



**Testimony of the Connecticut State Medical Society
Connecticut Chapter of the American College of Physicians
Connecticut Chapter of the American College of Surgeons
In support of
Senate Bill 182 An Act Concerning Cooperative Health Care Arrangements
Presented to the Labor and Public Employees Committee
February 28, 2012**

Senator Prague, Representative Zalaski and members of the Labor and Public Employee Committee, my name is Matthew Katz and I am the Executive Vice President/Chief Executive Officer of the Connecticut State Medical Society (CSMS). I am here representing the more than 8,500 physicians and physician-in-training members of CSMS and the Connecticut Chapters of the American College of Physicians and the American College of Surgeons 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 182 AAC Cooperative Health Care Arrangements** will begin to address and correct the issues I raise today that place undue burdens on physicians and cause access to care issues in Connecticut.

Today, it is still true that the vast majority of Connecticut physicians practice in small, non-integrated offices that have virtually no power to negotiate the terms of their provider agreements, especially with a health insurance market that is consolidated and highly concentrated. This situation is in dire need of a state-based legislative solution in order to address this imbalance which often leads to limitations on access to care.

Today, I would like to offer our strong support, as well as some specific comments, regarding proposed Senate Bill 182 that has been before several committees over the past several years and is back for consideration this session at our urging.

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) 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.

A significant change in the environment this year is the implementation of the Patient Protection and Affordable Care Act (PPACA). The PPACA encourages the establishment of Accountable

Care Organizations (ACOs) as model for physician and provider integration as well as other models of medical care. However, federal antitrust laws prohibit Connecticut physicians from collective discussions about certain critical aspects of ACOs, especially in particular areas of the state with few physicians or few physicians of certain specialties, such as how best to improve patient access to quality medical care and how this access and the quality of the care provided can be tied to specific models or formulas of reimbursement.

Without cooperative arrangements, it will be virtually impossible for physicians in Connecticut to talk about cost, quality and efficiency as they relate to ACO and medical care model design. Furthermore, without cooperative arrangements, physicians cannot continue to discuss with one another how best to achieve improved access and better quality care with insurers and other entities that may wish to negotiate with ACOs or other similar entities developed by physicians consistent with PPACA and state-based reform measures. This is in large part because Connecticut's medical landscape is made up of a majority of non-integrated practices that must be allowed to talk to one another and negotiate with insurers about the quality of care provided, the cost of care and reimbursement for care if they wish to improve quality and reduce cost.

In addition to ACOs, physicians who participate in patient-centered medical home models need the ability to interact with their colleagues and negotiate on quality and cost with insurers if we are to expect greater care coordination and management of patient care that are part of this model. If we expect physicians to provide intensive care management for high-risk, high-need, high-cost patients; and provide routine, systematic assessment of all patients to identify and predict which patients need additional interventions, physicians must be able to communicate with their colleagues and other clinicians involved in the care plan design. Physicians must have access to patient data so they can continue to participate in care decisions with their patients and they must have information from all providers of medical care to better understand both the services and procedures that were provided and the cost.

Truly patient-centered care assumes policies and procedures designed to ensure that patient preferences are sought and incorporated into treatment decisions. In order to provide patient-centered care, physicians must be able to access and share relevant clinical and claims data, including cost and reimbursement data, to allow for choices and decisions that are in the best interest of the patient and where comparative effectiveness of the treatment modality is available. Such sharing is not available today without cooperative arrangements.

CSMS strongly believes that this bill would positively impact patient access to quality medical care and give Connecticut physicians the ability to fairly -- and with active 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, more than 80% of whom are in solo or small practices with fewer than five physicians.

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 prevent this from occurring in Connecticut today. The lack of meaningful bargaining power by non-integrated small-practice physicians has created 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 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.

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.

Joint negotiation of the type being proposed in this bill will be permitted in instances where the State, acting under the active 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 arrangement 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 arrangement if such terms and conditions of the agreement are not being met. This affords further protection, as it provides supervision and authorization of the cooperative arrangement's effective benefits to consumers, which is the ultimate goal of this legislation. 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 arrangement, assuring that the benefits of any negotiation will go to both parties and most importantly to benefit patients.

