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SENATOR LeBEAU:

Thank you, Mr. President. There -- I'd like to say there's no group of people that I would like more to spend my birthday with, but that wouldn't be quite accurate. But it is --

THE CHAIR:

I think the feeling's mutual there, too.

SENATOR LeBEAU:

Honest to God, Mr. President. But there's no greater honor that I have than serving in the Senate. And there's -- there are wonderful people in this room. I just wish we could do a few more bills. Thank you, Mr. President.

THE CHAIR:

Thank you, sir. Go back -- call of the Calendar.

THE CLERK:

Calendar page 26, Calendar Number 201, File Number 176, Substitute for Senate Bill 47, AN ACT CONCERNING HEALTH CARE PROVIDER CONTRACTS, favorable report of the Committee on Insurance and Public Health. Clerk is in possession of amendments.

THE CHAIR:

Senator Crisco.

SENATOR CRISCO:

Thank you, Mr. President. Mr. President, I move for acceptance of the joint committee's favorable report and passage of the bill.

THE CHAIR:

Acting on approval and acceptance of the bill, sir, will you remark further?

SENATOR CRISCO:

Yes, Mr. President. Mr. President, the Clerk has an amendment, LCO 8506. I ask that it be called and I be given permission to summarize.

THE CHAIR:

Mr. Clerk.

THE CLERK:

LCO 8506, which will be designated Senate Amendment Schedule A. It's offered by Senator Crisco of the 17th District.

THE CHAIR:

There's a motion on the floor for summarization by the Senator. Seeing no objection, please proceed, sir.

SENATOR CRISCO:

Yes, sir. I move for adoption of the amendment.

THE CHAIR:

Motion is on the floor for adoption. Again,

seeing no objection, please proceed.

Senator Crisco is trying to bring out a bill, if you could bring the noise level down or your conversation outside, that'd be greatly appreciated.

Senator Crisco.

SENATOR CRISCO:

Thank you, Mr. President. Mr. President, before I summarize the amendment let me just state that Senate Bill 47 is the product of discussion, negotiation and compromise between legislators, physician groups and the insurance industry. And let me just add, Mr. President, and members of the circle, there are times when there is constructive criticism issued against the insurance industry, but at least it's one time when they should really deserve credit for -- willing to come to the table and try to work out differences between the industry and the providers.

Remember, we did this bill last year. This bill would enhance the product that we adopted last year. It provides some important changes to current standards in the contracting process between physicians and insurers.

Mr. President, members of the circle, basically

there may be four major items of the amendment, which is a strike all. It limits the ability of the insured to make changes to the provider fee schedule. Currently, there are no limits that exist. It allows physicians to access fees, the entire schedule for codes applicable to his or her specialty. Currently there is a limit of 50 code -- 50 co-limitation that was previously enacted. This change puts us in the top five states in regards to this access.

It provides physician access via the Internet or other electric digital format, to policies and procedures. Currently, there are no provisions in Connecticut law that requires the insurers to provide such access. It also limits the recruitment period for administrative or eligibility errors to 18 months from the date of the receipt of the clean claim. Current -- currently there are no provisions on the Connecticut insurance law that will limit overpayment recovery.

This puts Connecticut in the top nine states for its particular feature. It strengthens the fraud provision for physicians. It does not shift the burden of proof to physicians regarding fraud, and anything that changes the amount of dollars paid is

considered material.

Mr. President and members of the circle, Senate Bill 47 provides significant benefits for Connecticut physicians. This bill offers greater protection than those that -- are currently exist for physicians when contracted with health insurance. And all the participants in their working group discussion that can -- that amounted to hours of discussion should be commended. The working group was chaired by Representative Schofield and my co chair, Representative Fontana, all made significant contributions to results of something that enhances our physicians' ability to provide care.

THE CHAIR:

Thank you, sir.

Will you remark further on Senate Amendment A. Senator Caligiuri.

SENATOR CALIGIURI:

Thank you, Mr. President. If I may, I have a question or through -- through you, to Senator Crisco.

THE CHAIR:

Senator Crisco.

SENATOR CRISCO:

Thank you, Mr. President. Through you, to

Senator Caligiuri, yes.

SENATOR CALIGIURI:

Thank you, Mr. President. Thank you, Senator Crisco. The section 2 of the bill limits the ability of a contracting health organization to make changes to a fee schedule, except under these circumstances laid out in section 2. The first is annually, so at least once a year they're able to make a change to the fee schedule. After that, though, it's prohibited except under certain circumstances, as I read it.

And I guess my question, through you to Senator Crisco is, does Senator Crisco believe this offers a contracting health organization sufficient flexibility to change the pricing of a product depending on changes, for example, that they make to an offering for instances and that sort or thing? Through you, Mr. President, does Senator Crisco believe there's enough flexibility built into the section 2?

THE CHAIR:

Senator Crisco.

SENATOR CRISCO:

Mr. President, through you to Senator Caligiuri, in reference to the amendment, which is a strike all, I would say, yes. As I stated that there are certain

exemptions that exist to allow them to changes to contracts, but there has to be a 30 day notice to the physician.

THE CHAIR:

Senator Caligiuri.

SENATOR CALIGIURI:

Thank you, Mr. President. Mr. President, I read that section 2, A2 which required 30 days notice as applying only if the conditions laid out beneath that applied, which was to comply with federal or state law, to comply with changes to medical data code sets, to comply with national best practice protocols. In other words, there was a list of circumstances under with you can -- under which you can make these changes at any time provided you gave at least 30 days notice.

