



Quality is Our Bottom Line

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Connecticut Association of Health Plans

**Insurance Committee Public Hearing
February 5, 2009**

**Testimony in Opposition to
SB 47 AAC Health Care Provider Contracts.**

The Connecticut Association of Health Plans respectfully urges the Committee's opposition to SB 47 AAC Health Care Provider Contracts.

With respect to 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. Health plans have implemented the 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.

If past history is any indication, the real intent of SB 47 is 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.

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. With respect to the language in SB 47 which allows providers to discuss and negotiate terms of the contract, these are the appropriate entities within which to have such conversations. To do otherwise, outside the umbrella of these entities, constitutes antitrust.

As for unilateral contract changes, some 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.

The segment of the bill related to coding seeks 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. This is true as well for section (3) of the bill which limits to 90 days the time under which an insurer can repeal or rescind an authorization even when there may be circumstances which warrant such action such as a loss of eligibility during the time of service or even fraud.

All of these distinctions are no small matters.

PA 06-178 also 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. Health plans maintain their commitment to continuing the dialogue around these issues and would welcome the opportunity to continue such discussions in this context.

We respectfully submit that many of 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.