The legal premise behind this bill is the State Action Doctrine. Federal law allows states to develop their own regulatory approach in areas where the federal government has already developed a regulatory method, under the concept of "state action." As highlighted above, the Attorney General, acting on behalf of the state, has a prominent and active supervision role in the formation of cooperative arrangements. As already noted, this bill has been before several committees over the past legislative sessions. Last year, many of you received a letter written by officials at the Federal Trade Commission (FTC) questioning the application of the State Action Doctrine as it was written in this and previous bills. In an effort to understand what needed to be done from the perspective of the FTC to satisfy their interpretation of the State Action Doctrine, late last year staff from CSMS met face-to-face with senior officials from the FTC and the Department of Justice (DOJ) to discuss the application of the State Action Doctrine. This outcome of this meeting was a very educational and productive discussion.

Based on that discussion, we strongly support and recommend the "state action" supervision in SB 182 be amended as follows:

- Require the Attorney General to issue a certificate of public advantage in connection with any cooperative arrangement;
- Increase the fees for submission, review and continued supervision by the Attorney General of each such cooperative arrangement;
- Require active supervision of each such cooperative arrangement by the Attorney General for the length of the term of the arrangement;
- Allow the Attorney General to immediately intervene and review any authorized cooperative arrangement if such arrangement is believed to no longer be effective; and
- Allow the Attorney General to observe any good faith negotiations between a managed care company and any authorized cooperative arrangement.

It's important to point out that group actions to boycott or cease medical services are NOT actions authorized under the proposed bill and these approaches are not supported or endorsed by CSMS, ACP, ACS or organized medicine in general. Our organizations are 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. We also do not seek a process in which the Attorney General plays a role in determining the outcome, but simply serves in active supervisory role ensure an appropriate and fair process. Rather, we are interested in allowing physicians to come together and negotiate in good faith with managed care organizations or other such entities or payors, 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 182 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.



General Assembly
February Session, 2012

Raised Bill No. 182

LCO No. 1031

01031 _____ LAB

Referred to Committee on Labor and Public Employees

Introduced by:
(LAB)

AN ACT CONCERNING COOPERATIVE HEALTH CARE ARRANGEMENTS.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. (NEW) (Effective October 1, 2012) (a) As used in this section:

- (1) "Cooperative arrangement" means an agreement among two or more health care providers for the purpose of sharing, allocating or referring patients, personnel, instructional programs, support services or facilities or medical, diagnostic or laboratory facilities or procedures, or negotiating fees, prices or rates with managed care organizations and includes, but is not limited to, a merger, acquisition or joint venture of two or more health care providers, including, but not limited to, physician practice groups;
- (2) "Health care provider" means: (A) A physician licensed under chapter 370 of the general statutes, (B) a chiropractor licensed under chapter 372 of the general statutes, (C) a podiatrist licensed under chapter 375 of the general statutes, (D) a natureopath licensed under chapter 373 of the general statutes, or (E) an optometrist licensed under chapter 380 of the general statutes;
- (3) "Certificate of public advantage" means a certificate issued by the Attorney General, that authorizes health care providers that are parties to a cooperative arrangement to engage in conduct that could tend to lessen competition in a relevant health care market, upon a showing that such cooperative arrangement meets the criteria set forth in subdivision (2) of subsection (c) of this section; and

(4) "Managed care organization" has the meaning set forth in section 38a-478 of the general statutes.

(b) ~~In order to pursue a cooperative arrangement, the Attorney General must issue a certificate of public advantage in accordance with this section. Any two or more health care providers shall apply to the Attorney General for a certificate of public advantage to authorize a cooperative arrangement. The application shall include (1) the name of the applicant or applicants, (2) a description of the nature and scope of the cooperative arrangement, (3) a description of any consideration passing to a party under the agreement, (4) evidence in support of the criteria set forth in subdivision (2) of subsection (c) of this section, and (5) such other information as the Attorney General may require. Each application shall be accompanied by a fee of one thousand dollars.~~ Any information of a proprietary nature submitted in such application that meets the standards set forth in subdivision (5), (8) or (10) of subsection (b) of section 1-210 of the general statutes shall be confidential and exempt from public disclosure.

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(c) (1) The Attorney General shall review each application submitted pursuant to subsection (b) of this section and, not later than ninety days after receipt of such application, issue a written decision approving or denying the application. ~~The Attorney General shall charge the applicants \$1,000 for the review of each such application.~~ The decision shall set forth the Attorney General's findings with respect to the benefits and disadvantages described in subdivision (2) of this subsection and a conclusion as to whether the benefits outweigh the disadvantages to the residents of this state. The Attorney General may conduct a hearing, after giving notice to all interested parties, to obtain information necessary in making such decision.

