



**Connecticut State Medical Society and Connecticut Orthopaedic Society  
HB 5345 An Act Concerning Cooperative Health Care Arrangements  
The Labor and Public Employees Committee  
March 11, 2014**

Senator Holder-Winfield, Representative Tercyak and members of the Labor and Public Employees Committee, on behalf of the physicians and physician-in-training members of Connecticut State Medical Society (CSMS) and the Connecticut Orthopaedic Society (COS), thank you for the opportunity to present this testimony to you today in support of **House Bill 5345 An Act Concerning Cooperative Health Care Arrangements**. HB 5345 will begin to address and correct many issues we raise today that place undue burdens on physicians in Connecticut and impact access to health care.

Today, it is still true that the majority of Connecticut physicians practice in small, non-integrated offices with virtually no power to negotiate the terms of their provider agreements, especially with a health insurance market that is consolidated and highly concentrated. These physicians want to maintain their independence. However, the unequal bargaining power between them and health insurers places Connecticut at a substantial risk of losing its independently practicing physicians. This situation requires a state-based legislative solution as considered in HB 5345 in order to address this imbalance.

The intent of HB 5345 would permit balanced, informed and good-faith negotiations by physicians 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. However, they are becoming increasingly 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 physicians 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.

Through the Affordable Care Act (ACA), or "health care reform" as it is sometimes known, many provisions are designed to improve efficiencies in health care delivery by encouraging physicians and other providers to coordinate their care efforts and reduce or eliminate duplicative and fragmented care. That is the goal of this bill: to encourage health care practitioners to create integrated care arrangements with the potential to improve care and lower health care costs. The concept of the health care collaborative gives us a pathway for the creation of integrative arrangements reviewed and approved by the state.

### State Action Immunity

The lack of clarity in how the antitrust laws treat physician-led integration efforts has historically deterred the formation of integrated care arrangements for the benefit of consumers and improved access to health care. HB 5345 proposes to use a legal doctrine known as "State Action Immunity." State Action Immunity allows states to develop a clear regulatory approach under the concept of "state action."

Under such regulatory framework, physicians forming a health care collaborative could seek approval from the Healthcare Advocate (Advocate) to form a Health Care Collaborative. If approved by the Advocate under statutorily prescribed criteria and subsequently followed by active supervision that promotes the public welfare, the collaborative would be awarded a certificate of public advantage that would provide the health care collaborative "state action immunity." This would allow for the much needed yet currently prohibited communication under strict state oversight.

### Collaborative Formation

Under this bill, an entity comprised of health care practitioners may qualify as a health care collaborative in one of two ways. First, it may institute real risk sharing arrangements that place the health care practitioners at financial risk for inefficient health care delivery. Alternatively, it may implement a clinical integration program that creates a high degree of interdependence and cooperation among the health care practitioners, creating a mechanism that reduces or eliminates unnecessary care, more effectively manages chronic health conditions, and reduces the need for patients to use hospital emergency rooms.

HB 5345 would supply physicians with a set of incentives to form and operate a health care collaborative. A health care collaborative would be granted the ability negotiate fees and other terms covered in provider agreements with health plans, again under strict, active state supervision and subject to state approval to promote the public welfare. As a result, this conduct too will be exempt from antitrust liability under state action immunity. Both health plans and the collaborative would be required to negotiate in good faith. The process would be subject to mandatory mediation by a state designated mediator should negotiations reach an impasse. Thus, physicians investing in expensive health information technology and other collaborative infrastructure will know that if they build it, health insurers will at least come to the table and be less likely to "free ride" by taking advantage of efficiencies, such as reduced health care utilization, generated by the collaborative without investment in their development. It should be emphasized that this good-faith bargaining obligation is mutual -- it applies to both the health plan and the collaborative.

### Federal Trade Commission

The Federal Trade Commission (FTC) historically has opposed all legislation through which a state regulates competition and thus displaces the antitrust laws, including legislation directed at state action

immunity. We recognize and respect the FTC's opinion. However, we strongly believe that that this regulatory scheme developed falls squarely within state action immunity exception.

The FTC, when asked last year by Connecticut legislators for its view on whether legislation similar to the present language complied with the state action immunity doctrine, expressed no concerns as to whether the bill's regulatory program satisfied the state action immunity doctrine. Instead FTC's opposition was limited to health policy concerns over the bill's alleged adverse effect on consumers and the alleged absence of any need to encourage physician-driven collaborative arrangements. Attached to this testimony we offer language that addresses the FTC concerns by demonstrating the appropriate checks and balances are in place to ensure that the health care collaborative will have a positive impact on consumers and afford greater access to quality health care in the private sector. It contains numerous provisions for state supervision ensuring that any negotiated health plan agreement fosters reasonably priced, quality, physician services.

