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James Weisz

Testimony of the
Connecticut ENT Society
Connecticut Urology Society
Connecticut Society of Eye Physicians
Connecticut Chapter of the American College of Surgeons
Connecticut Dermatology and Dermatologic Surgery Society

**on S.B. 393, AN ACT CONCERNING STANDARDS IN HEALTH CARE PROVIDER
CONTRACTS**

Before the Insurance and Real Estate Committee
March 9, 2010

Good Afternoon, Senator Crisco, Representative Fontana and other distinguished members of the Insurance and Real Estate Committee. I am Dr. James Weisz, a board certified ophthalmologist and retina specialist practicing in Bridgeport and New Haven. I am here today representing over 1500 physicians in the medical specialties of Ophthalmology, Otolaryngology, Dermatology, General Surgery and Urology to support S. B. No. 393 AN ACT CONCERNING STANDARDS IN HEALTH CARE PROVIDER CONTRACTS.

I want to thank this committee and say that we greatly appreciate your work and commitment to improving contracting standards between doctors and insurance companies, both this year and in the past. We understand that this is a work in progress and that addition details and language will be developed in the next few weeks. We truly appreciate that you and the Connecticut State Medical Society are willing to tackle this difficult but important issue.

I would like to call attention to one specific area of concern, the issue of "all products clauses". Simply put, this is the requirement that providers who chose to participate in one plan from an insurance company are subsequently required to participate in all the plans offered by that company. The requirement to participate in additional plans can occur in several ways. An insurer may chose to offer a new plan to gain a competitive edge or attract a new segment of the market. As you know, there has been considerable consolidation amongst payors in Connecticut, and all products requirements can also occur when insurers merge, and the products and plans of both companies are suddenly required. In some cases, this requires providers to participate in a plan they have previously rejected. In addition, the reimbursement rates are sometimes changed to match the lowest rate amongst the plans offered. Physicians are sometimes given the opportunity to "opt out", but even this can be problematic as there are requirements that they must file a specific request to do so. If they do not "opt out" by the specified deadline, it is often much harder for them to leave the plan and they may be required to continue to participate for months. In addition, this system greatly diminishes the ability of providers to negotiate more favorable contract terms.

The decision to participate in any plan is a business decision and it should not be automatic. Physicians and other providers would much prefer taking care of sick patients then spending countless hours researching plans for which MCOs provide little to no information. We believe it would be more appropriate to require specific action on the part of providers to "opt in", or accept the new plan; if they do not do so, they are not enrolled in the new plan. This would at least give providers the opportunity to discuss terms and conditions

and not be automatically enrolled into the plan if they do not receive the paperwork or miss the return date on the response, before joining any plan.

As is always the case, the devil will be in the details as we go forward. This can be easily demonstrated by the fact that the pre-authorization numbers issued by some insurers do not fit in the allowed space on the Medicare 1500 electronic form. This and other details clearly need to be worked out, and we look forward to working with this committee and CSMS to improve health care in Connecticut.

Thank you for your attention.