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Connecticut State Medical Society
Testimony Presented to the Insurance and Real Estate Committee on
Senate Bill 47 An Act Concerning Health Care Provider Contracts
February 5, 2009

Senator Crisco, Representative Fontana and Members of the Insurance and Real Estate Committee, my name is Matthew Katz, and I am the Executive Vice President of the Connecticut State Medical Society (CSMS). On behalf of our more than 7,000 members, thank you for the opportunity to testify before you today in support of **Senate Bill 47 An Act Concerning Health Care Provider Contracts**.

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. We are here again today with the same request.

The bill as currently drafted has three major provisions. It (1) prevents unilateral changes to contracts, (2) prevents "downcoding" or reductions on the level of coded services and (3) limits retrospective audit time periods to ninety days.

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 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. 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. 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.

One standard include in all settlements is a limitation on the timeframe for retrospective audits, while all insurers who have entered into national settlement have agreed to varying lengths of recover time, there is no statute to limit such audits. Therefore, it is possible that insurer can seek to extract information, records, documentation and even repayment years after a service was provide. This often places an administrative burden on physicians that cannot be met.

So before you today is also legislation to establish standards in contracts between physicians and Managed Care Organizations. We ask that several of those agreed to provisions from the settlements be enacted into state law to protect every physician and insured. Connecticut physicians ask that the proposed language be amended to comprehensively 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 patient's 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.

Thank you for the opportunity to present this testimony to you today. Please support Senate Bill 47.