

Legislative History for Connecticut Act

HB 5404	PA 163	1998
House	927, 1406, 2914-2915, 2927-2938, 3378-3380	(19)
Senate	2556-2557, 2716, 2724-2726, 2797-2799	(9)
Public Health	1444-1448, 1474-1482, 1498, 1591, 1592-1593, 1618-1623, 1829, 1831-1833, 1850-1875 1500-1501	(54)
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CONNECTICUT
GEN. ASSEMBLY
HOUSE

PROCEEDINGS
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House of Representatives Wednesday, April 8, 1998

REP. STILLMAN: (38TH)

Thank you, Mr. Speaker. I move that that be referred to the Finance, Revenue and Bonding Committee.

SPEAKER RITTER:

So ordered.

Clerk, please call Calendar 255.

CLERK:

On page 16, Calendar 255, Substitute for House Bill Number 5404, AN ACT CONCERNING PROVIDER SPONSORED ORGANIZATIONS. Favorable Report of the Committee on Public Health.

SPEAKER RITTER:

Representative Stillman.

REP. STILLMAN: (38TH)

Thank you, Mr. Speaker. I move that that be referred to the Insurance Committee.

SPEAKER RITTER:

So ordered.

Clerk, please call Calendar 257.

CLERK:

On page 16, Calendar 257, Substitute for House Bill Number 5437, AN ACT CONCERNING THE APPLICATION AND DECISION CRITERIA OF THE CONNECTICUT SITING COUNCIL. Favorable Report of the Committee on Government Administration and Elections.

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House of Representatives

April 17, 1998

Committee on Appropriations H.B. No. 5054, Committee on
Judiciary H.B. No. 5724, Committee on Planning and
Development H.B. No. 5535, Committee on Judiciary H.B.
No. 5709, Committee on Appropriations H.B. No. 5404,
Committee on Appropriations H.B. No. 5437, Committee on
Government Administration and Elections H.B. No. 5332,
Committee on Planning and Development H.B. No. 5679,
Committee on Public Safety H.B. No. 5635, Committee on
Planning and Development H.B. No. 5747, Committee on
Government Administration and Elections H.B. No. 5614,
Committee on Judiciary H.B. No. 5597, Committee on
Government Administration and Elections H.B. No. 5593,
Committee on Planning and Development H.B. No. 5551.

SPEAKER GERAGOSIAN:

Hearing no objection, so ordered.

THE CLERK:

Mr. Speaker, there's no further business on the Clerk's desk.

SPEAKER GERAGOSIAN:

Representative Fleischmann of the 18th District.

REPRESENTATIVE FLEISCHMANN: (18th)

Mr. Speaker, there being no further business on the Clerk's desk, I move that we adjourn subject to the Call of the Chair.

SPEAKER GERAGOSIAN:

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SPEAKER RITTER:

Seeing no objection, so ordered.

Clerk, please call Calendar 255.

THE CLERK:

On page 27, Calendar 255, Substitute for HB5404,
An Act Concerning Provider Sponsored Organizations.
Favorable report of the Committee on Appropriations.

SPEAKER RITTER:

The Honorable Chair of the Public Health
Committee, Representative McDonald.

REPRESENTATIVE McDONALD: (148th)

Good afternoon, Mr. Speaker.

SPEAKER RITTER:

Good afternoon, Madam.

REPRESENTATIVE McDONALD: (148th)

Mr. Speaker, I move acceptance of Joint
Committee's favorable report and passage of the bill.

SPEAKER RITTER:

Motion on acceptance and passage. Please proceed.

REPRESENTATIVE McDONALD: (148th)

This is a strike everything amendment. The Clerk
has LC05501. Will he please call and I be allowed to
summarize?

SPEAKER RITTER:

Motion on acceptance -- LC05501, if he can call

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then Representative McDonald would like to summarize.

THE CLERK:

LC05501, House A offered by Representative
McDonald.

SPEAKER RITTER:

Representative McDonald.

REPRESENTATIVE McDONALD: (148th)

Yes, Mr. Speaker. This amendment is a two-part amendment. The first section --

SPEAKER RITTER:

Hold on, hold on. We don't have that amendment either.

Sorry. We'll stand at ease and figure out our
next --

CHAMBER AT EASE

DEPUTY SPEAKER PUDLIN:

Clerk, please call Calendar 433.

THE CLERK:

On page 32, Calendar 433, Substitute for SB490, An
Act Concerning Eligibility for the Pretrial Accelerated
Rehabilitation Program and the Suspension of the
Operator's License of Persons Involved in Fatal
Accidents, as amended by House Amendment Schedule A.
Favorable report of the Committee on Judiciary.

House A was rejected by the Senate on April 29th.

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Mr. Clerk, forgive my quickness on the trigger.

Bill passes.

Clerk, please call Calendar 255.

THE CLERK:

On page 27, Calendar 255, Substitute for HB5404,
An Act Concerning Provider Sponsored Organizations.
Favorable report of the Committee on Appropriations.
House A has been designated.

DEPUTY SPEAKER PUDLIN:

Representative McDonald.

REPRESENTATIVE McDONALD: (148th)

Good afternoon, Mr. Speaker.

May I ask a question? What does he mean the LCO
number has already been called and we were just waiting
for the copy? When he says it's been designated, I
didn't understand that.

Well, just a minute. We already did that.

DEPUTY SPEAKER PUDLIN:

It meant that it already -- House A had already
been called. It's already been presented to us before
the bill --

REPRESENTATIVE McDONALD: (148th)

Yes.

DEPUTY SPEAKER PUDLIN:

-- went away.

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REPRESENTATIVE McDONALD: (148th)

All right. Thank you, Mr. Speaker.

House A is essentially divided into two parts. Section one and Section two includes an item that we've discussed before here on the floor and what it essentially says is that insurers may not charge patients or clients -- I'm sorry, excuse me.

Providers may not send bills to patients or clients when those bills are more properly kept -- excuse me -- when those bills are covered by insurance companies.

I move passage of the bill, excuse me.

DEPUTY SPEAKER PUDLIN:

On acceptance and passage. Proceed, Madam.

REPRESENTATIVE McDONALD: (148th)

Yes. And we have discussed this before. I have said -- mentioned in the other discussion that sometimes providers, doctors and other providers are not what they -- getting timely payments for their bills. So what they do is send those bills to patients and they testified in front of my committee that they did this, hoping the patient would call the insurance company and get them to pay the bill quicker.

But that's not what's happening. When a patient gets a bill and keeps getting dunning notices for the

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bill, they get very nervous and sometimes pay the bill, which they shouldn't pay in the first place.

This section one and two would prevent providers from doing that.

Section three of the bill brings up a concept that has been discussed widely. Many insurers and health care centers, that's HMO's, are -- have in the last year or two not been paying their providers in a timely fashion.

We already have a statute on our book and it goes back to the time where we had fee for service, mostly fee for service policies. And what that statute said is that insurers had to pay the patient within 45 days or incur five percent interest.

That doesn't apply any more, because insurers don't pay patients any more; they pay directly to the provider.

So what this does is really extend present law to bring it up to date and say that they must pay providers in concurrence with their contracts in 45 days or they will incur a fifteen percent interest charge.

Again, I move adoption.

DEPUTY SPEAKER PUDLIN:

Move adoption of A, on adoption of A, proceed

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Madam.

REPRESENTATIVE McDONALD: (148th)

I think I've explained the two sections adequately. I will be receptive to questions.

DEPUTY SPEAKER PUDLIN:

On the adoption of A, Representative Veltri.

REPRESENTATIVE VELTRI: (9th)

Thank you, Mr. Chairman.

Question to the proponent of the amendment.

DEPUTY SPEAKER PUDLIN:

Please frame your question.

REPRESENTATIVE VELTRI: (9th)

On the date you picked, is there any logic for picking the exact same number of days or was it just something that the physicians felt they needed?

REPRESENTATIVE McDONALD: (148th)

Through you --

DEPUTY SPEAKER PUDLIN:

Representative --

REPRESENTATIVE McDONALD: (148th)

Through you, Mr. Speaker.

The days we picked were picked because in the present law, those dates, 45 days and fifteen percent interest are presently state statute that go back to the time when insurers paid the patient and then the

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patient would pay the doctor.

That doesn't happen any more. So that's where that came from, from the present statutes. We're bringing it up to date now because insurers now pay the provider direct and do not go through the patient.

Through you, Mr. Speaker.

DEPUTY SPEAKER PUDLIN:

Representative Veltri.

REPRESENTATIVE VELTRI: (9th)

Thank you. And through you, Mr. Speaker, did the origin of the bill arrive from what we've read about in the paper, companies like Oxford not being able to pay their rates for a considerable period of time?

DEPUTY SPEAKER PUDLIN:

Representative McDonald.

REPRESENTATIVE McDONALD: (148th)

Through you, Mr. Speaker, they may have had a part of it. But recently many of the Fairfield County legislators attended a dinner in lower Fairfield County where many doctors were there and they were complaining loudly that they had done a survey in lower Fairfield County and they weren't getting paid for six or eight months for their bills.

And essentially what they accused the insurance company doing of holding their money and getting

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interest on it.

At the time they did their survey, they estimated that doctors were \$60 million in arrears of getting their -- their both -- both pay from the insurers and it was causing a lot of hardship on some sole practitioner physicians where you had to go out and take loans in order to pay their office expenses.

Through you, Mr. Speaker.

DEPUTY SPEAKER PUDLIN:

Representative Veltri.

REPRESENTATIVE VELTRI: (9th)

Through you, Mr. Speaker, thank you.

I can understand how it would be difficult to run an office without getting payment in. But what worries me a little bit is about your 45 days.

REPRESENTATIVE McDONALD: (148th)

I can't hear --

REPRESENTATIVE VELTRI: (9th)

What worries me a little bit is about the ability to establish 45 days.

In my dealings with insurance companies, if I mail a claim in on the second of a month and then I call to find out where it is, they will say, well, we checked our records and our records show it didn't get to us to the right desk until the 23rd of the month. And then

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they work their payments off that 23rd day.

And then even when you call them later, they'll say, oh, yes, we processed that, it's in billing and it should get to you soon. And you could go much beyond any 45 day increment by these dates going on and on within the insurance company.

How do you expect to clarify that with this bill?

DEPUTY SPEAKER PUDLIN:

Representative McDonald?

REPRESENTATIVE McDONALD: (148th)

Through you, Mr. Speaker.

DEPUTY SPEAKER PUDLIN:

Thank you.

REPRESENTATIVE McDONALD: (148th)

Very seldom nowadays does a patient ever send bills to an insurance company. It's all taken care of between the insurance company and the provider.

The providers contract with the insurance company lays out the reasons for saying 45 days. Now sometimes the insurer will say the provider didn't fill out the form correctly, didn't do this, that and the other thing.

There are provisions within the contract that it has to be a completed form. And the 45 days, as I say, came from existing law.

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Through you, Mr. Speaker.

DEPUTY SPEAKER PUDLIN:

Representative Veltri?

REPRESENTATIVE VELTRI: (9th)

Thank you, Mr. Chairman.

I understand what you're saying when you talk about the insurance companies being billed directly and referring directly to the doctor.

But there are many cases where people are fortunate enough to have two insurances. And there's always a prime and a secondary.

The time limits I'm talking about are going from the prime to the secondary. If the prime insurance, if a bill, let me give you an example, is \$85 procedure, the prime insurance will pay \$42, then you have to go to the secondary coverage for the last 38.

Those are the dates that can go on and on as long as six months. And I'm not sure your 45 days covers situations like that.

DEPUTY SPEAKER PUDLIN:

Was that a question, sir?

REPRESENTATIVE VELTRI: (9th)

Yes, I'm sorry. Does your 45 days cover the secondary payments between --

DEPUTY SPEAKER PUDLIN:

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Representative McDonald?

REPRESENTATIVE McDONALD: (148th)

This bill, through you, Mr. Speaker, doesn't address that.

What we're really saying is they should fulfil the provisions of the contract with the providers. Now whether the insurer, when they get the bill, stamps the date received on there, I presume that would be counting the 45 days from that date.

Through you, Mr. Speaker.

DEPUTY SPEAKER PUDLIN:

Representative Veltri.

REPRESENTATIVE VELTRI: (9th)

Thank you. But, through you, Mr. Speaker, are you aware of any of the neighboring states that have put this in, has it worked for the positions in Massachusetts or New York or any of our neighboring states to put in an exact time date above which the HMO's would have to pay a strict penalty?

DEPUTY SPEAKER PUDLIN:

Representative McDonald?

REPRESENTATIVE McDONALD: (148th)

Through you, Mr. Speaker, they did this in New York State.

DEPUTY SPEAKER PUDLIN:

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Representative Veltri.

REPRESENTATIVE VELTRI: (9th)

Thank you. And do we find it as worthwhile for them, are they able to get the results that you hoped out of the bill?

DEPUTY SPEAKER PUDLIN:

Representative McDonald?

REPRESENTATIVE McDONALD: (148th)

Through you, Mr. Speaker, I have not researched that.

DEPUTY SPEAKER PUDLIN:

Representative Veltri.