And when I looked at those list of circumstances I wasn't sure if it offered enough flexibility to deal with changing business situations for example. So through you, to Senator Crisco, I didn't read the amendment as permitting a change at any time as long as 30 days notice was given, under any circumstances without qualification. Am I misreading that? Through you, Mr. President to Senator Crisco.

THE CHAIR:

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Senator Crisco.

SENATOR CRISCO:

Mr. President, through you to Senator Caligiuri. Based on the working group's consensus, those five exemptions do exist in regards to limiting changes within 30 days notice.

THE CHAIR:

Senator Caligiuri.

SENATOR CALIGIURI:

Thank you, Mr. President. And I thank Senator Crisco for that response. Ultimately, I'm going to support this amendment because I believe that it represents, although not unanimity among the persons who were involved in working on this, as close to consensus as we're likely to get. And I believe a number individuals including Senator Crisco deserve credit for getting us to this point.

I have some concerns, especially in relation to section 2, about whether it provides enough flexibility to deal with real world business situations evolving over time on the ground, so to speak, but given the fact that I've heard from a number of the participants in the working group that this is something that just about everyone can live

with, I think it's probably the best product we could achieve at this time. And it -- that's why, ultimately, I'll be supporting it. So I thank you, Mr. President.

THE CHAIR:

Thank you, sir.

Will you remark further on Senate Amendment A? Senator Debicella.

SENATOR DEBICELLA:

Thank you, Mr. President. Mr. President, through you, a few questions to the proponent of the bill.

THE CHAIR:

Senator Crisco.

SENATOR CRISCO:

Yes, Mr. President. Through you, it's acceptable.

THE CHAIR:

Senator Debicella.

SENATOR DEBICELLA:

Thank you, Mr. President. I had voted no on this in committee and am reconsidering my vote at this point based on the compromise language, but just want to make sure my understanding of the bill is correct before I vote yes on -- on the amendment.

So Mr. President, following up on Senator Caligiuri, in section 2, the way I read section 2 is that the health organization gets to change their fee schedule once a year and then there's a whole list of exceptions.

My question, through you, Mr. President to Senator Crisco, is how often in reality do those exceptions come up? Are we de facto saying that health organizations can really only change their fee schedules once a year, or are the list of exceptions flexible in that they'll be able to change their fee schedule as the need arises? Through you, Mr. President.

THE CHAIR:

Senator Crisco.

SENATOR CRISCO:

Mr. President, through you to Senator Debicella, I don't consider five exceptions a whole lot of exceptions, but based on the individuals who are in the working group there was give-and-take and that's why they are exemption -- you know, exceptions to the rule. And so I wouldn't think, based on that, it's not something that occurs every week.

THE CHAIR:

Senator Debicella.

SENATOR DEBICELLA:

Thank you, Mr. President. I thank Senator Crisco for the answers to that. And Mr. President, in thinking about some of these exceptions and actually looking at what some of them are, they seem to be very event based. So they seem to be triggered by something, whether it's a drug is declared no longer safe, if there's payment or reimbursement for a new drug. But the last one in Section G, of Section 2-2-G is the one that's most intriguing to me. It is, as mutually agreed to by the contracting health organization and the provider.

So Mr. President, through you, there is kind of a, for lack of a better word, escape clause here that the fee schedule can be changed if there's agreement between the two parties. And through you, Mr. President, just wondering the thought process behind that, that the working group came up with to put that in here. Through you, Mr. President.

THE CHAIR:

Senator Crisco.

SENATOR CRISCO:

Mr. President, through you to Senator Debicella,

that is correct. You know, they're -- it's not always the glass being half empty, the glass can be half full and there could be an exception that, because of a complication that the fee could be increased for the provider.

So this gives protection on -- on both sides. So there could be a situation where some new technical improvement has been made which would reduce the amount of work by a physician. And so, perhaps the fee could be reduced on that part.

THE CHAIR:

Senator Debicella.

SENATOR DEBICELLA:

Thank you, Mr. President. I thank Senator Crisco for the answers to those questions. I too rise in support of this now with these changes having been made through this amendment.

I want to thank Senator Crisco and Senator Caligiuri for their hard work on making sure that all parties would find this acceptable. I join Senator Caligiuri in worrying a little bit that this might be too inflexible, but Mr. President, I think it is as most compromises, something that probably would not make everybody happy, which is usually a sign of a

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good compromise.

So I thank Senator Crisco for brining this forward and intend to support the amendment. Thank you.

THE CHAIR:

Thank you, sir.

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

SENATORS:

Aye.

THE CHAIR:

Opposed nays.

The ayes have it. Senate A is adopted.

Will you remark further on Senate Bill 47?

SENATOR CRISCO:

Mr. President, members of the circle, as I mentioned before, this is a hallmark of cooperation between all the constituencies that are concerned about this issue.

And once again, I have to give credit to the insurance industry from coming to the table again, as they did last year, and the physician groups, working together and our colleagues who put this product

together.

And if there is no objection, Mr. President, I ask that it be placed on the consent calendar.

THE CHAIR:

Is there any further discussion on Senate Bill 47? There's -- Senator Caligiuri.

SENATOR CALIGIURI:

There's an objection of putting it on the consent calendar, Mr. President.

THE CHAIR:

All right, sir.

We will do a roll call vote, then. Mr. Clerk please call for a roll call. The machine will be open.

THE CLERK:

Immediate roll call has been ordered in the Senate. Will all Senators please return to the chamber. Immediate roll call has been ordered in the Senate. Will all Senators please return to the chamber.

