

Connecticut State Medical Society  
American College of Surgeons Connecticut Chapter  
American College of Physicians Connecticut Chapter  
Connecticut Orthopedic Society  
Connecticut Society of Eye Physicians  
Connecticut Dermatology and Dermatologic Surgery Society  
Connecticut ENT Society  
Connecticut Urology Society

Testimony in Support of  
House Bill 6431 An Act Concerning Cooperative Health Care Arrangements  
Presented to the Labor and Public Employees Committee  
March 5, 2013

Senator Osten, Representative Tercyak and members of the Labor and Public Employee Committee, on behalf of the more than 9,000 physicians and physician-in-training members of organizations listed above thank you for the opportunity to present this testimony to you today and your willingness 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, **House Bill 6431 An Act Concerning 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.

We ask this committee to support House Bill 6431 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 in recent years is the implementation of the Patient Protection and Affordable Care Act (ACA). The ACA encourages the establishment of Accountable Care Organizations (ACOs) as model for physician and provider integration as well as other models of medical care that encourage and support greater cooperation and collaboration among and between physicians who are not owned or operated by one single

entity. However, federal antitrust laws prohibit Connecticut physicians from collective discussions about certain critical aspects of care coordination, 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 these new medical care model designs that focus on care coordination. Furthermore, without cooperative arrangements, physicians simply 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 these new systems of less than integrated care coordination consistent with ACA 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 and other new approaches to practice based care coordination, 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.

In the February 2011 issue of AMNews, a report by the American Medical Association reported that in 96% of markets, one insurer controls at least 30% of nearly every commercial health insurance and in half of metropolitan areas, one insurer controls 50% or more of the commercial insurance market. This market power creates a huge disadvantage to patients in the form of higher premiums and to physicians in the form of unfair contracting and policies.

In Connecticut, a handful of insurers control the commercial market and force physicians to participate in bad in one sided and onerous contracts that place all of the burden on physicians and their office and relieve insurers of certain liabilities and responsibilities. This encourages physicians to quit the private practice of medicine and seek hospital employment, or retire from

practice worsening physician shortages in some specialties. By legislating the ability for physicians to fairly negotiate under the watchful eye of the State's Attorney General and Healthcare Advocate, HB 6431 these trends can be reversed so that there is a level field of negotiation and engagement between physicians and insurers so that patients benefit.

For two decades, insurance companies have made unilateral demands on physician practices with contracts that deny payment, retroactively take back payment by garnering monies from current payments and unilaterally modify terms and reimbursement rates during the contract period without negotiation.

The ability of a physician to ask or demand a fair contract from an insurer grows worse every year as the recent AMA study highlights as the Connecticut state and local markets are even more concentrated than a year ago and these insurers have both monopsony and monopoly power. Over the past 12 years, more than 400 mergers and acquisitions have occurred among health insurers, with very little supervision or intervention by the federal agencies that are supposed to monitor and control such market consolidation. A lack of antitrust enforcement against insurers, and about 35 antitrust cases against physicians across the country for alleged antitrust violations when they resisted unreasonable insurance company contracts, have made insurers downright arrogant in their treatment of physicians and patients and believe that they can act without impunity, essentially an immunity to treat physicians and patients poorly.

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.

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.

In support the concept of Cooperative Healthcare Arrangements as established in the bill, we offer and ask that amended language be substitute as attached to our testimony. Joint negotiation of the type being proposed in this bill should be permitted in instances where the State, acting under the active supervision of the Healthcare Advocate determines that health plan possesses "buyer power" in certain geographic areas. Buyer power would be defined as the purchasing power of a health plan such that physicians located in the area may not practically refuse to sell services to the health plan. Several comprehensive and necessary requirements would need to be met by an established "Health care Collaborative" as defined in proposed substitute language to allow the Healthcare Advocate to grant a "Certificate of Public Advantage."

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. As mentioned any physicians or physician organizations to establish a Healthcare Collaborative, shall need to comply with the procedures outlined in this proposed bill. Adherence to these procedures

should clearly provide the Healthcare Advocate 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.