REPRESENTATIVE VELTRI: (9th)

Do we have the full backing of both the AMA on this bill or is it just one group of physicians that are having problems like GP's or internists?

DEPUTY SPEAKER PUDLIN:

Representative McDonald?

REPRESENTATIVE McDONALD: (148th)

Mr. Speaker, I couldn't hear the first part of the Representative's question.

DEPUTY SPEAKER PUDLIN:

Well, hold on one second.

Staff and guests please come to the well of the House. The Chamber please quiet down some.

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I think that's better. Representative Veltri, please reframe your question.

REPRESENTATIVE VELTRI: (9th)

Okay. I'm sorry. The question was, I think the bill is long overdue. Is the impetus of the bill just the specialist, the high-priced surgeons? Or is this coming right from the GP's and the internists?

DEPUTY SPEAKER PUDLIN:

Representative McDonald.

REPRESENTATIVE McDONALD: (148th)

Through you, Mr. Speaker, this has support from the Connecticut Medical Association who represents all the specialties of all the physicians in the state. It is not a special interest legislation for any one group of providers.

Through you, Mr. Speaker.

DEPUTY SPEAKER PUDLIN:

Representative Veltri.

REPRESENTATIVE VELTRI: (9th)

Through you, Mr. Speaker, thank you very much. And I think the bill is overdue, the amendment. Thank you.

DEPUTY SPEAKER PUDLIN:

Thank you, sir. Representative Bernhard.

REPRESENTATIVE BERNHARD: (136th)

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Thank you, Mr. Speaker.

I rise in support of this amendment. I applaud leadership for bringing it out. It sets the same standards for payment to doctors, as it does to individual claimants. It's a good idea, it's fair and I urge my colleagues to vote for it.

Thank you, Mr. Speaker.

DEPUTY SPEAKER PUDLIN:

Thank you, sir.

Will you remark further on A? If not, let me try your minds. All those in favor, signify by saying "aye".

ASSEMBLY:

Aye

DEPUTY SPEAKER PUDLIN:

Opposed, nay. Ayes have it, the amendment is adopted.

Representative Godfrey.

REPRESENTATIVE GODFREY: (110th)

Mr. Speaker, I move that this item be passed temporarily.

DEPUTY SPEAKER PUDLIN:

Without objection, so ordered. We almost made it through one.

Calendar 283, Mr. Clerk.

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House of Representatives

Friday, May 1, 1998

Resolution is adopted.

Representative Godfrey.

REPRESENTATIVE GODFREY: (110th)

Thank you, Mr. Speaker.

Mr. Speaker, I move for the suspension of our rules for the immediate transmission to the Senate of all of the Judicial and Workers' Compensation Commissioner that we have acted upon this morning.

SPEAKER RITTER:

This afternoon. Today. Seeing no objection, our rules are hereby suspended and all the items which are one Workers' Comp Commissioner and the Judicial nominations will be sent immediately up to the Senate.

Clerk, please call Calendar 255.

THE CLERK:

On page 30, Calendar 255, Substitute for HB5404,
An Act Concerning Provider Sponsored Organizations.
Favorable report on the Committee on Appropriations,
amended by House Schedule A on April 30.

SPEAKER RITTER:

That wild dancer from the 148th, Representative McDonald, you have the floor.

REPRESENTATIVE McDONALD: (148th)

Good afternoon, Mr. Speaker.

Mr. Speaker, I move acceptance of the Joint

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House of Representatives

Friday, May 1, 1998

Committee's favorable report and adoption of the bill.

SPEAKER RITTER:

Motion on acceptance and passage. Please proceed, Madam.

REPRESENTATIVE McDONALD: (148th)

Mr. Speaker, the other day, this was a strike anything amendment and HB5404. We adopted amended A, which in effect, gave providers the opportunity to insure that they get paid by insurance companies within 45 days or they would incur a 15 percent penalty.

The other thing that it did was tell insurance companies that they couldn't charge patients for procedures that were covered by insurance. They had been doing that, some of them, very few, sending bills to patients in hopes that the patients would call the insurance company to have them pay.

This frightened many patients because they thought that they owed the bill. This will prevent insurance companies to do that.

This amendment was already adopted, Mr. Speaker. And all we were left to do was to adopt the bill as amended from -- this bill was pt'd.

So if anybody wants any questions, I'd be happy to ask them. Otherwise, all we have to do is vote.

Thank you, Mr. Speaker.

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SPEAKER RITTER:

Will you remark further?

If not, staff and guests to the well of the House, the machine will be open.

THE CLERK:

The House of Representatives is voting by roll call, members to the Chamber. The House of the Representatives is voting by roll call, members to the Chamber, please.

SPEAKER RITTER:

If all members voted, please check your roll call machine, make sure your vote is properly cast. If it has, the machine will be locked. Clerk, please take the tally. Clerk, please announce the tally.

THE CLERK:

HB5404 as amended by House A. Total number voting 144, necessary for passage 73. Yea, 144, nay 0, absent not voting 7.

SPEAKER RITTER:

Bill passes.

Clerk, please call Calendar 398.

THE CLERK:

On page 34, Calendar No. 398, Substitute for HB5382, An Act Concerning Financial Matters Relating to Institutions of Higher Education. Favorable report of

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Senate

Monday, May 4, 1998

At this time I would ask that one of the PT'd items, Page 10, Calendar 457, bill HB5404. I would move this item to the Committee on Judiciary.

THE CHAIR:

Motion is to refer this item to the Committee on Judiciary. Without objection -- Senator Gunther.

Senator Gunther, please.

SEN. GUNTHER:

Madam Chairman, I oppose the referral of this to the Judiciary. I think it's been floating around here long enough. We've had about four or five changes here. I think it's about time we stood up and got counted on this particular issue.

This issue relate to the payment of the providers and the practice of them taking and stalling sometimes as long as months. And this would establish a policy for the state of 45 days. And I can see, and I don't think it should go to Judiciary. I see no reason for this. So I would oppose it, and ask for a roll call vote.

THE CHAIR:

The motion before us is for a referral to the Committee on Judiciary. And we've been, a request for a roll call vote has been ordered. Do you care to remark?

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Senate

Monday, May 4, 1998

SEN. GUNTHER:

Madam Chairman?

THE CHAIR:

Senator Gunther.

SEN. GUNTHER:

Madam President, I withdraw my objection.

Withdraw the roll call.

THE CHAIR:

Motion to have a roll call has been withdrawn.

But the motion before us is for a reference to

Judiciary. I will try your minds. All those in favor

indicate by saying aye.

SENATORS:

Aye.

THE CHAIR:

Opposed, nay? Aye's have it. The item is

referred to the Committee on Judiciary.

SEN. JEPSEN:

Madam President, at this time I would ask that the next Calendar item be called, which I believe is Page 13, Calendar 478, be PT'd at this time. We're waiting an Amendment.

THE CLERK:

Calendar Page 15. Calendar No. 165, File No. 176,
Substitute for SB503, AN ACT CONCERNING UNINSURED

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Senate

May 5, 1998

The Chamber will stand in recess subject to the Call of the Chair.

Upon motion of Senator Jepsen of the 27th, the Senate at 7:21 p.m. recessed.

The Senate reconvened at 10:05 p.m., the President in the Chair.

THE CHAIR:

The Senate please come to order. At this time the Chair will entertain points of personal privilege or announcements. Senator Jepsen.

SEN. JEPSEN:

Thank you, Madam President. We do have a new Go list. I'd like to start by taking from Senate Agenda No. 1. I'd ask we suspend the rules to take up Substitute for HB5404.

THE CHAIR:

Without objection, so ordered.

SEN. JEPSEN:

And from Senate Agenda No. 2 I would move we suspend to take up Substitute HB5421.

THE CHAIR:

Motion is for suspension. Without objection, so

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SEN. JEPSEN:

It should be marked Go.

The Clerk could call the Calendar.

THE CLERK:

Calling from Senate Agenda No. 1, Substitute for
HB5404 An Act Concerning Provider Sponsored
Organizations. The Senate referred the Appropriations
bill to Judiciary on May 4, as amended by House
Amendment Schedule "A". Favorable Report of the
Committee on Judiciary.

THE CHAIR:

Senator Harp.

SEN. HARP:

Thank you, Madam President. I move acceptance of
the Joint Committee's Favorable Report and passage of
the bill in concurrence with the House.

THE CHAIR:

The question is on passage in concurrence with the
House. Will you remark?

SEN. HARP:

Thank you, Madam President. This bill makes it an
unfair trade practice for any health care provider to
request payment for a managed care plan enrollee for
covered medical services except for a copayment or
deductible, or to report to a credit reporting agency

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and enrollee's failure to pay a bill for medical services when a managed care organization has primary responsibility for paying for the services.

Under the bill requesting payment means submitting a bill for services and not actual, and services not actually owed or submitting an invoice or other communication detailing those service costs without clearly marking it, this is not a bill.

Copayment or deductible means a portion of a charge for services covered by a managed care plan, excuse me. That the enroll is obliged to pay under the plan's terms.

The bill also requires insurers to pay health care provider's claims for payment or reimbursement within 45 days of the provider's claim for payment or filed according to the insurer's practices, the procedures, or as otherwise stipulated by contract.

This is an important bill and I urge its passage.

THE CHAIR:

The question is on passage. Will you remark?

Senator Prague.

SEN. PRAGUE:

Thank you, Madam President. Madam President, I would just like to wholeheartedly support this bill. I have had several calls from providers saying how they

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were waiting and waiting and waiting and waiting and waiting for payment. It has become a terrible problem and I'm very happy to see this piece of legislation before us.

THE CHAIR:

Will you remark further? Senator Freedman.

SEN. FREEDMAN:

Yes, thank you, Madam President. I, too, rise in support of this bill. I think we've probably heard from many of the providers about this and hopefully this will resolve a problem and by resolving that problem will assure better care for a lot of patients in this state. Thank you, Madam President.

THE CHAIR:

Thank you. Will you remark further? Senator Harp.

SEN. HARP:

Thank you, Madam President. I believe that this bill takes a lot of the confusion out of managed care and its billing practices and if there is no further discussion, I move this matter to the Consent Calendar.

THE CHAIR:

Motion is to refer this item to the Consent Calendar. Without objection, so ordered.

THE CLERK:

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Chamber.

An immediate roll call has been ordered in the
Senate. Will all Senators please return to the
Chamber.

THE CHAIR:

Have all members voted? If all members have
voted, the machine will be locked. The Clerk please
take a tally.

THE CLERK:

Motion is on HB5095 as amended.

Total number voting, 34; necessary for passage,
18; those voting "yea", 33; those voting "nay", 1.
Those absent and not voting, 2.

THE CHAIR:

The bill is passed.

At this time, Mr. Clerk, would you announce a roll
call vote on the Consent Calendar and call the Consent
Calendar, please.

THE CLERK:

An immediate roll call has been ordered in the
Senate on the Consent Calendar. Will all Senators
please return to the Chamber.

An immediate roll call has been ordered in the
Senate on the Consent Calendar. Will all Senators
please return to the Chamber.

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Madam President, calling the Consent Calendar, I intend to call those items placed on the Consent Calendar from Agendas 1, 2, 3, and 4 first, and then we'll proceed to the Calendar.

From Senate Agenda No. 1, Substitute for HB5404.

Senate Agenda No. 2, Substitute for HB5444.

Senate Agenda No. 3, Substitute for HB5500.

Substitute for HB5667.

Senate Agenda No. 4, Substitute for HB5034.

From the Calendar, Calendar Page 1, Calendar 333,

Substitute for SB533.

Calendar Page 2, Calendar 339, Substitute for

SB486.

Calendar Page 3, Calendar 423, Substitute for

HB5082.

Calendar Page 6, Calendar 480, Substitute for

HB5597.

Calendar 484, Substitute for HB5073.

Calendar Page 7, Calendar 197, Substitute for

SB571.

Calendar Page 10, Calendar 118, Substitute for

SB498, Committee on Conference Report.

Calendar Page 11, Calendar 280, Substitute for

SB520.

Calendar Page 13, Calendar 107, SB375.

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Calendar Page 14, Calendar 108, SB484.

Madam President, that completes the Second Consent Calendar.

THE CHAIR:

Thank you, Sir. Would you announce a roll call vote once again. The machine will be opened.

THE CLERK:

An immediate roll call has been ordered in the Senate on the Consent Calendar. Will all Senators please return to the Chamber.

An immediate roll call has been ordered in the Senate on the Consent Calendar. Will all Senators please return to the Chamber.

THE CHAIR:

Have all members voted? If all members have voted, the machine will be locked. The Clerk please take a tally.

THE CLERK:

Motion is on adoption of Consent Calendar No. 2.

Total number voting, 35; necessary for adoption, 18; those voting "yea", 35; those voting "nay", 0. Those absent and not voting, 1.

THE CHAIR:

The Consent Calendar is adopted.

Senator Jepsen. Good news?

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that currently for the Medicare program, the federal rules would still apply and if some legislation was passed that just broadened that to the commercial market there could be some problems for consumers down the line if there were less restrictive solvency requirements.

SEN. HARP: Thank you. Are there further questions? If not, thank you very much for your testimony. Our next speaker is Commissioner Raymond J. Gorman.