### Conclusion

The Connecticut marketplace needs more physician-driven health care collaboratives that can offer competitive alternatives to those formed by hospitals. Many hospitals are building ACOs through their acquisitions of physician practices. This practice is consolidating health care markets and raising significant competition problems, which will grow over time.

In order for independent physicians in Connecticut to continue to remain independent, the gap in the unequal bargaining power between physicians and health plans must be closed. This bill provides one method of closing that gap, at the same time increasing access to quality physician services. At the end of the day, many physicians lack the resources to hire sophisticated antitrust lawyers and health economists needed to obtain favorable agency advisory letters or counseling on antitrust compliance, or to defend enormously expensive antitrust challenges. Nor can physicians afford to incur the risk of antitrust liability that might result in treble damages, attorney fee awards and possible criminal sanctions-catastrophic outcomes for individual practitioners. HB 5345, coupled with our amended language attached, addresses these problems by providing a clear pathway for physicians to form health care collaboratives that are protected from antitrust liability. The result will benefit consumers by enhancing health care efficiency and by helping physicians remain independent.

Proposed Amended Language to HB 5345

Strike everything after the enacting clause and substitute the following in lieu thereof:

"Section 1. (NEW) (*Effective October 1, 2014*) As used in this section and sections 2 to 11, inclusive:

(1) "Health Care Collaborative" means an entity comprised of health care practitioners who practice in two or more separate firms or solo practices and (A) has entered or plans to enter into Provider Contracts with a Health Plan that incentivize quality over volume and that place Health Care Practitioners at risk for some or all of the costs of inefficient health care delivery, or (B) has arranged or shall arrange to implement an ongoing program to evaluate and modify Health Care Practitioner practice patterns and create interdependence and cooperation among Health Care Practitioners for the purpose of efficiently delivering health care;

(2) "Applicant" means a person or group of persons seeking recognition and approval by the Office of the Health Care Advocate as a Health Care Collaborative.

(3) "Health Care Practitioner" 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 naturopath licensed under chapter 373 of the general statutes, or (E) an optometrist licensed under chapter 380 of the general statutes;

(4) "Health Plan" means an entity that pays for health care services, including, but not limited to, commercial health insurance plans, self-insurance plans, health maintenance organizations, managed care organizations, as defined in section 38a-478 of the general statutes, or any insurer or corporation subject to the insurance laws of this state;

(5) "Certificate of Public Advantage" or "Certificate" means the written approval issued by the Office of the Healthcare Advocate of (a) a Health Care Collaborative pursuant to Section 4 of this Act; or (b) Provider Contracts between a Health Care Collaborative and a Health Plan pursuant to Section 5 of this Act.

(6) "Person" means an individual, association, corporation or any other legal entity; and

(7) "Health Care Collaborative Agreement" means an agreement or group of agreements concerning the formation and operation of a Health Care Collaborative.

(8) "Provider Contract" means an agreement between a Health Care Collaborative and a Health Plan under which the Health Care Collaborative's practitioners provide services to the Health Plan.

Sec. 2. (NEW) (*Effective October 1, 2014*) (a) A Health Care Collaborative may negotiate, enter into, and conduct business pursuant to a Health Care Collaborative Agreement exempt from the antitrust laws, provided that the Health Care Collaborative is covered by a Certificate of Public Advantage, as provided by sections 1 to 11, inclusive, of this Act.

(b) Nothing in sections 1 to 11, inclusive, of this Act shall be deemed to limit the right of persons to negotiate, enter into, and conduct business pursuant to, a Health Care Collaborative Agreement without complying with the requirements of sections 1 to 11, inclusive, of this Act.

(c) Nothing in sections 1 to 11, inclusive, of this Act shall be deemed to affect or limit a Health Care Practitioner from exercising his or her rights under the National Labor Relations Act, 49 Stat. 449 (1935), 29 USC 151 et seq., or any other applicable provisions of federal or state law.

Sec. 3. (NEW) (*Effective October 1, 2014*) (a) Any persons seeking to enter into a Health Care Collaborative Agreement for the purposes of this Act, if that person wants the Health Care Collaborative exempt from the antitrust laws, shall:

(1) Apply for a Certificate of Public Advantage from the Office of the Healthcare Advocate. Such application shall be in a form prescribed by the Healthcare Advocate and shall identify: (A) the name of the Health Care Collaborative; (B) the names of the Health Care Practitioners associated with the Health Care Collaborative; (C) an executed or unexecuted copy of any proposed Health Care Collaborative Agreement; (D) the manner in which the Health Care Collaborative's proposed method of health plan payment incentivizes quality over volume and places Health Care Practitioners at risk for some or all of any inefficient health care delivery, or how the Health Care Collaborative's arrangements implement an active and ongoing program to evaluate and modify Health Care Practitioner practice patterns and create interdependence and cooperation among Health Care Practitioners for the purpose of efficiently delivering care; and (E) any other information the Healthcare Advocate considers reasonably necessary for the proper review of the application.

