



**Connecticut State Medical Society Testimony in Support of**  
**House Bill 5446 An Act Concerning Standards in Contracts Between Health**  
**Insurers and Physicians**  
**Presented to the Public Health Committee**  
**February 29, 2008**

Senator Handley, Representative Sayers and Members of the Public Health Committee, my name is Matt Katz and I am the Executive Director of the Connecticut State Medical Society (CSMS). On behalf of our 7,000 members thank you for the opportunity to testify before you today House Bill 5446 AN ACT CONCERNING STANDARDS IN CONTRACTS BETWEEN HEALTH INSURERS AND PHYSICIANS.

CSMS and many of our state medical specialty societies have been before this Committee for a number of years asking for the establishment of certain standards in contracts between physicians and managed care companies.

Promoting transparency in all aspects of medical care leads to cost savings and quite frankly, better knowledge about the care being provided. Patients should know what things cost. Doctors should know what things cost. Everyone needs to know who's responsible for payment in order to have a truly patient-centered, reformed system.

As members of this committee well know, in 2006 session, the General Assembly passed legislation to require beginning this last October basic disclosure of certain fees schedule information to physicians by health insurers. This was a great first step and physicians today now have access to fee schedule information. However, many more standards such as those contained in this bill need to be enacted to require fair and just contracting between physicians and insurers. In fact, physicians may have the published, standardized or personalized fees that are posted or otherwise provided by health insurers, but they still do not know what they are getting paid and patients do not know how much they are responsible to pay for the care they receive.

The reason that confusion still persists despite having access to the fee schedule is that health plans continue to adjust physician coding of the actual services provided and bundle payments when more than one medical service or procedure has been provided by the physician. Despite the fact that physicians must and do comply with the codes, guidelines and conventions as clearly presented in the American Medical Association Current Procedural Terminology

(CPT) code book when recording and reporting the provision of medical procedures and services, health insurers often ignore these standards.

It is critical that health insurers play by the same set of rules and standards that physicians must follow and that health insurers do not unilaterally or arbitrarily (or inappropriately) reduce the level of service or decrease payment when multiple medically necessary services or procedures are provided. CSMS believes that correct coding methodologies, such as adherence to CPT codes, guidelines and conventions control for improper coding that could lead to inappropriate payment associated with the provision of medical procedures and services. In fact, The Centers for Medicare and Medicaid Services (CMS) developed its coding policies based on coding conventions defined in the AMA's CPT book, in addition to certain national and local policies and related code edits, as well as certain coding guidelines developed by national medical society societies. CMS also evaluated standard medical and surgical practices and performed a review of current coding practices. We believe that there needs to be standardization and adherence to CPT if physicians are to accurately report the medical procedures and services they provide to patients and health plans are to appropriately reimburse.

In addition to code editing and bundling, health insurers also continue to fail to provide physicians with the methodology or justification for fee reductions. The situation in New York is yet another example of the problems with how much (or really, how little) information health insurers provide physicians and patients about the methodology and the actual payments made to physicians.

The New York Attorney General Cuomo announced a few weeks ago that he is conducting an industry-wide investigation into, and I quote "a scheme by health insurers to defraud consumers by manipulating reimbursement rates." At the center of the scheme is healthcare billing information which Attorney General Cuomo indicated "serves as a conduit for rigged data to the largest insurers in the country."

The six-month investigation in New York found that most insurers use a "defective and manipulated database" "to set reimbursement rates for out-of-network medical expenses" and that at least two insurers "dramatically under-reimbursed their members for out-of-network medical expenses" by using this data. These health insurers benefit by distorting rates and forcing patients to absorb a higher share of the costs. We need transparency in both the in-network and out of network setting for both physicians and patients.

Cuomo stated in his press release that "The lack of accuracy, transparency, and independence surrounding..." these process was "astounding" and clearly "demonstrate[ed] a broken reimbursement system designed to rip off patients and steer them towards in-network-doctors that cost the insurer less money."

This same data is often used in the in-network setting to determine rates for physicians and payments by patients. There must be greater transparency in the data used by health insurers and the methodology employed by health insurers in determining the plan and patient responsibility for paying for the medical care provided. Patients should not be paying more than their share.

CSMS believes that standards in contracting that includes transparent information to both physicians and patients will go a long way in addressing the problems that presently exist for physicians and patients when it comes to health insurer payments.

Nationally, most major health insurers have already consented to these fairness standards during a long and complex lawsuit lead by Connecticut physicians. In fact, recently most of the nation's Blue Cross Blue Shield plans agreed to these standards in contracting. However, one settlement, Cigna, terminated in September 2007 and others, including Aetna with expire soon. In addition, these settlements do not include every insurer covering lives in the state. Therefore, we ask that several of those agreed to provisions be enacted into state law to protect every physician and insured. We also call on these health insurers who have settled with Connecticut and the nation's physicians to stand with us and behind these agreements and their business practice standards that better allow for physicians to practice medicine and patients to receive medical care.. So before you today is also legislation to establish standards in contracts between physicians and Managed Care Organizations.

Included in our testimony are several contract inclusions that many managed care organizations have previously agreed to through national class action lawsuit settlements.

We ask that several of those agreed to provisions from the settlements be enacted into state law to protect every physician and insured.

CT physicians ask any successful legislation include the following -

- **Disclosure of complete fee information to physicians showing applicable fee amounts as well as a disclosure of methodologies used to establish fee levels prior to acceptance of a contract.**
- **Prohibit changes to a fee schedule during a contract period**
- **Prohibit contractual changes during the contract period of non-fee related issues without the written approval of the physician**

- **Require each plan to establish an independent external review process to address physician contract issues and disputes similar to one already in place to address patient issues and disputes.**
- **Require each plan to prove compliance with the bill by submitting an independently conducted annual audit to the Department of Insurance.**
- **Prohibit the contracting health organization to reduce the level of service coded on a claim submitted by a physician without conducting a reasonable investigation based on all available medical records pertaining to the claim and adherence to CPT codes, guidelines and conventions**

These issues were developed through years of legal battles and legislative debate, and have been included in the settlements of national class action lawsuits between doctors all over the country many of the nation's largest managed care companies. The settlements will eventually expire, and many state residents obtain coverage from companies not involved in the national settlements. By incorporating these provisions in Connecticut Statutes, they will serve doctors and their patients forever- making sure that physicians, medical doctors, are making medical decisions.

We ask the Connecticut General Assembly to support and pass legislation to affirm the rights of physicians and define the role of managed care companies for playing by a set of fair and balanced rules when contracting for medical services for patients. We must protect the patient and standardize how health plans contract with physicians in order to level the playing field and provide greater transparency and simplicity to how, what and who is paying for medical care and at what level of payment.

Please support House Bill 5446.