COMM. RAYMOND J. GORMAN: Good morning, Senator Harp, Representative McDonald, Senator Gunther, Representative Gyle and other distinguished members of the Public Health Committee. I'm Raymond J. Gorman, Commissioner of the Office of Health Care Access and I thank you for affording me the opportunity to testify on various legislative proposals impacting the Office of Health Care Access.

In light of the ambitious agenda before the Committee and in the brief time available to me, I'll focus my remarks on four bills. HB5403 AN ACT CONCERNING CERTIFICATES OF NEED, HB5678 AN ACT CONCERNING PROGRAMS AND SERVICES WITHIN THE OFFICE OF HEALTH CARE ACCESS, SB473 AN ACT CONCERNING FUNDING OF THE OFFICE OF HEALTH CARE ACCESS and SB547 AN ACT CONCERNING HEALTH CARE DATA.

As it relates to HB5403 AN ACT CONCERNING CERTIFICATES OF NEED, as I'm sure you are aware, the Office of Health Care Access has long advocated simplifying and streamlining the certificate of need process. This bill before you is a significant step in that direction. The focus of my testimony before you today is to recommend changes to build upon this bill.

Section 1 definition of a related entity. While the present list in this bill clarifies that adding the term related entity is intended to go beyond what might customarily be considered an affiliate to address holding companies of holding companies, it really is not a clear definition. OHCA has submitted a more precise definition you and recommends that 50% be specified as controlling a

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SEN. HARP: Our next speaker is Charlotte Acquaviva.

CHARLOTTE ACQUAVIVA: Thank you. Senator Harp, Representative McDonald and members of the Public Health Committee, I'm Charlotte Acquaviva. I'm counsel of the Insurance Department and with me is Mary Ellen Breault, the director of the life health division.

Thank you for the opportunity to appear today. The Insurance Department has a number of concerns with HB5404 AN ACT CONCERNING PROVIDER SPONSORED ORGANIZATIONS, which seeks to establish separate regulatory standards for provider sponsored organizations, PSOs.

The legislation is unnecessary since there is nothing in current law that prevents a provider sponsored group from seeking and obtaining a license as an HMO.

The apparent intent of HB5404 would be to allow PSOs to do the business of HMOs in Connecticut without meeting all of the requirements that are provided as safeguards for HMO members.

We believe Connecticut consumers would be better protected if the state continues to provide equally stringent regulation for all entities that offer health care benefits to the public regardless of their sponsorship. The state should continue to maintain a regulatory framework that encourages a level playing field for all competitors, looking to the function that an entity performs, not its name or form of organization.

Without attempting a detailed commentary, I would like to note some of the features of the bill that would permit PSOs to operate under unique rules. Some of the proposed solvency requirements in Section 2 of HB5404 mirror our present statutory requirements for HMOs, health care centers, but others are novel.

Authorizing the use of the surety bond in subsection c to meet statutory initial net worth requirements is a departure from the asset

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requirements applicable to HMOs. Similarly, subsection d of Section 2 apparently offers two alternatives for measuring minimum net worth. It's not clear how these departures from current law would function to support the promises of PSO will have to make to the consumers who turn to it for health care benefits.

Subsection f of Section 2 provides for the establishment of a minimum \$300,000 deposit to be used for the protection of the interests of PSO enrollees and to assure continuation of health care services to enrollees of a PSO that is in rehabilitation or conservation.

The intent may be to establish a kind of guarantee fund that would continue payment for providers to insure continuity of service to enrollees. There are no directions for disbursement of these funds, however, except to note that they may be used for administrative costs.

The Insurance Department will be glad to provide more detail, comments, or analysis in response to inquiries from the Committee now or subsequently.

SEN. HARP: Thank you very much. Representative McDonald.

REP. MCDONALD: Yes. I would like to say that this is not our proposed bill. This is a bill from Kentucky that we just put in here to hold the place. We're going to probably strip it, I don't know what we're going to do to it.

Did you have a chance, just Friday we got the recommendations from the HCVA Committee that's setting up the regulations for the Medicare PSOs. It was a draft, but they seemed to think that it was pretty much what they were going to do within the regulations that are going to be adopted by HCVA on the first of April. Did you have a chance to look over the draft that was released on this past Friday.

CHARLOTTE ACQUAVIVA: Not in any detail. I'm sorry. We've been following the development and have had

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some concerns with some of their proposals, but have not seen the final.

REP. MCDONALD: (Inaudible-mike not on) HCVA just came out with the regulations, not the regulations, a Committee of HCVA of what this is going to, how they're going to regulate these PSOs and the question before the PSO task force is whether or not we're going to have one set of insurance companies being certified by HCVA for Medicare and then we'd have another one for the commercial policies.

We've had a task force on this but before any decision is made, we're going to be meeting extensively with the Insurance Department and with the PSO task force and that sort of thing.

Our attorney, by the way, is doing an analysis of this PSO and you sent him over the material yesterday to compare the HMO regulations with the PSO, is that correct?

CHARLOTTE ACQUAVIVA: Yes.

REP. MCDONALD: Okay. I don't have anything more to say on this but we will be back in contact with you and I just wanted to tell you this is definitely not the bill that we're going to use, you know.

MARY ELLEN BREault: We were aware of that but we just wanted to make a statement.

REP. MCDONALD: Put it on the record.

MARY ELLEN BREault: Right.

REP. MCDONALD: That you didn't like the bill. Okay.

SEN. HARP: Thank you. Are there further questions? Yes, Representative Winkler.

REP. WINKLER: Yes, thank you. Excuse me. When we passed the managed care bill, we did not make any reference in that to PSOs, I believe. Is that not correct?

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MARY ELLEN BREault: Not directly, no but we feel that they just by the, if they get into the commercial marketplace that just by the nature of the business that they are doing, they would be encompassing the definition of a managed care organization under the managed care bill.

REP. WINKLER: We would not have to address the managed care bill to include them specifically?

MARY ELLEN BREault: No, I don't believe so, because the definition of managed care organization, if they have a network and if they're doing the utilization review, would automatically make them part of those, well unless you put something forward that exempted them from that bill. We feel that they would be covered under PA97-99.

SEN. HARP: Thank you. Are there further questions? I have a question actually, since you mentioned that. The Medicare managed care instruments that are out in the market now, do they have to adhere to our managed care bill or are they exempt?

MARY ELLEN BREault: They are exempt. As you are aware, those are federal programs and they do not have to file their forms or their rates with this state department. We asked them to do so for informational purposes only but HCVA basically regulates those, sets the rates and oversees any of the other functions, the complaints. Even consumer complaints are handled by HCVA under that program.

One thing to keep in mind is that those programs are not only covering supplemental type of insurance that is available on the commercial market, but primarily they're covering the Medicare portion which is the federal program.

SEN. HARP: So I guess I'm wondering, if HCVA licenses the PSOs, why they would be handled any differently than the Medicaid programs? I mean the Medicare programs?

MARY ELLEN BREault: They wouldn't right now and I think the only danger of passing some legislation now is if this creeps into the commercial market. We feel

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centers, would also be regulated by the certificate of need laws. In other words, we would level the playing field to the extent we can.

We also believe that anyone who is acquiring a brand new MRI or CAT scan or linear accelerator should be subject to need regardless of the cost and we've added this to our bill and it's my understanding that I believe the Radiology Society would support this or a similar proposal.

We also have added a section that would raise the dollar threshold for certificate of need with respect to replacement equipment. That would probably fit into what Commissioner Gorman was discussing before about the exception for the year 2000 equipment, the point being that if OHCA has already thoroughly reviewed something and granted it a certificate of need and then the piece of equipment has to be replaced a couple of years later, it would seem that the threshold could be higher since all of the review in terms of the service already has been done.

We've also made a few technical corrections to the bill and again, what I've done is I've taken HB5403 and I've marked it up. Things that we would add are double underlined so you could see them and things that we would take out are indicated by strike through. And I have a cover memo called additional testimony of CHA that runs over what I've just said but in more detail. I don't know if I have any extra time, but I'll give it to Steve. Case of a lawyer not using all of his time.

STEPHEN FRAYNE: Members of the Committee, Senator Harp and Representative McDonald. I'm Steve Frayne, vice-president of finance to the Connecticut Hospital Association and I'm going to briefly comment on HB5404. I understand that the language that's being presented today or that we've seen is kind of a place holder and is not the ultimate language that the Committee is looking to use. So in that context, I'm just going to highlight my written testimony because you have it in detail here.

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A couple of things we think is important and one is to recognize that at least as the language is currently drafted, it has insurance commissioner of licensing networks. We think that the language should be specific that what you're licensing is a provider sponsoring organization. Currently today there do exist a number of networks which are taking risks downstream from otherwise licensed entities such as HMOs or indemnity carriers. Those entities are not currently licensed, I mean the insurance department, we don't think they should be licensed by an insurance department because those entities are in fact not the ultimate stakeholders. It's actually insurance companies that's the ultimate stakeholder. So we think it's just an issue of drafting.

In terms of solvency, I've attached to my testimony and I now know that you already have it, but you can have it again, a copy of what the negotiated rule making committee has come up with in terms of what are the appropriate solvency standards to be used by the health care financing administration. We think it's imperative that those same standards be used. They are patterned after the HMO model act. There is not many significant differences.

Our main reason for suggesting that they be used, quite simply is, so that we don't create a duality in the regulation of these entities. As you know, if the state statutes do not conform to HCVA's requirements then these entities will escape oversight and regulation for the Medicare population. We don't think that's appropriate. We think there should be a commonality and a consistency of how they're reviewed.

In terms of one issue, another issue that we think is important is that the bill should make clear that a PSO has to be majority owned by Connecticut licensed providers. In other words, this is a venue that we're creating for Connecticut licensed providers. We think the statute should be clear that if we contract with self-funded or welfare arrangements that those arrangements should not trigger the loss of ARISA exemption. That statute does not currently make that point clear.

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And then finally, it's our view that since at least the language as being proposed, does not permit providers to rely on themselves for continuation of benefits. We also think that that same provision should be repealed for HMOs. So, in other words, if we have to come up with the cash and the adequate reserve requirements in order to provide for continuation of benefits, then currently licensed HMOs should not be permitted to rely on the existence of a provider network and not have to have those same reserve requirements or cash requirements.

So as I said, again, we're in support of this bill. We're just outlining some very few changes. I'd be happy to answer any questions.

SEN. HARP: Thank you. Yes, Representative Cleary.

REP. CLEARY: I guess, your last comments about, is that about shifting down, the risk downstream to the providers and are you proposing that the HMOs would no longer be able to do that.

STEPHEN FRAYNE: Currently what exists in state statutes is a provision called continuation of benefits and that provision basically says that an insurer has to provide adequate means acceptable to the commissioner of insurance to provide for the continuation of benefits.

One mechanism for doing that would be to increase cash reserves, have available letters of credit or other forms of means to insure that if an HMO went defunct, it would have the ability to continue out the policy period.

The standard means that is used, at least as best I can tell almost universally is that contractually, providers are obligated to continue to provide services through the period to which premiums have been paid. And the way that the current bill is being drafted for provided sponsor organizations, we would not be afforded the same ability to use that provision as would an HMO, which just seems to us kind of unbalanced.

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I mean, if we're good enough to insulate the continuation of benefit reserve requirements for an HMO, we should be good enough to insulate it for ourselves. And if we're not, then there should just be an equality. We have to come up with the cash then, it seems to me they should have to come up with the cash as well.

REP. CLEARY: So as I understand that, you're saying if you can't pass that risk downstream and use a provider other than the PSO to cover part of that risk, then we should eliminate that ability for the HMOs to do that?

STEPHEN FRAYNE: Correct.

REP. CLEARY: Would you prefer we give it to you or eliminate it from them?

STEPHEN FRAYNE: Either way.

REP. CLEARY: Okay.

SEN. HARP: Thank you. Representative McDonald.

REP. MCDONALD: Yes. These two things, CON and the PSOs are things that I've worked on for two or three years, and I want to know, how many surgical centers can you recall are presently free-standing surgical centers are presently owned by hospitals or health systems, or anything else you might call the organization?

DENNIS MAY: You said free-standing?

REP. MCDONALD: Yeah.

DENNIS MAY: I don't know the exact number but it's probably in the ballpark of eight to ten.

REP. MCDONALD: That's most of them, is that not correct?

DENNIS MAY: Well, that's certainly all of the hospital ones. But there are several that are owned by organizations other than hospitals and of those, there's probably six to eight, is my recollection.

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What we're finding happening, and this has only really occurred within the last year or so, are physician organizations creating limited liability companies and proposing to build surgi-centers without CON off of their physician license. That's a new phenomenon that we didn't see a year ago, that we're beginning to see today. Now, I don't think any of those, but Mike may be able to answer this, have been approved yet. But there's clearly some in the pipeline.

MICHAEL EISNER: Well, there's no one to approve them. I know OHCA is investigating one right now where apparently of at least from what we've heard, the people who are going to run it would have other people come in and be part of the medical staff. Now OHCA's looking into that and I don't know what the answer is, but they're springing up all over and they're not, no one's coming in and asking for certificate of need.

