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Connecticut State Medical Society Testimony in Support of
Senate Bill 480 An Act Concerning Cooperative Health Care Arrangements
Presented to the Judiciary Committee
March 24, 2010

Senator MacDonald, Representative Lawlor and member of the Judiciary Committee, my name is Matthew Katz and I am the executive vice president of the Connecticut State Medical Society (CSMS). I am here representing the more than 7,000 physician and medical student members of the Connecticut State Medical Society to discuss the widening gap between the perception of the way the market works between physicians and managed care companies, and the reality of how it works -- or more appropriately, how it doesn't work -- today in Connecticut. With your support, **Senate Bill 480 AAC Cooperative Health Insurers and Health Care Providers** will begin to address the issues I raise today.

Despite what you will hear from managed care representatives, the vast majority of physicians have virtually no power to negotiate the terms of their provider agreements, especially in Connecticut where the health insurance market continues to consolidate. This situation is in dire need of legislative solutions in order to address this imbalance.

Today, I would like to offer our strong support, as well as some specific comments, regarding the proposed Senate Bill 480 that has been before several committees over the past several years and is back for consideration this session.

We ask this committee to support this piece of legislation which provides relief for physicians and is aimed at permitting balanced, informed and good-faith negotiations with health insurers and other entities, specific to how medical care is delivered to patients in the state of Connecticut.

Such good-faith negotiations do not regularly occur in today's managed care environment and are necessary to ensure that physicians and other health care providers can negotiate decisions on medical care and treatment such as: (i) transparent medical payment policies so physicians and the patients know what is covered; (ii) the language by which patients are informed about adverse claims decisions which involve a physician's medical judgment; (iii) how disputes get resolved; and (iv) receive fair and adequate reimbursement of exceptional costs that they incur for the costs of malpractice insurance, for employees' salaries, for rent and other costs, all while providing access to all manner of medical procedures for their patients.

CSMS strongly believes that this bill would positively impact patient access to quality medical care and give the physicians of Connecticut the ability to fairly, and with state oversight, bargain to recoup the costs associated with certain physician expenses, including the procurement of health information and related technology that today seems so far out of reach of most of Connecticut's practicing physicians.

Federal law allows states to develop their own regulatory approach in areas where the federal government has already developed a regulatory method, under a doctrine that is commonly referred to as "state action." This bill applies that doctrine for the purpose of enabling collective negotiations by nominally competing physicians of certain terms and conditions of a physician's provider contracts with health plans and other entities contracting for the provision of medical services.

Physicians must have the opportunity to advocate for their patients, patient safety and the quality of care that they know needs to be provided. Unfortunately, many market factors have prevented this from occurring in Connecticut. The lack of meaningful bargaining power by non-integrated physicians has created a number of difficulties which threaten to curtail access to certain kinds of medical services and compromise the quality of care received by Connecticut residents from their physicians. Examples that have been widely reported in medical journals include radiologists that are increasingly limiting annual mammograms, neurologists that are restricting the types of high-risk procedures they will undertake, and many OB/GYNs that are restricting their practice to gynecology and curtailing the delivery of babies - all this in order to afford an adequate level of insurance coverage for some of the medical services they are trained to do and want to provide to their patients.

Physicians in Connecticut, more than 80% providing care as solo- or small-practice physicians, today cannot afford the high cost of implementation and maintenance of health information technology (HIT), including, but not limited to, electronic medical record systems. Because of managed care organizations' strong-arm contracting methods, physicians cannot pass along any of these additional and increasingly necessary costs of doing business to the managed care organizations. Although the federal government has recognized the potential benefits of HIT, and recently approved \$19 billion in financial incentives for investment in HIT within the American Recovery and Reinvestment Act of 2009 ("ARRA"), this funding will only help with the acquisition costs, and does not address annual maintenance costs. What is more, the ARRA does not address the large and very real administrative burden HIT will impose on physician practices in Connecticut associated with training, personalizing the system to fit the practice and patient needs, and adopting physician work processes to achieve maximum benefit. To date, very few physician practices in Connecticut have concluded that the benefits from implementing HIT systems outweigh the tremendous costs, especially in light of how the HIT funding has been allocated and will be paid to physicians (tied to the provision of Medicare and/or Medicaid services).