THE CHAIR:

Have all Senators voted? If all Senators have voted, please check your vote. The machine will be locked. The Clerk will call the tally.

THE CLERK:

Motion is on passage Senate Bill 47 as amended by Senate Amendment Schedule A.

Total Number Voting	36
Those voting Yea	36
Those voting Nay	0
Those absent and not voting	0

THE CHAIR:

The bill as amended passes.

Senator Looney.

SENATOR LOONEY:

Yes. Thank you, Mr. President. Mr. President if calendar page 26, Calendar 256, Senate Bill 877 might be marked passed temporarily?

THE CHAIR:

Without objection, so ordered.

SENATOR LOONEY:

All right. And Mr. President I have some more items to, excuse me, to add to the consent calendar.

THE CHAIR:

Please proceed, sir.

SENATOR LOONEY:

Yes, thank you, Mr. President. Mr. President calendar page 7, Calendar 542, Senate Bill 753. If

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Senate Bill Number 995 as amended by Senate "A" in

concurrence with the Senate.

Total Number Voting	144
Necessary for Passage	73
Those voting Yea	141
Those voting Nay	3
Those absent and not voting	7

DEPUTY SPEAKER McCLUSKEY:

The Bill passes in concurrence with the Senate.

Will the Clerk please call Calendar Number 711.

THE CLERK:

On Page 25, Calendar Number 711, Substitute for Senate Bill Number 47 AN ACT CONCERNING HEALTH CARE PROVIDER CONTRACTS. Favorable Report of the Committee on Public Health.

DEPUTY SPEAKER McCLUSKEY:

The honorable Chair of the Insurance Committee, Representative Fontana, you have the floor, sir.

REP. FONTANA (87th):

Thank you, Mr. Speaker. Mr. Speaker I move for acceptance of the Joint Committee's Favorable Report and passage of the Bill in concurrence with the Senate.

DEPUTY SPEAKER McCLUSKEY:

The question before the Chamber is acceptance of the Joint Committee's Favorable Report and passage of the Bill in concurrence with the Senate. Will you remark, sir?

REP. FONTANA (87th):

Yes, Mr. Speaker. Thank you very much. Mr. Speaker, this Bill has come before us as a result of a painstaking process of negotiation, compromise and discussion that the Insurance Committee and several of its Members have undertaken over the past several months.

As many in the Chamber know, there's been for a number of years, bills put in to try to address so-called provider contract issues, that is, issues between healthcare providers and managed care organizations, health insurers, health plans and so forth.

Mr. Speaker, as I indicated earlier in the day, our goal on the Committee this year, on a bipartisan basis, and I have to thank Representative D'Amelio for this, was to try to address some of the intractable issues and try to cut through them and make progress this year, and I'm pleased to say that I stand before

you right now to bring forward this Bill, which begins to make progress in addressing some of these issues.

Before I do, I'd like to thank people. I will seek to thank them at the end of my comments, but I'd like to thank them initially. I'd like to thank first, Representative Linda Schofield for her many hours of effort that she put in, working with the stakeholder group.

I'd like to thank Senator Crisco for his support and collaboration as well.

I'd like to thank Representative Merrill for her leadership.

Mr. Speaker, we started the Session identifying two fairly discreet initiatives that we wanted to try to address this year as it relates to provider contracts.

One so-called unilateral changes in the part of contracts between health insurers and the providers, and so-called claw back provisions dealing with insurance companies, health plans, so forth, clawing back monies that they may have paid doctors for care provided, but for whatever reason reevaluating.

And so with that, we identified those two initial objectives and then after we voted this Bill out of

Committee, we created a stakeholder process with the health insurers, the medical providers, and thankfully, Representative Schofield volunteered for this effort, to lead this group and try to forge a consensus.

And thankfully, she did a great job in doing three things. First, she expanded access to providers for information about their fee schedules from health plans.

She focused again on limiting the changes in the fee schedules to once per year with a few exceptions.

And she prohibited the plan from recouping paid claims more than 18 months back with some limited exceptions.

So she wrote a very tight bill, again, forged consensus with these providers, and health insurers.

And with that, Mr. Speaker, I would like to ask the Clerk to call Amendment LCO Number 8506. I ask that he call and I receive permission to summarize.

DEPUTY SPEAKER McCLUSKEY:

The Clerk please call LCO Number 8506 previously designated Senate Amendment Schedule "A".

THE CLERK:

LCO Number 8506, Senate "A", offered by Senator Crisco, Representatives Fontana and Schofield.

DEPUTY SPEAKER McCLUSKEY:

The gentleman has asked leave of the Chamber to summarize Senate Amendment Schedule "A"? Is there objection? Is there objection? If not, sir, summarize Senate "A".

REP. FONTANA (87th):

Thank you, Mr. Speaker. This Amendment strikes the underlying Bill and replaces the provisions with revised and expanded versions of those provisions.

As I indicated, Mr. Speaker, it focuses in its language on accomplishing the three objectives, expanding access of providers to information about their fee schedules, limiting the changes to fee schedules to once per year with a few exceptions and prohibiting plans from recouping paid claims more than 18 months afterwards.

Mr. Speaker, again, this makes significant progress but it doesn't finish our work. I would like to alert the Chamber that I intend to work with Representative Schofield and the stakeholders and any other interested parties next year to revisit the issues that we left unaddressed this year by this

language and to do so in the manner that builds on the process that we've established this year, working with all the stakeholders, the insurers and health plans and their community, as well as all of the medical professions and healthcare providers, and any others interested in, available stakeholders.