Proposed substitute language also outlines a process by which the Healthcare Advocate is to notify the applicant of approval or disapproval consistent with the statutory requirements of review. Specific to the review, the Healthcare Advocate 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 Healthcare Advocate 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.

Our proposed language provides further protections in that it allows the Healthcare Advocate significant authority revoke an approval in situations where the Healthcare Advocate determines the agreement is not in substantial compliance with the terms of the application or conditions of approval and issuance of a certificate of public advantage. In other words, the Healthcare Advocate has the ability to affirmatively end 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 Healthcare Advocate is further authorized by the proposed bill adopt regulations necessary to implement the provisions of the statute, including fees for continued oversight.

Furthermore the attached 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 Healthcare Advocate, acting on behalf of the state, has a prominent and active supervision role in the formation of cooperative arrangements. This intent of this bill has been before several committees over the past legislative sessions. Two sessions ago, 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, 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. Additionally, CSMS has worked with national experts on anti-trust law to craft the language we submit to you today.

Based on the efforts, we **strongly support and recommend the "state action" supervision in HB 6431 be amended as follows:**

- Require the Healthcare Advocate to issue a certificate of public advantage in connection with any cooperative arrangement;
- Increase the fees for submission, review and continued supervision by Healthcare Advocate of each such cooperative arrangement;

- Require active supervision of each such cooperative arrangement by the Healthcare Advocate for the length of the term of the arrangement;
- Allow the Healthcare Advocate to immediately intervene and review any authorized cooperative arrangement if such arrangement is believed to no longer be effective; and
- Allow the Healthcare Advocate 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 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. We also do not seek a process in which the Healthcare Advocate plays a role in determining the outcome, but simply serves in active supervisory role ensuring 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, we urge you to support House Bill 6431 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.

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*TESTIMONY OF*  
*ATTORNEY GENERAL GEORGE JEPSEN*  
*BEFORE THE COMMITTEE ON LABOR AND PUBLIC EMPLOYEES*  
*MARCH 5, 2013*

Good afternoon Senator Osten, Representative Tercyak and members of the Committee. I appreciate the opportunity to testify about House Bill 6431, *An Act Concerning Cooperative Healthcare Arrangements*. This bill is nearly identical to Senate Bill 182 from the 2012 session. My Office opposed that measure last year. For your convenience, I have attached a copy of my testimony from last year, which remains the position of my Office.

It is my understanding, however, that the proponents of HB 6431 have shared substitute language with the Committee. My Office has reviewed the proposed substitute language and I am opposed to that proposal as well. While certain aspects of the proposed substitute bill are different, fundamentally it raises the same concerns as the prior version.

The substitute bill the proponents have shared with the Committee would permit medical doctors, upon receiving a "certificate of public advantage" from the Office of the Healthcare Advocate, to enter into "cooperative arrangements" for a variety of purposes, including the negotiation of "fees, prices or rates with managed care organizations." The bill explicitly exempts such arrangements from state antitrust laws. It also purports to create a state regulatory scheme aimed at providing such arrangements with a "safe harbor" from federal antitrust laws under the "state-action" doctrine.

In 2011, the Co-Chairs and Ranking Members of the Judiciary Committee contacted representatives of the Federal Trade Commission ("FTC") to inquire about the legality and likely competitive impact of a similar proposal. In response, the FTC warned that the proposal likely would not create immunity from federal antitrust laws. The FTC also expressed concerns that the proposed bill would be "likely to lead to dramatically increased costs and decreased access to health care for Connecticut consumers." A copy of the FTC's letter is attached to this testimony. For the reasons that follow, the FTC's letter should inform this Committee again this year.