REP. MCDONALD: All over Connecticut or all over the country? When you say all over.

MICHAEL EISNER: Well, I think it's a new phenomenon in Connecticut. I think in other parts of the country where there is no CON, they've been around for a long time.

REP. MCDONALD: I was told yesterday by someone, I can't remember who it was, that there's an HMO that has a free-standing facility in the New Haven area where they send their patients for all the outpatient xrays and you know, lab work and all the rest of it. Are you aware of that facility?

DENNIS MAY: I'm not.

REP. MCDONALD: You're not. I think it was the Insurance Department that told me of that facility. The other thing, I want to ask about these PSOs. You know, presently in the bill, is not our bill. It's a place holder, it's a Kentucky bill. Have you have time to analyze the rules that came out Friday from the Committee, the PSO Committee down in Washington?

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STEPHEN FRAYNE: Yes, we've gone through that. They're very --

REP. MCDONALD: I don't understand them all. Our attorney is presently comparing this to the HMO laws so we can see where they deviate.

Why don't I ask you, how important is it to you to have the PSOs and the Medicare PSOs operate with the same system and not allow the Medicare PSOs to be certified by HCVA and then next year we will look at the commercial. But, is it really important that there be the same supervision over these two different markets?

STEPHEN FRAYNE: One of the requirements, and that requirement has been somewhat changed, is that one of the means to participate in the Medicare program is you also have to have a certain proportion of commercial logs. So you know, these entities will have to get into that market one way or another.

I mean, if their ultimate reason for existing is to want to be able to participate in Medicare, one of Medicare's requirements, although they've changed their requirements somewhat, is that you must also have services being provided to other individuals, other than just simply Medicare beneficiaries.

So it's important for us not to be held up for another year, particularly when there is significant enrollments occurring for this Medicare population as it exists today. Its enrollments are averaging 5,000 to 6,000 individuals a month, who are signing up and are currently licensed HMOs with only 500,000 individuals available, two years makes a significant difference of terms of waiting to be able to provide coverage for that population.

REP. MCDONALD: We've allowed them to be certified by HCVA for the Medicare portion of it and as I understand it, then they'd have to come back and be, that's not a certification forever, was it three years, they'd have to come under the state's jurisdiction anyway or attempt to come under it, so it's not a long-standing certification.

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I still think, let's talk about this commercial market. Do you think there is a big commercial market for PSOs in the state, and if you do, why is it so different from the HMO? I mean, I know, like for example, Yale already has licenses in HMO. What benefits are they going to get to be certified or licensed as a PSO, that they don't already have.

STEPHEN FRAYNE: The experience, I think, that we can draw on really comes from other states where at least where, Medicare for example has run some demonstration projects where they permitted provider sponsored organizations, essentially prior to this legislation, to come into existence. The experience has been that a lot of the people who are served by these institutions would much prefer to be involved in a network of providers that they know and are familiar with.

I mean, there is a significant, obviously, as evidenced by the legislation that this Legislature passed last year, backlash against other kinds of forms of managed care. And people are looking for other alternatives to see if there's a better way to build that mousetrap.

PSOs might be it. PSOs may not be it. But at least the experience in other marketplaces has been a large attractiveness on behalf of those people who would use these services to want to try something different to actually be in a direct connection with the providers who are providing the care and having those providers look out for the whole aspects of their benefit package, not just the event they came for on that particular debt. So I think that's the reason for it.

REP. MCDONALD: One last question, and if I need to talk to you people, I'll get back to you. This PSO legislation that came through the balanced budget act was really from what I've read, an attempt to throw a carrot to the hospitals and doctors because they're going to cut the Medicare rates substantially to hospitals and physicians.

Do you know what percentage of the Medicare rates is going to be cut for the hospitals and physicians

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this year?

STEPHEN FRAYNE: There are significant cuts. I don't have the exact percentage in aggregate off the top of my head. I can certainly get that for you and communicate it to your staff. But our experience in the last few years is, it's either a freeze or it's a reduction so that there's not new money put into the pipeline and that's been our experience.

REP. MCDONALD: (Inaudible-mike not on) We're recording your testimony and I can't hear.

STEPHEN FRAYNE: Our experience has been, over the last few years is it's either cuts or it's frozen, but there's no increases in the expenditures being put forth by Medicare. But we can get you the exact percentages if that would be useful to you.

REP. MCDONALD: I'd just like to make a comment that in trying to regulate the certificate of need, we're kind of back and forth, but I know Senator Harp and I are very concerned.

The government pays about 60% of hospital costs in this state, we're paying for it through Medicaid and Medicare. That was the figure I read in the new state health plan. And if you were to add in the state and federal and local employees, government employees, it's probably up around 70%, the insurance for those people. So we're very interested in how you're operating and how you're expanding or what because we're paying the bill. The government is paying the bill for this.

And I'm trying, one of the things that really concerns us and when you're talking about this oversight of board and stuff, perhaps we'll have to come up with new language. It seems that a lot of the health systems and hospitals are just going up to the edge of the CON so they don't have to come, but they're acquiring many, many different kinds of entities. They're acquiring visiting nurses and rehab centers and we end up not knowing what's going on out there in the market. We have no idea what's going on because you're coming up to the level.

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So we're going to have to find some accommodation because what we're worried about is if some of these hospitals go under in certain sections of the state, we're going to have no access for our citizens. We've got to keep track of what's going on. I wish you would keep that in mind, what we're doing with trying not to micromanage, but we'd like to know what's going on and I wanted to explain that to you. Thank you. I'll probably may be talking to you later about this. I don't want to hold it up any longer. Thank you.

Oh, are there any other questions? Representative Winkler.

REP. WINKLER: Yes, thank you, Madam Chairman. A question regarding your testimony, Dennis, on SB547. The Department of Public Health presented a health plan for the State of Connecticut and what was obviously missing was the emergency room data reporting and looking at your testimony, you mention that there's no way of collecting that and it's connected with the clinic data in addition to the emergency department data and I don't understand why.

DENNIS MAY: Okay. Actually, emergency department data is being collected. I think we've collected it now for the last two to three years and we have consistently taken the position that if OHCA's law were to be amended allowing them to collect it, or they establish regulations, and if they had the authority today, we would have no problem with having emergency department data sit in OHCA's files. And the same is true of ambulatory surgery.

So, our difficulty becomes, when you get into what we call the private referred outpatient data, which really is xrays, lab tests, scoping procedures and so on that are being done in hospitals, but they're also being done in private radiologists' offices and all over the state.

The amount of data for each claim is so huge, we have decided years ago not to collect it ourselves simply because of the cost to the hospitals to collect it and for us at CHA to be able to maintain

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IN TOBACCO PRODUCTS. While we support the steps taken toward smoke cessation in SB573 and SB544, we believe that there is more that could be done to help reduce the number of children and adults who smoke. A 49 cent per pack tax increase on cigarettes would greatly reduce the number of people who smoke. Statistics demonstrate that for every 10% increase in the tobacco tax, there is a 4% to 13% decrease in the number of people who smoke, especially in children and a 9% decrease in the number of children who start smoking.

A 49 cent increase would generate an additional \$92 million of state income that could be used for smoking cessation as well as expanding health coverage for the uninsured in Connecticut. We ask that the members of this Committee support all of these bills. Thank you.

REP. MCDONALD: Thank you. Are there any questions? No questions. Thank you. Jan Spegele from the CBIA.

JAN SPEGELE: Good afternoon, Representative McDonald and other members of the Public Health Committee. My name is Jan Spegele from CBIA.

REP. MCDONALD: (Inaudible-mike not on)

JAN SPEGELE: Oh, I'm sorry, I didn't hear what you said. Connecticut Business and Industry Association, CBIA. My written testimony includes comments on four bills HB5403 and SB348 which deal with CONs. SB474 which deals with liability and HB5404 which deals with provider sponsored organizations.

I'd like to be clear when talking about the certificate of need bills that we do not so much oppose HB5403 and SB348 as we generally oppose continuation of the CON process as it now stands.

We believe that changes, when the Legislature is looking to make changes in the CON bill at minimum, it should be updating the dollar thresholds that trigger state oversight of capital expenditures.

Connecticut enacted its first CON law in 1973 and

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four certain days a week and we have office staff that are on the phone constantly with them. Then we wind up leaving a voice message. Then they don't call us back for a week. Then we try and call them again and we play telephone tag.

Then they say, well, we'll have to review the claim, please resubmit it. Now, this is very expensive to us for office staff. We'll resubmit the claim. Then it has to go before a committee. Then they'll come back two months later and say we need some additional information. We provide that additional information and we have to wait for the next time the committee meets and this goes on and on and on for months and months at a time. Insurance companies work on a tremendous amount of float this way.

REP. MCDONALD: All right, I think there are no other questions? Thank you very much for coming.

DR. MARK GERBER: Thank you.

DR. FRANK ROSENBERG: Thank you. SB574. Emily Smith followed by Dr. Branden.

EMILY C. SMITH: I have a lot to say, but I'll try to do it quickly. I have three bills. I'm Emily Smith from Anthem Blue Cross and Blue Shield. I wanted to speak on SB574 AN ACT CONCERNING THE PURCHASE OF MEDICAL PRACTICES BY HEALTH INSURERS AND THE SUBSEQUENT EXCLUSION OF PRACTICES NOT OWNED BY INSURERS, HB5404 AN ACT CONCERNING PROVIDER SPONSORED ORGANIZATIONS and SB319 AN ACT CONCERNING MANDATORY INSURANCE COVERAGE FOR PAIN MANAGEMENT TREATMENT.

I did speak on SB319, I believe it was on February 24th, you had another hearing so I won't spend too much time on that. We do oppose that bill because it's a mandate and I included in my testimony the fact that Blue Cross and Blue Shield is adding a pain management benefit to its blue care contract effective April 1st, so I just wanted you to be aware of that.

With regard to SB574, we oppose this bill. We really view it as kind of a back door approach to

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any willing provider. It requires managed care organizations to contract with any provider and we would really lose control over how we can build a network and lose control over the things that are important when we build a network.

We look at the quality of care that we're able to deliver when we put together a network. We like to guarantee to our members that there's a very high quality of care that's deliverable. We like to be able to credential all of our providers when we build a network and we have to take into consideration different geo access considerations when we put together a network and this bill would really not let us do that. It opens the door to any provider whether or not we need them in the network and we're opposed to that.

The result is higher costs with no real assurance of improved quality which is an essential element for our managed care delivery system.

With regard to HB5404 AN ACT CONCERNING PROVIDER SPONSORED ORGANIZATIONS, I recognize that this bill is not the bill that's going to be moving forward. We did participate in the provider sponsored organizations study committee, I believe it was during the fall and our national association of Blue Cross and Blue Shield Association did have a seat on the negotiate rule making committee that HCVA had down in Washington that basically was establishing the financial and solvency requirements for Medicare PSOs. We did sign on to those draft recommendations that Representative McDonald made reference to earlier in the hearing.

With regard to commercial PSOs, we believe that they should continue to be subject to the statutory financial requirements that HMOs are subject to currently and we feel that way because we believe that PSOs are conducting the same type of business that HMOs. There might be a different ownership interest but as far as the business that's being conducted, we believe that it's similar to HMOs.

And finally, we feel that commercial PSOs should continue to be subject to all of the consumer

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protection safeguards that HMOs are subject to, especially the ones that were passed last year by the Legislature in PA97-99. Thank you.

REP. MCDONALD: Thank you. Senator Harp.

SEN. HARP: Thank you. I guess I'm kind of in a way, I think that on SB574 that you make a point about it almost being like any willing provider. Although I don't really see it that way. We have laws in the state which prohibit doctors from steering patients to pharmacies that they have ownership interest in and basically this is a question of ownership interest.

If a plan owns practices and doesn't allow any other doctors or say, opticians or optometrists into their networks unless they also own those networks, I think that's an unfair practice. I think it's very different than any willing provider because basically what the insurance company is doing is owning the profit on the business as an insurance company as well as the business of the provider group that they own as well and they're limiting other providers from having any part of that business. I think that's very different than saying that you have to take any provider into your network because it does seem to be a double profit hit going on there. So that's a very fine, subtle, but important distinction in this bill.

Do you see that? I mean, we don't allow doctors to do it, so why would we allow insurance companies to do it?

EMILY C. SMITH: Well, with respect to that bill, Blue Cross and Blue Shield does not have an ownership interest in any provider.

SEN. HARP: We're not talking about you. We're talking about the concept. We're not talking about Blue Cross per se, but any insurance company that also owns provider groups, because what can happen if they're big enough, they can cause people who they don't, providers that they don't have an ownership in, to go out of business.

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increase litigation by inviting more litigation and that in itself could raise prices.

REP. MCDONALD: Would you please try to summarize.

JAN SPEGELE: Just final comment on provider sponsored organizations and I'd like to associate my remarks with that of Charlotte Aquaviva from the Department of Insurance. We don't believe that PSOs should be governed by different lesser or stricter requirements than any other health care plan offered in the commercial marketplace. Thank you very much.

REP. MCDONALD: Have you read the new PSO Committee's recommendation that came out on Friday? Have you read it yet?