And I will be personally involved in this process, and I look forward to working again with Senator Crisco and any others, Representative Schofield, who would care to work on this but I believe we have some other issues left to be addressed.

With that, Mr. Speaker, I will move for the Amendment's adoption.

DEPUTY SPEAKER McCLUSKEY:

The question before the Chamber is adoption of Senate "A". Will you remark on Senate "A"? Will you remark? The Ranking Member of the Insurance Committee, Representative D'Amelio, you have the floor, sir.

REP. D'AMELIO (71st):

Thank you, Mr. Speaker. I also rise in support of the Amendment that's before us. Believe it or not, this was a work in progress right up until the very

last minute before it was called. There's a lot of hard work that went into this legislation. It is an important first step in bringing, I believe, the healthcare providers, patients, and the insurance companies together on billing procedures and other contract provisions.

I am also willing to work with Representative Fontana in the next Session to continue this work, because this issue, although this Bill I believe goes very far, there needs to be a continued dialogue to make sure that all parties are okay with it.

So I urge adoption. Thank you, Mr. Speaker.

DEPUTY SPEAKER McCLUSKEY:

Thank you, sir, for your remarks. Will you remark further on Senate "A"? Will you remark further on Senate "A"? If not, I'll try your minds.

All those in favor of Senate "A" please signify by saying aye.

REPRESENTATIVES:

Aye.

DEPUTY SPEAKER McCLUSKEY:

All those opposed, Nay. The Ayes have it. Senate "A" is adopted.

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Will you remark further on the Bill as amended? Will you remark further on the Bill as amended? If not, will staff and guests please come to the Well of the House. Will Members please take your seats. The machine will be opened.

THE CLERK:

The House of Representatives is voting by Roll Call. Members to the Chamber.

The House is taking a Roll Call Vote. Members to the Chamber, please.

DEPUTY SPEAKER McCLUSKEY:

Have all the Members voted? Have all the Members voted? Will the Members please check board to determine if your vote has been properly cast.

If all Members have voted, the machine will be locked. Will the Clerk please take and announce the tally.

THE CLERK:

Senate Bill Number 47 as amended by Senate "A" in concurrence with the Senate.

Total Number Voting	148
Necessary for Passage	75
Those voting Yea	148
Those voting Nay	0

Those absent and not voting 3

DEPUTY SPEAKER McCLUSKEY:

The Bill passes in concurrence with the Senate.

DEPUTY SPEAKER GODFREY:

Representative Olson.

REP. OLSON (46th):

Good evening, Mr. Speaker. I move for suspension of the rules for the immediate consideration of Calendar Number 718. Thank you, Mr. Speaker.

DEPUTY SPEAKER GODFREY:

The question's on suspending the rules to take up Calendar Number 718. Is there objection? Hearing none, Mr. Clerk, please call Calendar Number 718.

THE CLERK:

On Page 26, Calendar Number 718, Senate Bill Number 586 AN ACT CONCERNING A COLLINSVILLE HYDROELECTRIC FACILITY. Favorable Report of the Committee on Energy and Technology.

DEPUTY SPEAKER GODFREY:

The distinguished Chairman of the Energy and Technology Committee, Representative Nardello.

REP. NARDELLO (89th):

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I do have a personal interest in it as well. Although I'm really not in that business anymore, I'm one of the lucky ones who actually found a job. But I do help raise quite a bit of money for the school through our charities and fund raisers and it's difficult. And that's what brought me to this idea. It wasn't necessarily how can I get rid of my personal inventory, like what am I going to do, how am I going to raise this money this year to help out the school so --

SENATOR CALIGIURI: Well, thank you. And I guess I would just say that, you know, you say you had an interest in it, but the whole idea of enlightened self interest is where everybody walks away a winner, and it sounds like the whole purpose behind this is to create a scenario where everybody involved can walk away a winner. And so I thank you for taking your time to testify. And I thank you, Mr. Chairman, for your indulgence.

REP. FONTANA: You're welcome, Senator.

Any other questions?

Seeing none pat, thank you. Thanks for your input.

That concludes testimony on House Bill 5984. We'll now proceed to Senate Bill 299, and we have no one signed up to testify on Senate Bill 299. So unless there is someone, we'll proceed to Senate Bill 47 and Susan Halpin.

SUSAN HALPIN: Good afternoon, Representative Fontana, members of the committee. My name is Susan Halpin and I'm here on behalf of the Connecticut Association of Health Plans to testify in opposition to Senate Bill 47, An

Act Concerning Health Care Provider Contracts. This is an issue that's been before this committee several times in the past. With respect to the requirements around the fee schedules, and we together worked on legislation Public Act 06-178 that required disclosure of fee information by health insurers. You have my written testimony and are probably well aware of the issues that we came to agreement on regarding release of the reimbursement amounts for the top 50 procedure codes performed. We understand that this process is being used fairly consistently with no reported problems.

If past history is any indication, we believe the real intent of Senate Bill 47 is to codify portions of the legal settlements that several of the large health insurers entered into on a national basis with medical societies across the country, the Connecticut State Medical Society being one of the most active and vocal organizations in that process and such settlement policies apply to all the practicing physicians, including eye physicians and dermatologists. While it is true that the settlements address some of the components that are under consideration in this legislation, it is not true that the agreements were identical across the board. They do differ in application and definition and timetable for phase-in purposes. The reason that the benefit -- the reason that -- the benefit of national settlements for both providers and insurers is precisely the fact that they are national. It's enormously difficult and expensive for all parties involved to develop claim systems and contracting standards that are specific to one state, and if Connecticut were to pass legislation that was -- I'm sorry, I'm only

halfway through, but I'll try to summarize -- would deviate from these negotiated agreements it would be extraordinarily expensive. We look forward to the opportunity to continue a conversation with you on the issue. There was a part of one of the former pieces of legislation that passed that called for a continuing dialogue on this issue. We welcome that and would love to continue those discussions.