First, under the judicially created "state action" doctrine, a state may override the national policy favoring competition only where it expressly decides to govern aspects of its economy by state regulation rather than market forces. A state may not simply authorize private parties to violate the federal antitrust laws. *See Parker v. Brown*, 317 U.S. 341, 351 (1943). Instead, it must actually substitute its own active control for the discipline that competition would otherwise provide. In order to meet the requisite elements of the state action doctrine, therefore, (1) the state legislature must clearly articulate a policy to displace competition with regulation,

and (2) state officials must actively supervise the private anticompetitive conduct. See *California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc.*, 445 U.S. 92 (1980).

The present proposal likely fails to meet either prong of the "state action" immunity doctrine. As to the first prong, the proposed substitute bill fails to articulate any clear public policy for displacing competition with regulation. It also lacks any articulated standards for the Healthcare Advocate to consider when deciding whether to grant, deny, revoke or modify a certificate. The Healthcare Advocate would need to have clear legislative guidance on what would constitute "interdependence and cooperation among physicians for the purpose of efficiently and/or effectively delivering medical care..." for example.

The proposal also lacks an adequate platform and set of criteria for continuing supervision and regulation of these cooperatives, as is required to meet the state action doctrine requirements set forth by the United States Supreme Court. Under that prong of the doctrine, state officials must have a meaningful opportunity to review the anticompetitive conduct of private parties and exercise discretion to disapprove those that do not meet the standards adopted. Here, the Healthcare Advocate appears bound by the terms of the original grant, and would be unable to ensure that the cooperative agreement continues to further state regulatory policies. The "biannual summary" and the ability to request information "regarding compliance" would not provide the Healthcare Advocate with the ability to exercise independent judgment and control. The agency with primary regulatory authority must have the authority to make sufficient inquiries to recognize and remedy undesirable consequences of anticompetitive activity

In addition, even if the proposal did provide the Healthcare Advocate with an adequate platform and set of criteria for granting certificates and actively supervising the cooperatives, I am not confident that her Office would have the resources necessary to perform that function. I criticized last year's bill, for instance, because it would have required my Office to conduct a detailed and complex review of the benefits of a particular healthcare cooperative arrangement within only 90 days of receiving an application. This year's proposed substitute bill would require the Healthcare Advocate to make a decision within 20 business days.

My Office has experience in complex antitrust investigations. A recently concluded investigation of the competitive impact of a proposed hospital merger in Connecticut took well over a year and included interviews of stakeholders, the study of hospital financial and planning documents and significant support from economists at the FTC. These are resource and time-intensive investigations. This bill would require a state agency with no antitrust expertise and insufficient time and resources to both: (a) conduct the prerequisite analysis necessary to identify and supervise the potential competitive and anticompetitive implications of a proposed cooperative; and (b) actively monitor and supervise the cooperatives. As you know, the Healthcare Advocate's mission is to assist consumers with health care issues through the establishment of effective outreach programs and the development of communications related to consumer rights and responsibilities as members of healthcare plans. Simply put, that office lacks the staff and expertise to conduct a complicated and ongoing antitrust analysis of the type contemplated by this bill.

Lastly, even if the legislature decided to provide the Healthcare Advocate with the resources necessary to perform the functions contemplated by the proposal, there would be significant and ongoing fiscal implications for the State above and beyond the potential costs associated with increased healthcare costs. In 2011, the Office of Fiscal Analysis ("OFA") considered the likely fiscal impact of a similar proposal. A copy of the 2011 OFA Fiscal Note for HB 6343 (2011) is attached to my testimony. At that time, the OFA concluded that the bill would result "in an estimated annual cost of \$663,108 for four attorneys, one paralegal and one health care analyst in the Attorney General's office (AG) to certify and oversee authorized cooperative health care arrangements. This cost "would continue into the future subject to inflation and any violations of the bill's provisions." Moving these responsibilities to the Healthcare Advocate, which lacks the antitrust expertise of my Office, does nothing to diminish the anticipated costs. Rather, it would likely increase those expenses far beyond the \$1,000.00 filing fee provided for under the proposed substitute bill.

For all of these reasons, I urge the Committee not to act favorably upon this proposal at this time. Thank you once again for the opportunity to testify about this proposal.