Sec. 4. (NEW) (*Effective October 1, 2014*) (a) The Healthcare Advocate shall find that an applicant is a Health Care Collaborative if it: (1) has placed or plans to place its associated Health Care Practitioners at risk for some or all of any inefficient health care delivery through methods, including, but not limited to, pay-for-performance, capitation, shared savings and costs, bundled payment arrangements or other financial incentives or risk assumption mechanisms based in whole or in part on per episode, per population or per procedure costs, outcomes, patient satisfaction, education or welfare activities; or (2) implements an active and ongoing program to modify practice patterns by the Health Care Collaborative's Health Care Practitioners and creates a high degree of interdependence and cooperation among the Health Care Practitioners to insure quality, including: (A) administering mechanisms to monitor and control utilization of health care services that are designed to control costs and assure quality of care; (B) selecting network Health Care Practitioners who are likely to further these efficiency objectives; and (C) investing capital, both monetary and human, in the necessary infrastructure and capability to realize the claimed efficiencies. The Healthcare Advocate may conduct a hearing, after giving notice to all interested parties.

(b) The Healthcare Advocate shall determine whether the Health Care Collaborative shall be entitled to antitrust immunity in accordance with the following process:

(1) Not later than sixty days after submission of the prospective or actual Health Care Collaborative Agreement, the Healthcare Advocate shall decide whether to issue a Certificate of Public Advantage to the Health Care Collaborative. The Healthcare Advocate shall provide such written decision after issuing public notice and providing a thirty-day opportunity for public comment regarding its decision to issue or refuse to issue a Certificate. The Healthcare Advocate's written decision shall address the Health Care Collaborative's expected effects on the efficiency and access to health care services, including the quality and price of healthcare practitioners services. The Health Care Advocate can add an additional thirty-day period to the review process if it chooses to conduct a hearing pursuant to Section 4(a) of this Act.

(2) A Health Care Collaborative shall be exempt from the antitrust laws if, following the evaluation period set forth in Section 4(b)(1), above, the Healthcare Advocate approves the Health Care Collaborative and issues a Certificate of Public Advantage on the basis that the Health Care Collaborative fosters reasonably priced, reasonably accessible, quality practitioner services.

(c) The participating physicians may execute a proposed Health Care Cooperative Agreement after a Certificate is granted without any further review by the Healthcare Advocate except as provided in Section 5 below. The Healthcare Advocate may collect whatever information it reasonably deems necessary to evaluate the impact of the proposed agreement on the health care marketplace.

(d) If the Healthcare Advocate declines to find that the applicant is a Health Care Collaborative or is not in the public interest, then the Healthcare Advocate shall furnish a written explanation of any deficiencies, along with a statement of specific proposals for remedial measures to cure such deficiencies.

(e) The Healthcare Advocate shall adopt rules and regulations, pursuant to chapter 54 of the general statutes, establishing application and review procedures, methods for determining whether to issue a Certificate of Public Advantage and any other procedures or standards necessary for the administration of sections 1 to 11, inclusive, of this Act.

Sec. 5. (NEW) (Effective October 1, 2014) (a) Any Health Care Collaborative granted a Certificate of Public Advantage and seeking to negotiate Provider Contracts with Health Plans, exempt from the antitrust laws, shall notify the Healthcare Advocate and shall supply the name of the Health Plan not later than fourteen days before offering to negotiate with the named Health Plan. Both parties to the negotiation shall further notify the Healthcare Advocate of the occurrence of any of the following events not later than 14 days after the occurrence of such event: (1) the failure of either party to respond to a negotiation request; (2) the commencement of negotiations; (2) the conclusion of negotiations; (5) the cancellation of negotiations (3) an impasse in the negotiations; or (4) the refusal of either party to negotiate in good faith with respect to fees or other terms and conditions of services.

(b) A Health Care Collaborative and Health Plan shall negotiate in good faith. Whenever, in the

judgment of the Healthcare Advocate, a Health Care Collaborative or Health Plan has refused to negotiate in good faith in violation of this subsection, or any regulation adopted or order issued pursuant to this section, at the request of the Healthcare Advocate, the Attorney General may bring an action in the superior court for the judicial district of New Britain for an order directing compliance with this subsection.