So, thank you for your time I know the hour is late and we appreciate you hearing from us once again on this issue.

REP. FONTANA: Thank you, Sue.

And just correct me if I'm wrong, you said that you thought that this bill would codify the national settlement?

SUSAN HALPIN: Yes.

REP. FONTANA: But then if it codifies it, it wouldn't deviate from it, would it?

SUSAN HALPIN: Well, each settlement is a little bit different in its nature and timetable. And I think the settlements have been kind of living breathing documents that had the ability to change and morph over time, you know, with conversations from either party, putting something in the statute around that, we have fairly I think presents significant problems.

REP. FONTANA: I hear you, but you and I have been discussing this now for how many years?

SUSAN HALPIN: Several years.

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REP. FONTANA: And my guess is this bill is here because some provider or some insurer somewhere isn't actually even doing those national agreements you were talking about. So it sounds like we've got work to do here.

SUSAN HALPIN: We'd be happy to continue our conversations with you, Mr. Chairman.

REP. FONTANA: Thank you.

SUSAN HALPIN: Thank you.

REP. FONTANA: Questions for Sue.

Representative Megna.

REP. MEGNA: Sue, just to remind me again the process with the contract and the providers what power is there with the providers now in establishing that contract or parts of the contract or --

SUSAN HALPIN: Sure. Providers and health plans operate in different ways. Providers group together in organizations called IPAs, Independent Practice Associations that allow them to essentially collectively negotiate with health plans. In fact, the Connecticut State Medical Society has one of the largest IPAs in the state and they negotiate at the block with health plans. You can't negotiate kind of on a onesi twosi because that's antitrust. They have to share some kind of business operations and many of them do. There's a lot of large organizations out there, but there are health plans that still negotiate with independent practitioners. And in terms of unilateral contract changes, one of the reasons why health plans attain the ability to do unilateral contract change is

precisely for that reason. If they had to go out and renegotiate 8,000, 6,000, you know, contracts and give, you know, whatever 30 days notice for them to terminate from the contract, you wouldn't know who was in or out of the network at any given time. It would be very difficult for your members to say, okay, I'm going to go to Dr. Megna's office, well, Dr. Megna hasn't completed, you know, his -- hasn't signed the form to stay in the network, so who's in the network, who's out of the network, are those claims covered because he was a participating provider at what level are they covered. It presents all kinds of logistical problems which is one of the concerns that we have with it.

REP. MEGNA: Thank you.

Thank you, Mr. Chairman.

REP. FONTANA: Thank you, Sue, and I'm sure we'll be talking again shortly.

SUSAN HALPIN: I look forward to it, Mr. Chairman.

REP. FONTANA: Matt Katz followed by Joe Angel, if Joe is here.

MATTHEW KATZ: Representative Fontana and the remaining members of the Insurance and Real Estate Committee, thank you for allowing me to speak to you again today. My name is Matthew Katz and on behalf of the more than 7,000 physician members of the Connecticut State Medical Society, thank you for the opportunity to voice our strong support of Senate Bill 47, An Act Concerning Health Care Provider Contracts.

As you've heard previously and discussed,

we've been before you before on this issue. We're asking you again for greater transparency and a reduction in the administrative burden not only placed on physicians but also on patients. This bill, as currently drafted, really addresses three major provisions I'd like to discuss with you today. It prevents the unilateral changes of contracts. Again, when changes in contracts are done by health insurers without physician notices, patients may be billed incorrectly, inappropriately, untimely, further delaying the payment but also causing great confusion and expense. It prevents down coding or reduces the level of coding services and procedures, which I'll get to in a minute, which limits the ability for real time claim processing adjudication and payment and it limits retrospective audit time periods to 90 days.

In the 2006 general session the General Assembly did pass legislation that became effective last year on transparency in fee schedule information, primarily payment specifics for individual codes and procedures. Unfortunately health plans still down code, adjust, reassign and deny payment in order for -- in an ability to an attempt to prevent physicians from further understanding what in fact they are going to get paid and how they are going to get payment as well as preventing them from billing the patient appropriately. This bill prevents that. Physicians are required to follow CPT, the American Medical Association current procedural terminology. This is the book of more than 7,000 codes. Physicians bill it on a daily basis for everything they do for a patient, every service and procedure that they do they appropriately code for using this process.

We're asking for a codification of that within the Connecticut statute to ensure that health insurers also adhere to that guideline that codes guidelines and conventions that physicians must follow to ensure that there is a level playing field and allow patients to understand what's being billed, when it's being billed, how it's being billed, and what they're responsible to pay for. It's also that health -- it's critically important that health insurers recognize that when they pay, they pay the appropriate amount the first time. Unfortunately they don't often do that and they go back years, if not decades, looking for payment.

We're asking for a 90-day provision to allow them to go back if they've made a mistake. We think anything beyond that though is excessive and abusive and creates problems not only for the physician's practice because of costs and administrative burden but also for the patient because often time when the patient gets for those services if it's determined not to be medically necessary or if there's a problem associated with the coding of those services.

