



*Quality is Our Bottom Line*

**Insurance Committee Public Hearing  
Tuesday, January 25, 2011**

**Connecticut Association of Health Plans  
Testimony in Opposition to**

**SB 16 AAC Standards for Health Care Provider Contracts.**

The Connecticut Association of Health Plans respectfully urges the Committee's opposition to SB 16 AAC Standards for Health Care Provider Contracts.

The "standards" bill has been before this Committee in a variety of iterations for the last several years and the health insurance industry has worked in good faith with many of the members of this Committee, both past and present, to address numerous issues. In fact, Public Act 06-178 requires that the Chairs and Ranking Members of Insurance Committee convene a meeting of physicians and managed care organizations at least two times annually to discuss issues related to contracting and we welcome the continuation of that dialogue and would argue that it is the more appropriate venue in which to continue a discussion around the elements of SB 16.

Health plans and providers contract 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.

We would argue that the elements of contracting should be left to the two private parties involved within the context of current statute and not be subject to yet another layer of government intervention as envisioned under Section 2 of SB 16. The Department of Insurance has a valuable role to play in assuring the viability of the health insurance market and the access to quality health care that it provides to consumers. However, regulation that ties the hands of insurers in developing innovative delivery systems has the potential to be extremely detrimental particularly in the context of federal health care reform which embraces new and unique delivery models such as medical homes and accountable care organizations.

Furthermore, requiring in statute that health plans comply with a singular aspect of a single accrediting body, we believe is ill-advised. While recognition by NCQA is a well respected and sought after designation, its standards, as well as those of other accrediting bodies, should be adhered to within the context of accreditation rather government regulation.

Section 4 of SB 16, attempts to tie guaranteed provider payment to designations of prospective medical necessity determinations, however, such determinations are really separate and aside to payment provisions which are tied to an individual's eligibility status as opposed to a medical necessity approval. For instance, if it's determined that a member was no longer insured on the date that a certain procedure is performed, regardless of whether such procedure is medically necessary, a health plan can't be held responsible for payment for a member that they no longer insure. Such a requirement, if it were passed, would have untold consequences in terms of increased premium costs.

Lastly, the Association is opposed to Section 5 which, we believe, is fundamentally anti-consumer. While the insurers contemplated under this section do not provide coverage for all associated dental procedures, they do provide their members with important price protection by prohibiting participating dentists from charging a health plan's member more that they would charge the health plan itself.

We would respectfully urge your rejection on SB 16. Thank you for your consideration.