Unfortunately, while managed care organizations continue to receive financial benefits from efficiency created by HIT systems, they have yet to really demonstrate any real and meaningful interest in paying for those benefits or the improved care patients receive. In order to give physicians the incentives to purchase HIT systems, as well as allow for a more equitable sharing in the cost savings achieved the systems' efficiencies, Connecticut physicians need the ability to enter into joint negotiations with managed care organizations.

The issues involved go far beyond cost to the quality of medical care in Connecticut. Physicians are starting to use HIT systems to improve access to patient care as well as dramatically improve patient care outcomes by sharing information on treatment methods that demonstrate best practices. Physician collaborations that are designed to facilitate the development of best practices and rely on more efficient treatment protocols should be the foundation of medical care in Connecticut.

There has also been widespread reporting of the practice of "defensive medicine" and some recent articles and reports, including some federal government findings, that defensive medicine costs billions of dollars a year in this nation. Though there has not been a specific study as of yet to capture the true costs of defensive medicine in Connecticut, it is quite readily apparent that in a state with some of the highest liability rates in the nation, there would be a high likelihood of defensive medicine costing the system millions of dollars a year- this is not a small amount of the health care dollar that we expend in this state or this nation.

Joint negotiation of the type being proposed in this bill will be permitted in instances where the state, acting under the supervision of the office of the Attorney General, either: (i) finds that a health plan has significant market power, enabling it to virtually dictate the terms of provider agreements to physicians, or (ii) finds that negotiations on fee-related issues have been one-sided in favor of the health plan or have not occurred due to the market power of the health plan.

A number of new statutory definitions are being proposed to both implement the purpose of the proposed bill and to assist the State in the implementation of its purpose.

Any physicians or physician organizations seeking to negotiate the terms and conditions (including fees) with a managed care organization, in concert with or on behalf of more than one non-integrated physician, shall need to comply with the procedures outlined in this proposed bill. Adherence to these procedures should clearly provide the Attorney General with an understanding of the intent of the negotiations. This state supervision of the intent of the negotiations is an important first step in the process of assuring that patient care and patient benefits are achieved through cooperative arrangements.

This bill also outlines a process by which the Attorney General is to notify the applicant of approval or disapproval consistent with the statutory requirements of review. Specific to the review, the Attorney General is to focus on the public advantage and benefits of any such cooperative arrangements, such as the enhanced quality of medical care for consumers, any cost efficiencies associated with the provision of medical care services, the improvement in the utilization of, and access to, medical care and medical equipment, and avoidance of duplication of health care resources. The Attorney General is also to consider and make certain that these benefits outweigh any potential disadvantages, including, but not limited to, any potential reduction in competition or negative impact on quality, access or price of medical care for consumers.

The bill provides further protections in that it allows the Attorney General to suspend the cooperative agreement if there is reason to believe that the approved cooperative arrangement is not performing or providing services as described in the application or required annual progress report. In other words, the Attorney General has the ability to affirmatively suspend the agreement if such terms and conditions of the agreement are not being met. This affords further protections, as it provides some supervision and authorization of the cooperative agreement's effective benefits to consumers, which is the ultimate goal of this legislation. In other words, it provides a demonstrated benefit to patients through a collective approach not only to negotiation, but also to the clinical integration of medical care.

The Attorney General is further authorized by the proposed bill to implement such rules and procedures as are necessary or convenient to implement the provisions of the statute, including the filing of application fees.

The proposed bill requires managed care organizations and like entities to engage in informed negotiations in good faith with parties to a cooperative agreement, assuring that the benefits of any negotiation will go to both parties and most importantly to benefit patients.

Finally, it is important to point out that group actions to boycott or cease medical services are NOT actions authorized under the proposed bill and approaches that are not supported or endorsed by CSMS or organized medicine in general. CSMS is not interested in physicians threatening to stop the provision of quality patient medical care, especially at a time where we are starting to see shortages of physicians and decreased access to certain services, procedures and medical specialists. Rather, we are interested in allowing physicians to come together and negotiate in good faith with managed care organizations, to implement and utilize similar or like technologies to access patient medical information, and provide quality patient medical care in a manner that benefits consumers.

Thank you for your time and attention to this important matter. On behalf of Connecticut's physicians and their patients, I urge you to support Senate Bill 480 and consider this unique opportunity to help Connecticut's physicians advocate for their patients and ensure that quality patient medical care is received while protecting the public good.