So we ask today that you follow the lead of the Workers Comp Commission in this state and pass legislation that allows physicians to understand what is appropriately coded and billed, patients to understand and health insurers to appropriately pay for those services. Thank you very much.

REP. FONTANA: Thank you, Matt. Well, we'll keep talking. I was just thinking the last point you mentioned about the 90 days, you know, and that is a valid one, but the legislation talks about how it can't be more than 90 days after

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a clean claim is filed. I could see very easily if this legislation passed, there would never be a clean claim, would there?

MATTHEW KATZ: That's why it's so critically important that the first component of this legislation talking about down coding and bundling be adopted as well. It prohibits the health plan from saying the claim isn't clean as a result and changing those codes that a physician submits based upon the services they provide. So you're essentially insuring an adequate clean claim if the physician bills correctly the first time which we believe they do most of the time and then requires them to pay within that period, and if they've made a mistake the state law does have a timelines provision, if they've made a mistake they can then go back and correct it.

We think that that's appropriate. We think the time frame needs to be consistent and appropriate with other standards out there in the business and allow the physician to appropriate then bill the patient. What ends up happening is if the health plan changes that payment the physician would then then have to go back and adjust the payment that they request from the patient, whether that's more or less it's an undue burden for the both the patient and the physician's office. And we're happy to of course continue the dialogue.

REP. FONTANA: Great, thank you.

Questions?

Representative Megna.

REP. MEGNA: Just one question, Matt, following up

on the questions I asked about the contract process from Sue. When you have a large group of providers that come to this agreement and reach the contract, you mean to tell me they just -- they can just alter the terms that are agreed to at any point in that contract?

MATTHEW KATZ: First, if I might Representative, 80 percent of physicians in the State of Connecticut practice in small groups, 60 percent are solo. So when you're talking about large groups, you're talking about a very small percentage of the physicians who practice in Connecticut. We are not like Maine and in fact most of the New England states. We still have that solo practicing physician in the small towns. In fact, one will be testifying later on this very bill. So there is no ability for a large group -- there are abilities for a large group that do not reflect the physician practice in Connecticut. That being said, the large groups are still provided with a contract that based upon the contractual language allows the health insurer to unilaterally and arbitrarily change the contract, and the physician practice, no matter how big, prevents them from the ability to negotiate that or terminate that as a result of those changes in the contract.

The other issue is that often times notice is not provided giving those changes unless it's a quote unquote material change in the contract. The problem becomes who determines what's a material change. If you ask a physician's practice when it comes to what is or what isn't accurate when it comes to what they should be coding, how they should be coding what's covered under those contracts, you know, everything is material. If you ask

the health plan nothing is material until they tell you it's material. So I think the problem is the language allows the health insurers the out to not give notice or give limited notice and there is no ability to negotiate or walk away from the physician's standpoint and there is every ability of the health insurer to walk away whenever they deem fit.

REP. MEGNA: So the language of the contract allows them to more or less change --

MATTHEW KATZ: Or the lack of language in the contract. At times when it's silent it also creates a problem and a barrier for physicians because then still no notice is provided because the insurers refer to the contract and ask where in the contract does it require that they provide that kind of notice or that ability to renegotiate.

REP. MEGNA: So it sounds like doctors or providers don't have the bargaining power that I'm thinking they do through the group?

MATTHEW KATZ: Again, there aren't that many groups in the State of Connecticut and you're talking about a handful with more than 50 physicians and not many more with more than 20. Most our groups are four or less, so they don't have that ability. It is an issue of scale, it is an issue of what's called menops, any power of the health insurers. We have what's called a concentrated market of insurance in the State of Connecticut by something called the HHI, which is an economic index that looks at how competitive or lack thereof a market is. Do we have a market that does not have competition from the standpoint of allowing a physician to effectively negotiate with the

health insurer.

REP. MEGNA: Okay, thank you.

Thank you, Mr. Chairman, for the time.

REP. FONTANA: You're welcome.

Other questions from members of the committee?

Seeing none, thank you, Matt.

MATTHEW KATZ: Thank you very much, Mr. Chairman.

REP. FONTANA: You're welcome. Joe Angel, is Joe Angel here? Joe Angel followed by Dr. Steven Thornquist, if he's back.

JOSEPH ANGEL: Good afternoon, Chairman Fontana and distinguished members of the insurance committee, I am Joseph Angel, the legislative chair of the Connecticut Association of Ambulatory Surgery Centers and administrator of an Ambulatory Surgery Center in Fairfield County. I'm here today to speak on SB 47, Senate Bill 47, An Act Concerning Health Care Provider Contracts.

In the fall we participated in a public health committee working group to look at the issue of site of service differentials. More and more insurance companies across the country are turning to what they call site of service differentials as a primarily mechanism for reducing their overall reimbursement rates to providers.

Following the committee meeting, the cochairs of the working group suggested that this issue could be addressed for the standards in contracting legislation. Conceptually HMOs

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and insurers use site of service differentials as a way to shift health care away from more expensive settings and more expensive procedures to settings and procedures that they deem to be less expensive. Typically providers who perform their procedures in their offices or outside of facilities are rewarded with a bonus payment or a higher percentage reimbursement while reimbursement rates are cut for those medical personnel who continue to utilize hospitals or surgery centers. While there is no doubt that reducing costs for patients is very important, doctors, but unfortunately not many insurance companies, understand that medical decisions must always be based on best medical practices. Recent developments in non facility based endoscopies are a prime example of how site of service differentials can lead to inappropriate medical outcomes.

