



Quality is Our Bottom Line

Connecticut Association of Health Plans

**Public Health Public Hearing
February 29, 2008**

Testimony in Opposition to HB 5446 AAC Standards in Contracts Between Health Insurers and Physicians.

The Connecticut Association of Health Plans respectfully urges the Committee's strong opposition to HB 5446 AAC Standards in Contracts Between Health Insurers and Physicians.

With respect to Section 1(b) and the requirements around fee schedules, legislation is already in effect regarding this matter - PA 06-178 AA Requiring the Disclosure of Fee Information by Health Insurers. Just this past October, the health plans implemented provisions of the Act which represented a compromise on the "standards in contracts" issue. As such, each organization is now required to make available upon the request of any contracted physician, the reimbursement amounts for the top 50 procedure codes performed. Based on information we've received from one of our largest plans, the new process is being used fairly consistently with no reported problems. We respectfully submit that the process should be granted an opportunity to work before consideration is given to widening its scope.

Likewise, Section 1(b)(5) of the bill before you requires the incorporation of a definition of "medical necessity" in all health plan contracts. This is also addressed under current law with last year's passage of Public Act 07-75 AAC Medical Necessity and External Appeals. PA 07-75 specifically states, in statute, a particular definition of "medical necessity" that all health plans - not subject to a national settlement (as described below) - must adhere to.

Furthermore, current law provides that any dispute over a "medical necessity" determination, may be appealed to an independent outside panel of experts via the Commissioner of Insurance pursuant to Section 38a-478n. That same section also provides that if the Insurance Commissioner receives three or more appeals of denials or determinations by the same managed care organization or utilization review company with respect to the same procedure or diagnostic code, that the Commissioner may issue an order specifying how such MCO shall make such determinations in the future.

It is our understanding that the true underlying intent of HB5446, is really 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.*** Such 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, 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. Most, if not all, of the settlements are still in effect, some just a year or so old.

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, as provided for under similar proposals, 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.

Portions of the other bills under consideration aim 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.

With respect to the task force provisions of the bill, again an ongoing mechanism for continued dialogue is already established in statute. PA 06-178 requires that the Insurance Committee

convene periodic meetings of physicians and managed care organizations to discuss issues relative to contracting, including those related to any national settlement agreements, as permitted. We would argue that this is the appropriate venue for ongoing discussion.

We respectfully submit that the elements of the bill before you today are already addressed in current statute and that the true intent of the legislation under consideration is strongly ill-advised and should be rejected.

Thank you, as always, for your consideration.