JAN SPEGELE: I have not. But because it applies to Medicare and not the commercial marketplace, I'm not sure that it would affect CBIA's point of view because we're really looking at the commercial consumer of health insurance in the State of Connecticut and we're looking at the products that are out there and the sort of expectations that the consumer or purchaser of commercial products have when they're looking at health care products.

The expectation is that they're solvent, that they have the mandates that are part of every insurance product in the state and that they're subject to the series of laws that this Legislature has passed.

It is not something, we do not believe that the consumer should have to check the credentials or the ownership of a particular health plan before they can determine what their protections are under the law. The law protecting consumers and governing requirements of health plans should really be the same when it comes to all products within that commercial marketplace.

REP. MCDONALD: Do you think these HMOs or health centers as we call them in the statutes, do you think they ever practice medicine? Let me give you an example. I hear over and over and over again

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that a physician will say, he recommend something, some procedure and then the HMO says yes, but we've determined it's not medically necessary. I hear those words constantly, medically necessary.

In using those words, are they practicing medicine?

JAN SPEGELE: They're giving an opinion about coverage. The contract of insurance between the individuals or the employer that purchases the insurance and the insurance plan is that coverage is provided for medically necessary services and interventions. So it is a coverage decision.

But I think this discussion of whether that is or is not a medical decision is nevertheless something that this Legislature looked at to some extent last year when it determined that the decisions of health care plans should be subject to an external review and the managed care bill that was enacted last year does provide for an outside independent review of some of those decisions when they are not, when they're directly under the category of medical necessity.

That law just went into effect January 1st and I think we should all see how well that works in order to protect, to address some of the concerns that some have raised about accountability of health care plans. Certainly that external review is looking to that issue of accountability for health plans.

REP. MCDONALD: Thank you. Are there any other questions? No other questions. I thought this was the last speaker on this bill but two more had signed up. One is Bernard Joy, followed by Robert Russo. Bernard Joy.

DR. BERNARD JAY: Hi. I'm Bernard Jay, I'm sorry I didn't make my name clear enough for you. Well, I think I have an individual thing I would like to present, so it's sort of by myself.

Dear Committee Members. I'm Bernard Jay, a practicing radiologist in the shore line area of Connecticut, specifically the towns of

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choir here, the only option we have is to do something like an amendment on the floor. But that's not out of the realm of thinking. Thank you.

DR. JOHN BIGOS: Thank you, Representative.

REP. MCDONALD: Thank you. Are there any other questions? Thank you very much.

DR. JOHN BIGOS: Thank you for having me.

REP. MCDONALD: We're going to go now to HB5404 and the first person to speak is Patty Shea followed by Jerry Hardison. Dr. Hardison. Is Patty Shea here? You better jump. When people hear where you're coming from, Patty.

PATRICIA SHEA: I'm always pleased to do that. For the record, my name is Patricia Shea from Robinson and Cole and I'm here representing today the Association of Connecticut HMOs.

I signed up to testify for HB5404 which is the provider sponsor organization bill. I sat on the task force that looked at this issue. The Association very strongly opposes doing anything that would allow provider sponsored organization to sell what looks like what is an HMO product in the commercial marketplace if they are not licensed as an HMO.

If it walks and talks and looks like an HMO, it should do what other provider sponsored organizations have done in the past which is to go to the Insurance Department and get a license so that they have to abide by all the consumer protections that the HMOs do.

The hospitals, the CHA, will argue that they should be regulated under different statutes, different agency, different solvency standards and we will strongly oppose that. I have submitted written testimony and it outlines, I can't go into all of the various types of consumer protections, but I've outlined a number of them.

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If you do what they are asking, you will take away a lot of the protections that over the years we have fought very hard against but that you have succeeded in passing, like the managed care act. They will not have to abide by those. Regulation of solvency is one. There are many other protections to protect consumers against insolvency. The managed care act. The grievance procedures you've established, utilization review. The expedited review. Those would all be lost. Adjusted community rating would be lost.

All the coverage requirements and the mandates that you have passed over the years, Senator Prague, that we have fought but you passed, they will be lost.

REP. MCDONALD: Excuse me a minute. The group down at the door, I guess they've disbanded. There were a lot of people talking. I was going to ask them to move themselves to the hall but they've left now. I'm sorry to interrupt you.

PATRICIA SHEA: The unfair insurance practices which controls what kind of advertising. The agents' activities. Confidentiality. The health reinsurance association, which the HMOs pay to insure those individuals who are high risk. I can go on and on. My written testimony is here.

Basically what we're saying is, we're not talking about the Medicare financial solvency that's going to come down from HCVA. What we're talking about is the commercial market. If they're going to be a player in the commercial market, and the consumers are going to have a choice between an HMO that is operated by providers, or an HMO that's operated by any other entity, it is not clear to a consumer who owns and operates, to the consumer it doesn't matter. What should matter is that all the regulations and standards that you have set forth apply across the board so that they can compare.

I mean, part of the managed care act, a big part of that was the ability to compare across the board, consumer report card. Well, where will this consumer report card be if you have all different

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requirements for different plans?

I also wanted to testify briefly. We have submitted additional written testimony on a lot of the bills today on the liability of managed care plans. I just wanted to address some of the things that I've heard in the prior speakers' testimony.

The bill in Texas that passed is very different from what you have before you. In Texas there was a statutory prohibition on the corporate practice of medicine so that if a consumer tried to sue in Texas, they could not effectuate a claim because of this prohibition.

We don't have that in Connecticut. In Texas they had to repeal that law in order to allow a lawsuit. You don't have that in Connecticut, so the law's not necessary. In Connecticut, it's a common law action from negligence. That's what I'm hearing people say and you can make that right now. I heard the trial lawyer representatives talk about some cases. They have not been denied a right of action against HMOs in Connecticut that I am aware of. They have every right to sue. If they're suing for negligence, they have to prove who was responsible for the negligence, whether it was the provider or the HMO.

But you don't have a situation like you had in Texas where there was a statutory prohibition and you don't need a statutory, you don't need to create a statutory right of action. There is no statutory cause of action against a provider. Why do you need to create a statutory cause of action against an HMO? If it's a negligence, you sue in negligence. Common law theory.

REP. MCDONALD: I allowed her to go more because I interrupted her testimony. (Inaudible-not using mike)

PATRICIA SHEA: I would also, the mention was made of the hold harmless bill that passed last year and I think that almost gives you a clear look at, if the hold harmless bill had to be passed and said that an HMO cannot push its liability off on someone

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else, then implicitly the Legislature has acknowledged that there is liability.

REP. MCDONALD: Now you can sum up.

PATRICIA SHEA: I'm sorry?

REP. MCDONALD: You want to sum up?

PATRICIA SHEA: I'm ready to answer questions if you have any.

REP. MCDONALD: Let me ask you. Have you read the (inaudible) recommendation that came out last Friday. Have you seen it yet? On the HCVA commission?

PATRICIA SHEA: I have not seen it.

REP. MCDONALD: Okay. It's around if you haven't.

PATRICIA SHEA: I'll stop up to see Steve.

REP. MCDONALD: (Inaudible-mike not on) because I'd like to hear what your comments are. Let me ask you a question. Do any hospitals belong to NCQA? That's the National Committee on Quality Assurance for the audience that looks at HMOs, how they're performing. Do hospitals belong?

PATRICIA SHEA: They have, JACO and another.

REP. MCDONALD: (Inaudible-mike not on) You mentioned a report card. Now, most of those report cards are going to come from (inaudible) data that you submit the National Committee on Quality Assurance and then they ship it back to the insurance commissioner.

PATRICIA SHEA: Right.

REP. MCDONALD: Or you give it to the insurance commission.

PATRICIA SHEA: Right.

REP. MCDONALD: The hospitals won't be able to, you said

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you wanted them to produce the same report card as HMOs have to do. How are they going to do it?

PATRICIA SHEA: What I'm saying actually, is, if the hospitals want to compete in the commercial marketplace, and what they want to do is exactly what we do. They want to sell insurance through an employer to the employees. That's what they're asking you to allow them to do under a different regulatory scheme.

And so, if they are going to do that, the consumer has, the consumer is blind to who owns that entity. They only see that they have you know, choice a, b, c, d and what I'm saying is, if you want them to have a true comparison about performance and quality, then the entity whether it's an HMO or a provider sponsored network, should have to give those same quality measures.

REP. MCDONALD: We're going to have another meeting on that task force if everybody's digested this thing. But let me ask you a question. Do you say you're not concerned with the Medicare implementation of the PSO bill, that it doesn't bother your organization if they get certified by HCVA?

PATRICIA SHEA: HCVA will set the financial solvency requirements for Medicare.

REP. MCDONALD: And if we don't do it as a state --

PATRICIA SHEA: Right.

REP. MCDONALD: Right.

PATRICIA SHEA: But I think what I have heard the hospitals say, well whatever those standards are that are established for Medicare, let us abide by those in the commercial marketplace so that it's easy for them but it's not going to protect the consumers in the commercial marketplace. It may be easy for them to just abide by one set of rules but they're going to be completely different than what the rules are for everybody else in the commercial marketplace and it will be confusing for the consumer, not to mention the fact that we'll have

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to do, the HMOs will have a lot more regulatory constraints than they will.

REP. MCDONALD: It will be difficult for your member companies to have two sets of rules, one for the commercial market and one for the Medicare market because that certification, HCVA's only good for three years and you've got to come back into the state insurance market.

Is it all right with you to have two different kinds or do you want to try to make the Medicare market conform. We probably won't be able to do that because of HCVA but do you think there should be one system or two different systems?

PATRICIA SHEA: I think the system should depend on ultimately the end user, or the consumer, whoever the consumer is. If the consumer is a Medicare consumer, then the Medicare rules should apply. HMOs right now are selling Medicare risk and they abide by what HCVA says. On the commercial side, they abide by what the Legislature and the insurance commissioner says. And so, ultimately I think you should be looking toward making it easier for the consumer to compare plans and it's dependent upon where the consumer sits, not where the entity who's selling the product sits.

Because as an HMO, we've often got to have different regulations, depending upon where we're selling the product.

REP. MCDONALD: Are there any other questions on this? Senator Prague.

SEN. PRAGUE: Thank you, Madam Chairwoman. Patty, I, you addressed SB474 and said that Connecticut doesn't need this legislation. The Attorney General at the Insurance hearing on this issue clearly said that Connecticut does need this legislation in order to protect consumers. And I don't have a copy of his legislation before me but clearly according to law, it is this kind of legislation that is needed, not what we currently have and has been referred to what we passed in 93.

JOINT
STANDING
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HEARINGS

PUBLIC
HEALTH
PART 6
1771-1976

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TESTIMONY OF
JAN SPEGELE
CONNECTICUT BUSINESS & INDUSTRY ASSOCIATION
BEFORE THE
PUBLIC HEALTH COMMITTEE
MARCH 10, 1998

My name is Jan Spegele and I am the vice president of Regulatory Affairs for the Connecticut Business & Industry Association (CBIA). CBIA represents over 10,000 businesses, the vast majority of which are small companies employing fewer than 50 people.

I am here to speak on four bills: HB 5403, SB 348, SB 474 and HB 5404.

HB 5403, AAC Certificates of Need and SB 348, AA Extending Certificate of Need Requirements of Health Maintenance Organizations

CBIA opposes HB 5403 and SB 348. These bills further expand the state's oversight and involvement with health care facility operations and expenditures, but do nothing to update the dollar thresholds that trigger state oversight.

Connecticut enacted its first Certificate of Need (CON) law in 1973 to comply with the federal National Health Care Planning and Development Act and thus qualify for federal health care funding. It was intended as a tool to limit expansion of unnecessary technology and health care facility capacity. The law establishes dollar thresholds for capital and medical equipment expenditures and subjects health care facilities to state review and approval for expenditures above these thresholds.

Initially, Connecticut established a capital-expenditure threshold of \$100,000. From 1973 to 1987, Connecticut increased this threshold six times to reflect increased costs and inflation. And, in 1983, it established a separate threshold for major medical equipment. But in the past decade, Connecticut has not updated the dollar threshold for capital expenditures or the dollar threshold for major medical equipment. The capital expenditure threshold for triggering CON review had remained at \$1 million since 1987, and the threshold for major medical equipment remains at \$400,000 -- the same level as in 1983, the year that this threshold was first established.

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This is Texas' legislation designed to address a Texas problem found in Texas law. Yet SB 474 incorporates this language directly from the Texas legislation, even though there is nothing in Connecticut law that prevents an injured party from bringing a medical malpractice suit against a health plan.

In Connecticut, injured persons have a common law right to sue health providers, and they have a common law right to sue health plans for personal injury caused by negligence. Connecticut does not need a statute to enable individuals to bring medical malpractice claims against a health provider or against a health plan.

While injured persons have nothing to gain from legislation creating a statutory right to sue, they have something to lose. Creating a statutory right to sue is an invitation to increase malpractice litigation. And increasing malpractice litigation only increases costs -- costs that are already substantial. For example, the individuals and institutions who were sued for malpractice won nearly 70% of the lawsuits that went to trial in 1996. But the average cost of defending these suits was nearly \$95,000. And, for every dollar spent on medical malpractice litigation, only 43 cents ever reached injured patients as compensation.