A few years ago the Connecticut General Assembly recognized patient safety concerns and appropriately acted to ensure that procedures requiring more extensive anesthesia must be done in safe and appropriate environments and no longer in the physician's office. As part of this effort, Connecticut established detailed regulations improving patient safety by eliminating unregulated unlicensed surgical centers and also requiring surgery centers in hospitals to contract with patient safety organizations. Unfortunately insurers are now using this legislation to penalize providers for complying with state statute and providing care in the hospital or surgery center.

In some cases insurers have actually recognized the benefit of supporting utilization of surgical centers as the most

effective way to provide patients with high quality care outside of the traditional hospital settings. However, in other situations insurers have lumped surgical centers in with hospitals and have proposed cuts in reimbursement rates as a way to limit patient access to care in these appropriate settings. A few years ago Anthem Blue Cross Blue Shield proposed a site of service payment system for selected procedures only to reverse itself after discussions with medical leadership in the state. A similar scenario occurred in Massachusetts.

REP. FONTANA: Joe, thank you. Thank you. So essentially you're just seeing this ongoing problem, I guess?

JOSEPH ANGEL: Yes, that's true.

REP. FONTANA: And it's not getting resolved?

JOSEPH ANGEL: No, but we believe it's part of the overall reform of contracting that this bill is about.

REP. FONTANA: Well, questions from members of the committee?

Seeing none, thank you, Joe, for coming. Thanks for your testimony.

Is Dr. Thornquist here? Dr. Thornquist followed by Christine Cappiello.

SB47

STEVEN THORNQUIST: Thank you, Mr. Chairman, good evening and -- actually I guess it is evening, isn't it -- and other distinguished members of the committee, my name is Steven Thornquist. I'm a pediatric ophthalmologist. I'm here representing 700 physicians of the eye, ENT

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and skin specialties to testify on the needs for standard and health care contracting and in support of SB 47.

First, I'd like to thank you all, the chairs and this committee for, once again, bringing a significant issue to a public hearing. Many of you recall our testimony every year since 2000. We thank you for the act, it was referenced earlier, that required partial fee disclosure in 2006, and act 775 which established a much needed definition of medical necessity for 2009. And while we are grateful for these improvements, physicians are still having to sign take-it-or-leave-it contracts that provide no fee guarantees, partial and inadequate fee schedules, which is an absolute necessity for sound business decisions and reduced payments from unjustified bundling of services. Physicians still have no bargaining power and antitrust laws restrict physicians from collectively negotiating. The need for standards and contracting legislation between physicians and the managed care industry is now far beyond critical, it is code blue.

I cannot imagine that anyone in this room thinks that the health care delivery system is better off than it was eight years ago. Many of my colleagues and patients question where the money in health care is going. Physician payments have remained flat or decreased and, as you've just heard, so have facility payments, while premiums experience double digit inflation and co-pays go through the ceiling. Consumers also read that insurance companies are paying outrageous compensation packages to CEOs and administrators and are making record profits.

We need to bring back a balance of power to the health care system by providing some badly needed protections to abused health care providers. It is time to make the insurance industry accountable to the consumer through increased transparency. Let consumers decide which carrier makes the best use of their health care premiums. It is our hope that this committee consider the transparency issue and some basic standards and contracting language. Number one, to provide a payment methodology and full fee disclosure. Number two, to provide the medical directors name for appeal purposes. Number three, to prevent unilateral changes to the health care contract once a physician has signed a contract. Number four, to allow the physician to discuss the fees and negotiate the terms of the contract. Number five, to prevent the automatic down coding of claims and ensure fair payment for services rendered and prevent bundling of the services and to limit carrier take backs. Texas, by the way, has a limit of 95 days on carrier take backs and they've been functioning just fine. The insurers have not left the state. We would urge that you include a Worker's Comp carve out because that's a separate system and should not be covered by this sort of contracting issues and that would also leave the state out of any liability financially for a system that was passed.

I would like to reference officially a series of resources that were supposed to be provided, I'm not sure if they got scanned in, but they provided a number of independent definitions of a lot of the terms like bundling that we keep referring to. Thank you and I'll answer any questions if you have any.

REP. FONTANA: Doctor, I don't know if that material was disseminated so please just check with the clerk.

STEVEN THORNQUIST: I will make sure, yes.

REP. FONTANA: And you mentioned Texas and that's interesting because that would be something I'd be curious to see if you got resources that talk about --

STEVEN THORNQUIST: It's actually in here.

REP. FONTANA: Well then, let's make sure that we got that, if we didn't get it, all right. Good. Thank you, Doctor, and we'll look forward to reading that material.

Questions from members of the committee?

Seeing none, thank you, Doctor. We'll look forward to reading that material.

STEVEN THORNQUIST: Thank you.

REP. FONTANA: Christine Cappiello.

CHRISTINE CAPPIELLO: Good evening, Representative Fontana, Senator Caligiuri, Representative Megna and Representative Wright, for the record, my name is Christine Cappiello, and I'm a director of government relations for Anthem Blue Cross Blue Shield. I'm here to speak against Senate Bill 47, An Act Concerning Health Care Provider Contracts.