(2) In reviewing applications under this section, the Attorney General shall consider the provisions of chapter 368z of the general statutes concerning long-range health planning that the Attorney General deems relevant to the application for a certificate of public advantage, and any benefits of such cooperative arrangement, including, but not limited to: (A) Enhancement of the quality of health services to consumers; (B) gains in cost efficiency of providing health services; (C) improvement in utilization of and access to health services and equipment; and (D) avoidance of duplication of health care resources. The Attorney General shall not approve an application for a certificate of public advantage unless the Attorney General finds that the benefits of the proposed cooperative arrangement outweigh the disadvantages, including, but not limited to: (i) The potential reduction in competition; (ii) the adverse impact on quality, access or price of health care services to consumers; and (iii) the availability of arrangements that achieve the same benefits with less restriction on competition.

(3) Conduct by health care providers in furtherance of a cooperative arrangement that has received a certificate of public advantage shall not be subject to the provisions of chapter 624 of the general statutes, except that the Attorney General may utilize the

powers set forth in section 35-42 of the general statutes when the Attorney General has reason to believe that the approved cooperative arrangement is not performing or providing services as described in the application or in the annual progress report. (4) Health care providers in a cooperative arrangement that has received a certificate of public advantage pursuant to this section shall submit an annual progress report to the Attorney General on a form prescribed by the Attorney General. The report shall be accompanied by a fee of one thousand dollars for annual monitoring of the cooperative arrangement.

Deleted: This section shall not be construed to require a health care provider to obtain a certificate of public advantage in order to enter into a cooperative arrangement, and, absent a certificate of public advantage, the legality of such cooperative arrangement shall be determined by applicable antitrust law.¶

(5) The Attorney General shall actively supervise any cooperative arrangement authorized pursuant to this section, for the length of the term of such cooperative arrangement, to determine whether the conduct undertaken by the health care providers in furtherance of the cooperative arrangement should continue to be authorized. The Attorney General shall review such conduct through annual progress reports submitted by the health care providers in a cooperative arrangement in accordance with subdivision (4) of this subsection to evaluate whether the conduct is consistent with the application and whether the benefits continue to outweigh the disadvantages. Notwithstanding the submission of annual progress reports, if at any time during the term of such cooperative arrangement, the Attorney General has reason to believe that the likely benefits no longer outweigh the disadvantages, the Attorney General shall have the authority to conduct an immediate review of the cooperative arrangement. If the Attorney General has reason to believe that the likely benefits no longer outweigh the disadvantages, the Attorney General shall notify the holder of the certificate of public advantage and hold a hearing to determine whether such certificate should be modified or revoked. Such modification or revocation shall take effect ninety days from the mailing of notice of a final decision by the Attorney General.

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(d) Any health care provider denied a certificate of public advantage by the Attorney General pursuant to this section and any holder of a certificate of public advantage that has been modified or revoked by the Attorney General pursuant to subdivision (5) of subsection (c) of this section may appeal therefrom as if such denial, modification or revocation were a contested case within the meaning of chapter 54 of the general statutes.

Deleted: The Attorney General shall not modify or revoke a certificate of public advantage more than three years after the initial issuance of such certificate.

(e) No managed care organization shall refuse to negotiate in good faith with parties to a cooperative arrangement authorized by the Attorney General. Any managed care organization that violates this section shall be subject to a civil penalty of not more than twenty-five thousand dollars per day for each violation. The Attorney General shall have the discretion to observe such good faith negotiations between the managed care organization and the authorized cooperative arrangement. The Attorney General may institute proceedings to enforce the provisions of this section in the superior court for the judicial district of Hartford.

(f) A violation of subsection (e) of this section shall be deemed an unfair or deceptive trade practice under chapter 735a of the general statutes.

This act shall take effect as follows and shall amend the following sections:		
Section 1	October 1, 2012	New section

Statement of Purpose:

To permit health care providers to enter into cooperative arrangements that would not be subject to certain antitrust laws after approval by the Attorney General, and to require managed care organizations to negotiate in good faith with providers who participate in such arrangements.

[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]