It's no wonder that medical practitioners have long criticized the malpractice system as an expensive, inefficient and ineffective way to resolve medical claims.

Last year, the Connecticut legislature passed the Managed Care Act that contains a provision enabling patients and providers to seek an independent, outside review of health-plan decisions. The external-review process, which became effective Jan. 1, should help resolve medical claim disputes and hold health plans accountable -- without the costs that result from expanding malpractice litigation.

I urge you to allow the new managed care law to work, and to reject SB 474.

HB 5404, AAC Provider Sponsored Organizations

CBIA welcomes the increasing availability of PSOs and the expansion of consumer options that their presence in the marketplace represents. At the same time, we believe they should be subject to the same regulations and requirements that apply to any other health plan marketed and sold in the commercial marketplace. Specifically, the state Department of Insurance licensing and financial requirements that protect consumers of

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HMOs should continue to apply to health plans that are owned and operated by health care providers -- i.e., PSOs.

Current law requires HMOs (herein, and within statute, referred to as "health care centers") to obtain a certificate of authority from the insurance commissioner in order to conduct business in the state of Connecticut. And the insurance commissioner cannot issue this certificate unless the health care center has complied with the solvency standards and the hold-harmless and continued-benefit provisions of Connecticut's insurance statutes.

Just as these provisions apply to shareholder-owned health care centers and mutually owned health care centers, they should continue to apply to health care centers that are owned and operated by health care providers. Consumers and purchasers of health care center plans have an expectation, backed up by current statutes, that the plans in which they enroll are financially viable and will remain solvent, and that consumers are protected if the plan becomes insolvent. The consumer should be able to rely on these protections without first studying and analyzing whether a provider or a non-provider owns and operates the health care center.

Likewise, purchasers and consumers have every reason to expect that health plans marketed and sold in the commercial market adhere to the small employer underwriting and rating laws (Sec. 38a-564 et al.), that they provide coverage for all the conditions and services provided by statute (Sec. 38a-514-549), and that they provide the benefits and protections afforded by the Managed Care Act (P.A. 97-99).

HB 5404 attempts to apply many of these solvency standards, consumer protections and plan requirements to provider-owned and -operated health care plans. But it tries to do so by creating a whole new statutory structure with provisions that are applicable only to PSOs.

In setting up this new structure with separate provisions, is it the intent of the bill to exempt PSOs from existing statutes and provisions that would otherwise apply? For example, Section 3 (c) of the bill requires PSOs to "submit information to the commissioner" that demonstrates that the PSO "(4) Has the ability, policies and procedures to conduct utilization management activities."

Since, generally, health plans are subject to extensive requirements concerning information they must submit to the commissioner of insurance, and there is a complete statutory system governing utilization review management, is the requirement in Section 3(c)(4) in addition to, or in place of, existing requirements?

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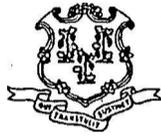
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Whatever the intent, we see nothing about provider-ownership of a health care center that warrants different state oversight, statutory treatment or financial licensing requirements. We do not believe that PSOs should be governed by different, lesser or stricter requirements than any other health care centers.

Thank you for considering CBIA's views on these important issues.

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STATE OF CONNECTICUT
INSURANCE DEPARTMENT

STATEMENT
INSURANCE DEPARTMENT
BEFORE THE
PUBLIC HEALTH COMMITTEE

HB No. 5404 An Act Concerning Provider Sponsored Organizations

Tuesday, March 10, 1998

Senator Harp, Representative McDonald, and members of the Public Health Committee. The Insurance Department has a number of concerns with House Bill 5404, An Act Concerning Provider Sponsored Organizations, which seeks to establish separate regulatory standards for provider sponsored organizations, PSO's. The legislation is unnecessary, since there is nothing in current law that prevents a provider sponsored group from seeking and obtaining a license as an HMO.

The apparent intent of House Bill 5404 would be to allow PSO's to do the business of HMO's in Connecticut without meeting all of the requirements the provided as safeguards for HMO members. We believe Connecticut consumers would be better protected if the state continues to provide equally stringent regulation for all entities that offer health care benefits to the public, regardless of their sponsorship. The state should continue to maintain a regulatory framework that encourages a level playing field for all competitors, looking to the function that an entity performs, not its name or form of organization.

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Without attempting a detailed commentary, we would like to note some of the features of the bill that would permit PSO's to operate under unique rules.

Some of the proposed solvency requirements in Section 2 of House Bill 5404 mirror present statutory requirements for HMO's (health care centers), but others are novel. Authorizing the use of a surety bond in subsection (c) to meet statutory initial net worth requirements is a departure from the asset requirements applicable to HMO's. Similarly, subsection (d) of Section 2 apparently offers two alternatives for measuring minimum net worth in subparagraphs (3) and (4). It is not clear how these departures from current law would function to support the promises a PSO will make to the consumers who turn it for healthcare benefits.

Subsection (f) of Section 2 provides for the establishment of a minimum \$300,000 deposit to be used for the protection of the interests of PSO enrollees and to assure continuation of health care services to enrollees of a PSO that is in rehabilitation or conservation. The intent may be to establish a kind of guaranty fund that would continue payment for providers to ensure continuity of service to enrollees. There are no directions for disbursement of these funds, however, except a note that they may be used for administrative costs attributable to a receivership. The amount on deposit would seemingly remain constant, without regard to growth in the PSO's business.

The Insurance Department would be glad to provide more detailed comments or analysis in response to inquiries from the Committee.

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March 10, 1998

**Statement of Anthem Blue Cross and Blue Shield of Connecticut
regarding H.B. 5404, AAC Provider Sponsored Organizations**

Good morning Representative McDonald, Senator Harp and members of the Public Health Committee. My name is Emily C. Smith and I represent Anthem Blue Cross and Blue Shield of Connecticut, the state's largest managed care organization. I am here to speak on H.B. 5404, AAC Provider Sponsored Organizations.

Anthem Blue Cross and Blue Shield of Connecticut supports a health care marketplace that offers consumers a choice of secure, high-quality private health plans. We believe these choices should include health maintenance organizations (HMOs), point of service plans (POSs), provider sponsored organizations (PSOs) and others. Fair and vigorous competition is the best way to assure that affordable, high quality coverage will be available to consumers.

To achieve this healthy, competitive marketplace, we believe the state should create a regulatory framework that ensures both equal protection for consumers and equal treatment of competitors. Consumers deserve equal protection regardless of the type of health plan they choose, be it an HMO or a PSO. Complex, separate and unequal regulatory requirements lead to consumer confusion and ultimately consumer dissatisfaction with the marketplace. All attempts to avoid this outcome should be made. Likewise, we would oppose any special treatment of a competitor, based on its ownership form. Competitors in the marketplace should compete on price and their ability to deliver a superior product to the consumer, not on their ability to achieve advantages through regulation or legislation.

Financial/Solvency Standards

HMOs in Connecticut are required to have a minimum of \$1.5 million for their initial licensure and they must maintain the greater of \$1 million or 2% of annual premium for the first \$150 million plus 1% of annual premium for amounts over \$150 million. Health insurers, other than HMOs, must have a minimum surplus of \$1 million for initial licensure plus they must meet the NAIC Risk Based Capital requirements for either life insurers or property and casualty insurers. These requirements assure that health plans will have the financial resources necessary to cope with unanticipated expenses, such as treating a large number of individuals with catastrophic illnesses or an unexpected number of out of network claims.

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The federal government is currently in the process of adopting regulations addressing financial and solvency issues as they relate to Medicare PSOs. We recommend that Connecticut adopt state standards that mirror the federal regulations for Medicare PSOs only. This will prevent the state from losing the ability to regulate PSOs by having regulation automatically revert to the federal government.

As to commercial PSOs, we recommend that they continue to be subject to the same financial/solvency requirements the HMO market is subject to. This is a very important concept that we feel will provide important protection to consumers. Regardless of what an entity calls itself, once it accepts a payment (premium or capitated fee) in exchange for providing a specific range of benefits or services, it is functioning in a manner identical to how HMOs now function.

Managing a health plan requires skill in financial planning, risk management, accounting and other business practices. Many PSOs are still developing these critical skills. Less than one-third of PSOs recently surveyed by Ernst and Young reported making a profit, and many did not even know their financial status. Failure on the part of the state to adequately regulate the financial stability of the industry will lead to reduced levels of quality and, ultimately, insolvencies. These consequences should be avoided by imposing the current financial safeguards on all players in the commercial marketplace.

We understand that there may be a need for flexibility in the development of solvency standards. Numerous risk-based capital models have been put forth that would promote such flexibility for health care entities. We support the use of these models as they apply to the industry as a whole, (not just one segment of the industry) and would be happy to discuss further how solvency standards can be developed based upon them.

Consumer Protection Standards

Connecticut imposes numerous consumer protection requirements on HMOs, managed care entities and utilization review organizations. Indeed, many of these requirements were passed during the last legislative session and were advocated for by the provider community.

These consumer protections address quality assurance, disclosure, grievance procedures, marketing and enrollment practices and many other areas relating to the business practices of a managed care entity.

Complying with these requirements is both time consuming and costly for the entities involved. Despite this, we believe strongly that all entities, including PSOs, should be subjected to these same consumer protection standards. This would maintain a level playing field which is important to fostering a healthy, competitive marketplace.

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Barriers to Licensure

The Association of Physician Hospital Organizations estimates that there are over 1,000 PSOs in operation today. Many PSOs (e.g. Kaiser and the Mayo Clinic) have been operating with state licenses for years. Locally, Yale Health Plan and MedSpan are two provider sponsored organizations licensed as HMOs.

This demonstrates that PSOs can obtain licenses through the normal process and that they are willing and able to meet the same quality standards as HMOs.

Conclusion

Connecticut currently has a very healthy, competitive managed care marketplace. Regulatory standards have been developed over the years to assure that all consumers receive the same level of protection and financial security. Anthem Blue Cross and Blue Shield of Connecticut believes strongly that these regulatory standards must be applied to the commercial marketplace evenly and that a level playing field be maintained. The unintended consequences of "jump-starting" a particular type of health plan through lower regulatory standards need to be considered seriously before any such action is taken.

HB5404

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THE ASSOCIATION OF CONNECTICUT
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TESTIMONY OF THE ASSOCIATION OF CONNECTICUT HMOS
before the Public Health Committee
March 10, 1998
regarding
HB 5404 AAC PROVIDER SPONSORED ORGANIZATIONS

The Association of Connecticut HMOs opposes HB 5404 and any other legislation which would authorize provider sponsored organizations to operate like HMOs without having to abide by the same statutory and regulatory requirements as HMOs.

While the Federal Government will establish financial solvency requirements for Medicare PSOs, regulation of the state commercial insurance marketplace is left to the individual states. Current law in Connecticut requires that regardless of ownership, any entity which operates as an HMO in the commercial marketplace - accepting risk through contracts with employers or other entities which provide health care coverage - must be licensed as such. In the interests of fairness and consumer protection, Connecticut must continue to license PSOs as HMOs (or "health care centers" as they are more broadly referred to in 38a-175 (9) of the General Statutes) if they accept risk in the commercial market.

A level playing field among all health plans is critical to a competitive marketplace where health plans, regardless of ownership can be singled out and compared to competitors based on quality and affordability. The ability for consumers to compare health plans was the basis of many of the provisions adopted in the Managed Care Act, P.A. 97-99. For example, the legislature mandated the creation of a consumer report card as well as various filings with the Insurance Department regarding utilization review and quality measures. The goal was to enable all health care consumers to make informed decisions in selecting their health care plans through information which is consistent and informative. It would be unfair to the health plans and confusing to the consumers if different health plans were subject to different regulatory requirements and oversight. Regulation of all health plans - HMOs and PSOs must be uniform.

PSOs, however, argue that they should be regulated under different statutes, under a different agency and with different solvency standards. This is contrary to the public interest. *If PSOs were to be regulated differently from other health care centers and HMOs, the consumers would not have the benefit of the many and various statutory*

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and regulatory protections afforded to enrollees of HMOs, including the Managed Care Act. The following is a partial list and discussion of some of those consumer protections which would be lost if PSOs were to be regulated differently:

1. **Regulation of Solvency.** HMOs and Health care centers must have an initial net worth of one million five hundred thousand dollars and continue to maintain a net worth equal to the greater of one million dollars or two percent of its annual premium revenues on the first one hundred fifty million dollars of premium revenues plus one percent of annual premium revenues in excess of one hundred fifty million dollars. PSOs argue that they should not have to meet these standards because they are owned by providers who will be providing "sweat equity". First, the PSO proposals which we have seen do not require the owners to be the providers who are delivering the care. In fact, a typical PSO may be a legal entity which is separate and distinct from the actual providers of care. PSOs can be owned by national hospital chains, physician investor groups, or other entities that deliver care almost exclusively through contracted physicians who have no ownership interest in the PSO. Second, even if the owners and providers were the same, the entity would still have the operational expenses common to any health care delivery entity – including administration, salaries of nurses and others in utilization management, rent or mortgage expense. Moreover, in many cases, hospitals and other physical assets are already being used as collateral against existing debt. Additionally, it would not be feasible for a PSO that plans to continue doing business to sell its hospital or other physical assets in order to meet a temporary shortfall.
2. **In addition to the HMOs Financial Solvency Requirements, enrollees have additional protections under the law to protect them from insolvency.**
 - a) Hold Harmless. Every contract between a health care center and a participating provider must be in writing and set forth that in the event the health care center fails to pay for health care services, the enrollee shall not be liable. No participating provider may maintain any action at law against a subscriber or enrollee to collect sums owed by the health care center. 38a-193.
 - b) Continuation of benefits. The commissioner requires that each HMO has a plan for handling insolvency which allows for continuation of benefits for the duration of the contract period for which premiums have been paid and continuation of benefits to members who are confined to inpatient facilities on the date of insolvency until their discharge. This can be accomplished in a number of ways including reinsurance, insolvency reserves and contract provisions with providers. 38a-193(d). The PSO proposals which we have seen do not contain the same level of protection for consumers.
 - c) HMOs have a premium reserve equal to the unearned portion of the gross premiums charged for covering the risks.
 - d) HMOs are subject to insurance department approval with respect to acquisition of controlling interest. 39a-129 through 140, inclusive.

e) There are requirements for replacement coverage for enrollees of an HMO which becomes insolvent. 38a-194.

