the General Assembly having cognizance of matters relating to insurance shall convene, at least two times each year, a group of physicians and managed care organizations, to discuss issues relative to contracting between physicians and managed care organizations, including issues relative to any national settlement agreements, to the extent permitted under such settlement agreements.