(c) If at the request of either the Health Plan or the Health Care Collaborative the Healthcare Advocate determines that an impasse exists in the negotiations for any reason, the Healthcare Advocate shall:

(1) Designate a mediator to assist the parties in commencing or continuing such negotiations and in reaching a settlement of the issues presented in such negotiations. The mediator designated shall be experienced in health care mediation and shall be drawn from a list of such mediators maintained by the Healthcare Advocate, the American Arbitration Association or the Federal Mediation and Conciliation Service. The mediator so designated may only serve if approved by both parties. If the mediator is successful in resolving the impasse, the Health Care Collaborative shall proceed as set forth in subsections (d) and (e), below, of this Act; and

(2) If, after a reasonable period of mediation, the parties are unable to reach an agreement, the mediator shall declare an impasse and the negotiations shall terminate.

(d) In determining whether the fees and other terms contained in a proposed Provider Contract are reasonable, the Healthcare Advocate shall consider whether the terms and fees: (A) are consistent with fees in similar practitioner communities; (B) ensure reasonable access to practitioner care; (C) improve the Health Care Collaborative's ability to render services efficiently; (D) provide for the financial stability of the Health Care Collaborative and Health Plan; and (E) encourage innovative approaches to medical care that may improve patient outcomes and lower health care costs.

(e) A Provider Contract and associated fee schedule shall be deemed reasonable and exempt from the antitrust laws if the Healthcare Advocate approves the Provider Contract and issues a Certificate of Public Advantage. No notice or comment period is required. The Healthcare Advocate shall issue or refuse to issue a Certificate for the proposed Provider Contract within sixty-days of its submission for review. The Healthcare Advocate shall provide a written decision following the sixty-day review period regarding its decision to issue or refuse to issue a Certificate.

Sec. 6. (NEW) (*Effective October 1, 2014*) (a) The Healthcare Advocate shall actively monitor a Health Care Collaborative approved under sections 1 to 11, inclusive, of this Act to ensure that a Health Care Collaborative's performance under the Health Care Collaborative Agreement remains in compliance with the conditions of approval.

(b) Any material modification of a Health Care Collaborative Agreement or Provider Contract which is the subject of a Certificate of Public Advantage issued pursuant to this Act shall be subject to the prior review and approval by the Healthcare Advocate according to the process set forth by Section 4 and Section 5, as applicable.

(c) Any party to a Health Care Collaborative covered by a Certificate of Public Advantage that intends to terminate or dissolve or liquidate the Health Care Collaborative shall file a notice of termination with the Healthcare Advocate at least 60 days prior to termination.

(d) Upon request and at least annually, each Health Care Collaborative operating under a Certificate of Public Advantage shall submit to the Healthcare Advocate a written report, in the form and manner prescribed by the Healthcare Advocate, concerning the factors set forth in Section 4(a) of this Act. The Healthcare Advocate may revoke a Certificate of Public Advantage upon a finding that the Health Care Collaborative is not materially complying with the performance goals identified in Section 4(a) of this Act.

Sec. 7. (NEW) (Effective October 1, 2014) Any person aggrieved by a final decision of the Healthcare Advocate under sections 1 to 11, inclusive, of this Act may appeal the decision to the Superior Court in accordance with section 4-183 of the general statutes.

Sec. 8. (NEW) (Effective October 1, 2014) Any applications, reports, records, documents or other information obtained by the Healthcare Advocate pursuant to sections 1 to 11, inclusive, of this Act shall not be subject to disclosure under the Freedom of Information Act, as defined in section 1-200 of the general statutes.

Sec. 9. (NEW) (Effective October 1, 2014) (a) The Healthcare Advocate shall charge each prospective Health Care Collaborative an administrative fee of one thousand dollars for each Certificate requested.

Sec. 10. (NEW) (Effective October 1, 2014) On or before October 1, 2014, and annually thereafter, the Healthcare Advocate shall submit, in accordance with the provisions of section 11-4a of the general statutes, to the Governor and the joint standing committee of the General Assembly having cognizance of matters relating to labor and public employees an annual report on the operations and activities of the Healthcare Advocate pursuant to sections 1 to 11, inclusive, of this Act.

Sec. 11. (NEW) (Effective October 1, 2014) If any provision of this section and sections 1 to 10, inclusive, of this Act, or its application to any person or circumstance, is held invalid by a court of competent jurisdiction, the invalidity shall not affect any other provisions or applications of this section and sections 1 to 10, inclusive, of this Act, that can be given effect without the invalid provision or application, and to this end such provisions are severable. The provisions of this section and sections 1 to 10, inclusive, of this Act shall be liberally construed to effect the purposes thereof.