3. **The Managed Care Act, P.A. 97-99.**

The Managed Care Act contains numerous provisions which impose reporting requirements on HMOs and various consumer protections including internal and external grievance procedures, utilization review notification requirements and coverage for emergency room services. The Managed Care Act was intended to

benefit all health plan consumers. Those who enroll in a health plan owned by a provider group should have those same benefits.

4. **Insurers and HMOs are subject to underwriting laws including requirement of adjusted community rating, guaranteed eligibility and guaranteed renewability, and prohibitions on preexisting condition limitations.**

a) Insurers and HMOs are subject to guaranteed issue and guaranteed renewability in the small group market (up to 50 employees). They must also use a community rate, subject to limited classifications. (Sec. 38a-564 et seq.)

b) Insurers and HMOs are prohibited from imposing preexisting condition limitations except in very limited circumstances. (Seq. 38a-476)

5. **Coverage Requirements.** Insurers and HMOs are required by statute to cover the following:

a) *Biologically based mental illness* to the same extent that they cover physical illnesses. Coverage for other mental illnesses must include the specified minimum number of hospital days, residential treatment facilities, and outpatient treatment. 38a-514.

b) In the case of mental health benefits payable for the services of a licensed physician, such benefits shall be payable for the same services when rendered by a *psychologist, clinical social worker or marital and family therapist* as provided in Section 38a-514.

c) mentally retarded or physically *handicapped* dependent children. 38a-515.

d) newborn infants. 38a-516.

e) specific additional coverages for children in the *birth-to-three program*. 38a-516a.

f) "comprehensive rehabilitation services, occupational therapy, ambulance services, services of physicians assistants and certain nurses. 38a-523 through 526.

g) Certain coverage for *mammography and breast cancer survivors*. 38a-530 and 530a.

h) Direct access to obstetrician-gynecologists. 38a-530b.

i) Treatment of *alcoholism and substance abuse*. 38a-533.

j) Treatment for diabetes.

6. **Unfair Insurance Practices.**

Insurers and HMOs are prohibited in engaging in Unfair practices as defined in Section 38a-815 et seq. Such prohibited practices include misleading advertising, restraint of trade, filing of false financial statement, unfair claim settlement practices, failure to maintain complaint handling procedures, certain forms of discrimination including discrimination based on certain disabilities, victims of domestic violence, and those who may have had genetic testing.

7. **Confidentiality.** Insurers and HMOs are subject to the Connecticut Insurance information and privacy Protection Act at 38a-975 et seq. This protects consumers from disclosure of privileged information.
8. **Health Reinsurance Association.** Insurers and HMOs participate in and contribute to the Health Reinsurance Association which covers those individuals who cannot obtain coverage elsewhere. 38a-551 et seq.
9. **Agents must be licensed.** Producers and agents who sell health insurance policies written by insurers or HMOs are licensed and regulated by the insurance department. 38a-782 et seq.
10. **Policy forms must be approved.** All policies must be approved by the Insurance Commissioner and must contain language which is readable by the consumer. 38a-295 et seq.

It is critical to the protection of the consumer, as well as to the competitive market, that the same regulations apply to all health plans – regardless of ownership. The statutes and regulations which have been established by the legislature and the Insurance Department, to govern insurers and HMOs, have been primarily intended to protect the interests of consumers. There is no good public policy reason why those same regulatory protections should not apply to PSOs who want to sell health plans to Connecticut consumers. From a consumer standpoint, there is no difference between an HMO and a PSO. Nor should there be a regulatory difference. *PSOs which accept risk in the commercial marketplace are operating as HMOs, and therefore should be licensed as HMOs.* However, the legislature could make it perfectly clear, by affirmatively stating that health care centers and HMOs include "provider sponsored organizations."

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STATE OF CONNECTICUT

Bill No.

Page 1 of 6

Referred to Committee on

Introduced by

LCO No.

General Assembly

February Session, A.D., 1998

AN ACT CONCERNING PROVIDER-SPONSORED ORGANIZATIONS

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

Section 1. Definitions. As used in this act:

- (a) "Affiliate" means an "affiliate" as defined in section 19a-659(5) of the general statutes.
- (b) "Commissioner" means the insurance commissioner.
- (c) "Department" means the department of public health.
- (d) "Licensed provider" means an institutional provider of health care licensed pursuant to the provisions of chapters 368v, or physician providers licensed pursuant to chapter 370 or 371.
- (e) "Provider-sponsored integrated health delivery network" or "network" means a combination of providers that share risk and jointly deliver, as such terms may be defined by the Secretary, the health care services for which the provider-

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sponsored organization contracts. Each network must include physician providers licensed under chapters 370 or 371, and one or more acute-care hospitals licensed by the department.

(f) "Provider-sponsored organization" or "PSO" means a legal entity organized under the laws of Connecticut that is owned, governed, controlled and managed by licensed providers or their affiliates. Connecticut-based licensed providers must own at least fifty-one percent of the PSO. The PSO shall have a board of directors whose responsibilities include oversight of the PSO, a medical director, and a quality assurance committee. A PSO may offer, directly, or indirectly through arrangements with others, health benefit plans, including but not limited to plans for persons eligible to receive benefits under titles 18 and 19 of the federal social security act or under chapter 319v.

(g) "Secretary" means the Secretary of the federal department of health and human services.

Section 2. A PSO must deliver services necessary to satisfy the requirements of a health benefit plan by contracting with a network or networks covering each geographical area in which the PSO offers benefits, but may enter into other necessary contractual relationships to provide a full range of services to the plan. With respect to the beneficiaries in a particular geographical area for which the network bears risk, such network shall directly deliver, through its providers, a substantial

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majority, as defined by the Secretary, of the health services offered by the health benefit plan.

Section 3. The commissioner shall issue licenses to PSOs seeking to deliver all or a substantial part of a range of health care services in a coordinated and cost-effective manner through a network or networks.

Section 4. A PSO eligible to apply for a license shall apply on forms prescribed by the commissioner and the department.

Section 5. In deciding whether to issue a license, the commissioner shall determine whether the applicant PSO:

(a)(1) meets the financial solvency requirements established from time to time by the secretary for provider-sponsored organizations in accordance with the provisions of section 1856(a) of the federal balanced budget act of 1997 (or, until such requirements are established, complies substantially with the factors to consider for financial solvency set forth in section 1856(a) of the federal balanced budget act of 1997); and
(2) demonstrates that it has, by itself or through contract, adequate claims processing and management information systems.

(b) demonstrates, to the satisfaction of the Department, that it shall: (1) provide reasonable assurance that it will deliver high quality and fiscally sound services, including specialty services, by itself or through a network to the enrolled population; (2) implement acceptable procedures to assure quality

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care and utilization review; (3) establish patient complaint and grievance procedures with respect to services provided by the applicant or its network(s); (4) implement appropriate credentialing and recredentialing standards for physicians and other individuals holding delineated clinical privileges that shall include but not be limited to verification of license or certification and DEA registration where appropriate, evidence of adequate professional liability insurance, agreement to comply with relevant professional codes of ethics, requisite hospital admitting privileges, review of information concerning any loss of licensure or clinical privileges, and maintenance of credentialing files; (5) terminate providers who do not meet the PSO's standards or who have been suspended or terminated by the Medicare or Medicaid program; (6) comply, where applicable, with JCAHO and NCQA accreditation standards; and (7) demonstrate that it has by itself or through contract adequate claims processing and management information systems.

Section 6. Health care centers and licensed insurers shall be subject to the jurisdiction of the department with respect to quality of care matters as defined by regulations to be issued by the department.

Section 7. PSOs and networks may enter into capitated or partially capitated contracts with employer-sponsored self-funded ERISA plans; such contracts shall not cause the PSO or

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network to be subject to additional or other regulation by the commissioner, or to affect the self-funded ERISA exemption.

Section 8. A PSO or network may contract for administrative services with any entity licensed by the insurance department as an insurer or a health care center.

Section 9. A PSO or network licensed pursuant to the provisions of this act may directly market its services or benefits to the public.

Section 10. Section 38a-193(d) of the General Statutes hereby is repealed and the following substituted in lieu thereof:

(d) The commissioner shall require that each health care center have a plan for handling insolvency which allows for continuation of benefits for the duration of the contract period for which premiums have been paid and continuation of benefits to members who are confined to inpatient facilities on the date of insolvency until their discharge or expiration of benefits. In considering such a plan, the commissioner may approve one or more of the following: (1) Insurance to cover the expenses to be paid for continued benefits after an insolvency; (2) [provisions in provider contracts that obligate the provider to provide services after the health care center's insolvency for the duration of the period for which premium payment has been made and until the enrollees' discharge from inpatient facilities; (3)] insolvency reserves; ([4]3) acceptable letters of credit; ([5]4) any other

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arrangements OTHER THAN SHIFTING THE RESPONSIBILITY TO PROVIDERS to assure that benefits are continued as specified above.

Section 11. This act shall be effective upon passage.

STATEMENT OF PURPOSE: To enable institutional and physician providers to establish provider-sponsored integrated health delivery organizations and networks and thereby assure the continued availability of quality medical care to the people of Connecticut by Connecticut provider entities.

[Proposed deletions are enclosed in brackets. Proposed additions are all capitalized or underlined where appropriate, except that when the entire text of a bill or resolution or a section thereof is new, it is not capitalized or underlined.]

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ATTACHMENT B

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DRAFT -- MARCH 4, 1998**NEGOTIATED RULEMAKING COMMITTEE ON
PSO SOLVENCY STANDARDS****Committee Statement****MARCH 5, 1998**

The Negotiated Rulemaking Committee on PSO Solvency Standards has concurred in the following recommendations, considered as a whole, on the content of an interim final rule (and its preamble) pursuant to section 1856(a) of the Social Security Act, establishing solvency standards that entities must meet to qualify as provider-sponsored organizations (PSOs) under Part C of Title XVIII of the Social Security Act. In its negotiations, the Committee took into account the factors listed in the Act. Some of these factors are explicitly mentioned in the Committee Statement. Others are implicitly reflected in the recommended provisions. For example, the ability to deliver care directly (including the concept of "sweat equity") is reflected in the provision on "subordinated liabilities" and the treatment of intangible assets, and projected losses in the financial plan may be reduced through the use of reinsurance.

INITIAL STAGE (At Application)**A. NET WORTH**

1. **Minimum net worth amount:** \$1.5 million, with HCFA discretion to lower to no less than \$1 million based on business/financial plan demonstrating that the PSO has or has available to it an administrative infrastructure that will reduce the PSO's start-up costs.

2. **Calculation--Health Care Delivery Assets:** Admit 100% of book value (GAAP depreciated value) of Health Care Delivery Assets on the balance sheet of the legal entity that applies for a waiver.

Health Care Delivery Assets = any tangible asset that is part of PSO operation, including:

Hospitals, medical facilities, and their ancillary equipment, and such property as may reasonably be required for the PSO's principal office or for such purposes as may be necessary in the transaction of the business of the PSO.

Statement on asset concentration and quality standards for Health Care Delivery Assets:

The Committee agreed that HCFA will look at SAP codification after codification is completed and will consider whether any codification standard on asset concentration or quality applicable to Health Care Delivery Assets should be applied to waived PSOs. HCFA will request public comment on whether to use and/or modify any such standard. Comments will be sought in the notice on the NAIC RBC (see below). Meanwhile, HCFA may apply judgment in evaluating Health Care Delivery Assets for concentration and quality.

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3. Calculation--intangible assets:

If at least \$1 million of the initial minimum net worth requirement is met by cash or cash equivalents, then HCFA will admit the GAAP value of intangible assets up to 20% of the minimum net worth amount required.

If less than \$1 million of the initial minimum net worth requirement is met by cash or cash equivalents or HCFA has used its discretion to reduce the initial net worth requirement below \$1.5 million, then HCFA will admit the GAAP value of intangible assets up to 10% of the minimum net worth amount required.

Deferred acquisition costs will not be admitted.

If, once the three-year waiver period ends, the PSO intends to continue to contract with Medicare, it must demonstrate, through the required financial plan (I.B.), how it will comply with State minimum net worth requirements under State standards for admitting intangible assets at the end of the three-year waiver period.

4. Calculation--other assets:

SAP treatment to be given to other assets not used in the delivery of health care for purposes of meeting the minimum net worth requirement.

B. FINANCIAL PLAN

1. Plan Content and Coverage:

At the time of application, the PSO (which has been waived under subsection xxx) [or the legal entity of which the PSO is a component,] must submit a financial plan, satisfactory to HCFA, covering the first twelve months of operation under the contract and meeting the requirements of (stated below). If the plan projects losses, the financial plan must cover the period through twelve-months beyond projected break-even.

A financial plan must include--

- (A) A detailed marketing plan;
- (B) Statements of revenue and expense on an accrual basis;
- (C) A cash flow statement;
- (D) Balance sheets;
- (E) The assumptions in support of the financial plan; and,
- (F) If applicable, availability of financial resources to meet projected losses.

2. Funding for Projected Losses:

In the financial plan, the PSO must demonstrate that it has the resources available to meet the projected losses for the entire period to break-even. Except for the use of guarantees as provided in section (a) below, letters of credit as provided in section (b) below, and other means as provided in section (c) below, the resources must be assets on the balance sheet of the PSO in a form that is either cash or will be convertible to cash in a timely manner, pursuant to the financial plan.

(a) Guarantees will be acceptable as a resource to meet projected losses, under the following conditions:

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HCFA's requirements for guarantors/guarantees are met. These requirements will be modified for PSOs by HCFA.

In the first year, the guarantor must provide the PSO with cash or cash equivalents to fund the projected losses, as follows:

- prior to the beginning of the first quarter, in the amount of the projected losses for the first two quarters;
- prior to the beginning of the second quarter, so that the PSO has cash or cash equivalents sufficient to meet projected losses through the end of the third quarter; and
- prior to the beginning of the third quarter, so that the PSO has cash or cash equivalents sufficient to meet the projected losses through the end of the fourth quarter.

If the guarantor provides the cash or cash equivalents to the PSO in a timely manner on the above schedule, this will be considered a sign of the guarantor's commitment to the PSO. In the third quarter, the PSO shall notify HCFA if the PSO intends to reduce the period of funding of projected losses. HCFA shall notify the PSO within 60 days of receiving the PSO's notice if the reduction is not acceptable.

If the above guarantee requirements are not met, HCFA may take appropriate action, such as requiring funding of projected losses through means other than a guarantee. HCFA retains discretion, however, to require other methods or timing of funding, considering factors such as the financial condition of the guarantor and the accuracy of the financial plan.

(b) An irrevocable, clean, unconditional letter of credit may be used in place of cash or cash equivalents if satisfactory to HCFA.

(c) If approved by HCFA, based on appropriate standards promulgated by HCFA, PSOs may use the following to fund projected losses for periods after the first year: lines of credit from regulated financial institutions, legally binding agreements for capital contributions, or other legally binding contracts of a similar level of reliability.

The exceptions in (a), (b) and (c) may be used in an appropriate combination or sequence.

C. LIQUIDITY

The PSO must have sufficient cash flow to meet its obligations as they become due.

In determining the ability of a PSO to meet this requirement, HCFA will consider the following:

- (a) the timeliness of payment,
- (b) the extent to which the current ratio is maintained at 1:1, or whether there is a change in the current ratio over a period of time, and
- (c) the availability of outside financial resources.

The following corresponding remedies apply:

(a) If the PSO fails to pay obligations as they become due, HCFA will require the PSO to initiate corrective action to pay all overdue obligations.

(b) HCFA may require the PSO to initiate corrective action if any of the following are evident: 1) the current ratio declines significantly; or 2) a continued downward trend in the current ratio. The corrective action may include a

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change in the distribution of assets, a reduction of liabilities or alternative arrangements to secure additional funding requirements to restore the current ratio to 1:1.

(c) If there is a change in the availability of the outside resources, HCFA will require the PSO to obtain funding from alternative financial resources.

Amount of minimum net worth requirement to be met by cash or cash equivalents:

\$750,000 cash or cash equivalents

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II. ONGOING (Starts day one of operation, like HMO Model Act.)

A. NET WORTH

1. Amount of Minimum Net Worth:

Every PSO must maintain a minimum net worth equal to the greater of:

- a) One million dollars (\$1,000,000); or
- b) Two percent (2%) of annual premium revenues as reported on the most recent annual financial statement filed with HCFA on the first \$150,000,000 of premium and one percent of annual premium on the premium in excess of \$150,000,000; or
- c) An amount equal to the sum of three months uncovered health care expenditures as reported on the most recent financial statement filed with HCFA; or
- d) An amount equal to the sum of:

Eight percent (8%) of annual health care expenditures paid on a non-capitated basis to non-affiliated providers as reported on the most recent financial statement filed with HCFA; and

Four percent (4%) of--

annual health care expenditures paid on a capitated basis to non-affiliated providers plus
annual health care expenditures paid on a non-capitated basis to affiliated providers; and

Zero percent (0%) of annual health care expenditures paid on a capitated basis to affiliated providers (regardless of downstream arrangements from the affiliated provider).

2. Preamble Statement on NAIC RBC:

The Committee discussed whether to include, among the factors considered in setting ongoing net worth requirements for PSOs, the authorized control level capital requirement derived from the NAIC Managed Care Organization Risk-Based Capital Formula. The Committee agreed that HCFA should consider adding that RBC factor to the ongoing net worth requirements after evaluating whether it is a valid indicator of PSO solvency and after considering the manner in which states have regulated managed care plans using that factor. In 1999, after PSOs have begun to operate under the waiver requirements and after they have begun reporting financial data, HCFA will issue a notice requesting comment on adding this factor to the net worth calculation for PSOs. As part of HCFA's normal data collection process for all Medicare + Choice plans, HCFA would expect to be collecting information necessary to complete the RBC calculations.

3. Calculation -- liabilities:

In calculating net worth, liabilities shall not include fully subordinated debt or subordinated liabilities. For purposes of this provision, subordinated liabilities are claims liabilities otherwise due to providers that are retained by the PSO to meet net worth requirements and are fully subordinated to all creditors.

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4. Calculation -- Assets:

Asset rules same as initial stage, except for intangible assets.

If at least the greater of \$1 million or 67% of the ongoing minimum net worth requirement is met by cash or cash equivalents, then HCFA will admit the GAAP value of intangible assets up to 20% of the minimum net worth amount required.

If less than the greater of \$1 million or 67% of the ongoing minimum net worth requirement is met by cash or cash equivalents, then HCFA will admit the GAAP value of intangible assets up to 10% of the minimum net worth amount required.

Deferred acquisition costs will not be admitted.

B. FINANCIAL PLAN

During the start-up phase, the pre-break-even financial plan requirements would apply.

After the point of break-even, the financial plan requirement would be focused on cash needs and the financing required for the next three years.

If, however, a PSO [or the legal entity of which the PSO is a component] did not earn a net operating surplus during the most recent fiscal year, the PSO must submit a financial plan, satisfactory to HCFA, meeting all of the requirements [established for the initial financial plan].

C. FINANCIAL INDICATORS

The PSO must file an Orange Blank form, modified to include supplemental information relating to Federal PSO solvency standards, according to the following schedule:

- on a quarterly basis until break-even; and
- on an annual basis after break-even, if the PSO has a net operating surplus; or
- on a quarterly or monthly basis (as specified by HCFA) after break-even, if the PSO does not have a net operating surplus.

D. LIQUIDITY

The PSO must have sufficient cash flow to meet its obligations as they become due.

In determining the ability of a PSO to meet this requirement, HCFA will consider the following:

- (a) the timeliness of payment,
- (b) the extent to which the current ratio is maintained at 1:1, or whether there is a change in the current ratio over a period of time, and
- (c) the availability of outside financial resources.

The following corresponding remedies apply:

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(a) If the PSO fails to pay obligations as they become due, HCFA will require the PSO to initiate corrective action to pay all overdue obligations.

(b) HCFA may require the PSO to initiate corrective action if any of the following are evident: 1) the current ratio declines significantly; or 2) a continued downward trend in the current ratio. The corrective action may include a change in the distribution of assets, a reduction of liabilities or alternative arrangements to secure additional funding requirements to restore the current ratio to 1:1.

(c) If there is a change in the availability of the outside resources, HCFA will require the PSO to obtain funding from alternative financial resources.

Minimum of net worth that must be in cash or cash equivalents:

The greater of--
\$750,000 cash or cash equivalents; or
40% of the minimum net worth required (determined under the greater of test for minimum net worth at the ongoing stage).

Cash or cash equivalents held to meet the net worth requirement are current assets.

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III. INSOLVENCY

A. FEDERAL BANKRUPTCY vs. STATE RECEIVERSHIP

While the Committee discussed this issue (including the implications for beneficiaries, providers, and regulators), the Committee concluded that resolution of the issue is outside the scope of its negotiations. HCFA will share information on PSOs' financial condition with relevant State regulators on an ongoing basis.

B. UNCOVERED EXPENDITURES

If at any time uncovered expenditures exceed ten percent (10%) of total health care expenditures [a PSO] shall place an uncovered expenditures insolvency deposit with HCFA, or with any organization or trustee acceptable to HCFA through which a custodial or controlled account is maintained, cash or securities that are acceptable to HCFA. Such deposit shall at all times have a fair market value in an amount of 120% of the PSO's outstanding liability for uncovered expenditures for enrollees [], including incurred but not reported claims, and shall be calculated as of the first day of the month and maintained for the remainder of the month. If a PSO is not otherwise required to file a quarterly report, it shall file a report within forty-five days of the end of the calendar quarter with information sufficient to demonstrate compliance with this section.

The deposit required under this section is . . . an admitted asset of the PSO in the determination of net worth. All income from such deposits or trust accounts shall be assets of the PSO and may be withdrawn from such deposit or account quarterly with the approval of HCFA.

A PSO that has made a deposit may withdraw that deposit or any part of the deposit if (1) a substitute deposit of cash or securities of equal amount and value is made, (2) the fair market value exceeds the amount of the required deposit, or (3) the required deposit under [section xxx] is reduced or eliminated. Deposits, substitutions or withdrawals may be made only with the prior written approval of [HCFA].

The deposit required under this section is in trust and may be used only as provided under this section. HCFA may use the deposit of an insolvent PSO for administrative costs associated with administering the deposit and payment of claims of enrollees

C. HOLD HARMLESS & CONTINUATION of COVERAGE/BENEFITS

While the Committee discussed these issues, the Committee was advised that PSOs will be subject to the same hold harmless and continuation of coverage/benefits rules as other Medicare Part C contractors, which will be published in the June 1998 Medicare Part C regulations.

D. INSOLVENCY DEPOSIT (for administrative costs)

\$100,000 held in accordance with HCFA requirements
Counts toward net worth.

E. OTHER

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Since termination of the contract is the trigger for replacement coverage in the law, there is a need for standards to have quick termination, not dependent on insolvency declaration.

IV. RURAL PROVIDERS

The Committee recognizes the unique needs of rural communities, consistent with the intent of section 1857, and requests HCFA to solicit public comment for the purposes of determining whether downward adjustments to the net worth and liquidity requirements contained in this document are appropriate for rural PSOs.

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PUBLIC HEALTH COMMITTEE PUBLIC HEARING
MARCH 10, 1998

Members of the committee, I am Dr. Jerry Hardison, practicing optometrist here in Hartford and a member of your committee's Provider Sponsored Organizations Study Group. I am here today to speak in favor of HB 5404 with some additions.

Provider sponsored organizations (PSO) are becoming increasingly more common and popular models for health care delivery basically because they allow providers to be more in control of the delivery of care. It is anticipated that with the passage of the Federal Balanced Budget Act of 1997 the PSO will become even more popular within Medicare Managed Care.

The bill as presented addresses the important issues of solvency, assets, guarantees, hold harmless clauses and grievance procedures. With regard to the provider, I am particularly pleased with the forbidding of exclusionary contracts and the requirement of standardized claims processing.

There is an attempt to insure adequate numbers and types of providers but I would urge you to be somewhat stronger and specific in the bill's intent. Unfortunately, classes of providers are in some cases being discriminated against in managed care by not being allowed to participate, receiving a lower reimbursement rate for identical services or not being allowed to practice to the fullest scope allowed by law. Some hospital provider organizations have locked out entire classes of provider groups because their board policies do not extend staff privileges to these groups. In many cases this is done in direct violation of state law or in violation of the spirit of the law. Therefore I would request you consider the following addition to this bill in the form of Section 3 (C) #17:

- ❖ Does not discriminate against a provider in plan participation, reimbursement or indemnification solely on the basis of the provider's license or certification. Hospital privileges should not be recognized as a requirement for provider participation unless the affiliated hospital has a process for extending privileges to all classes of providers.

Thank you for your time and efforts and I will be pleased to continue to provide input to the PSO study group.

Sincerely,
Jerry S. Hardison, OD
576 Farmington Avenue
Hartford, CT 06105

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