We strongly oppose this legislation because while we realize the goal of the bill is to establish a set of standards for health insurance plans and the providers that we contract with, this bill has numerous and

financially crippling problems in the implementation of that goal. I think you've heard some of them before, and in the interest of time I won't go through those again, but Anthem is one of those companies that generally contracts with individual providers. We have about 5,000 physicians and about 12,000 ancillary providers. And so if we were in a situation where if we needed to make a change to the contract, and that could be a number of things. There could be Medicare sends down some change that requires us to change the contract or for some other reason, we would have to get signatures from 5,000 physicians and 12,000 ancillary providers. And I think Susan alluded to the fact that that would really put the consumer in the middle of this, not knowing whether their doctor is in the network or out of the network because they haven't signed the contract, they were chasing the contract.

We have under the lawsuits that occurred in let's see, we settled ours in 2005. The multi-district lawsuits that were filed by many of the physicians across the country with the health plans all across the country we have to give 90 days notice if we make a change to the contract. So there is plenty of time. Within that time we can have a conversation with the provider about what their issue might be. And one of the reasons I know that people feel like we maybe shove things down their throats, if you will, but we need to have as many providers in our network as possible. When people come to us for health insurance, one of the things is selling points because we're certainly not the cheapest health plan is our large provider network. So we need to have a lot of doctors in our network and so it behooves us to make

sure that the contract is signed with the provider and that we have them in there, so I think that's an important point to make.

Also on the coding issue, that's certainly a large issue for us. We process about 6 million claims a year at Blue Cross and there are times when they come in improperly coded for various reasons, sometimes it's simple mistakes and sometimes it's things that are in my testimony like the unbundling of global fees. And we realized a couple of years back I think that we had about $22 million of money that would have been spent on claims had we not been able to look at those claims and correct them or send them back for mistakes or for unbundling, particularly the unbundling.

So I think that those things are worth pointing out and so again we are opposed to Senate Bill 47. I can answer any questions that you might have hopefully.

REP. FONTANA: I have too many or not enough.

CHRISTINE CAPPIELLO: Oh, no.

REP. FONTANA: No, I think, Christine, that this is getting into the weeds a lot about how you guys do your business and it's always been that way. And all I can say is we never resolved it and maybe this is the year to get it done.

CHRISTINE CAPPIELLO: That's true, there's been attempts, yes, we passed legislation three years ago about fee schedules or disclosing fee schedules and --

REP. FONTANA: Claims and bundling and down coding, and you and I are both tired, I think, of this

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so this year it needs to end, I think.

Questions?

Senator Caligiuri has a quick question.

SENATOR CALIGIURI: Christine, did you say that as to part one of this provision about prohibiting unilateral changes really doesn't apply because you already give your docs 90 days notice?

CHRISTINE CAPPIELLO: No, it would -- I mean, are you saying if it passed?

SENATOR CALIGIURI: Are you saying it's not necessary because you're already giving your docs 90 days?

CHRISTINE CAPPIELLO: Yes, it's not necessary, correct, correct.

SENATOR CALIGIURI: And when you were talking about your claims and needing to go back, were you referring to section 2 or section 3 of the bill? Because section 2 talks about reducing a level of service coded without conducting an investigation?

CHRISTINE CAPPIELLO: Yes.

SENATOR CALIGIURI: And 3 talks about, you know, kind of going back and denying something more than 90 days after a claim has been filed.

CHRISTINE CAPPIELLO: We're talking about the down coding without having a medical investigation.

SENATOR CALIGIURI: And that's number 2?

CHRISTINE CAPPIELLO: Yes.

SENATOR CALIGIURI: But is the idea of just requiring that an investigation take place, which is what this would do, isn't that functionally already probably what you're doing before you do the down coding?

CHRISTINE CAPPIELLO: Not necessarily because an investigation assumes we would have to ask for medical records. So there is lots of times when a doctor may -- when they sign a contract with us they agree to a global rate. The best one is -- example is for rhinoplasty for surgery for nose surgery, there is a global fee for that and they have agreed to it. And within that is a couple of codes. It's the operating room, it's the doctor, it's the anesthesiologist, they are all on this one global rate. What ends up happening is when a claim is unbundled, they take this -- instead of billing with this one global rate let's just pick a number, you know, $5,000, they take all the codes that make that up and they send them in individually and they may be $20,000. And so our system sees that and says no, no, this surgery should be a global rate and it bundles them. So it isn't anything that's necessarily done, it's all automated. A doctor can then appeal it in which case we ask for medical records which can take a lot of time. Meanwhile the claim is pended and we have to chase the medical records, and then there can be an investigation so much of it is automated.

SENATOR CALIGIURI: I appreciate that. And not having had the benefit that the chairman has had of being in the weeds as many years as he has --

CHRISTINE CAPPIELLO: He's heard that. You've

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heard the rhinoplasty --

SENATOR CALIGIURI: I'll talk to you off line because this is not as quick as I know the Chair would have preferred. But thank you very much, Christine.

Thank you, Mr. Chairman.

REP. FONTANA: Thanks. Thank you, Christine. We'll look forward to talk to you more about this.

That finishes Senate Bill 47.

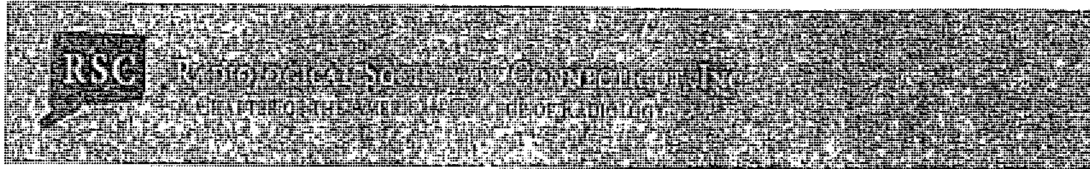
We'll move on to the last bill, House Bill 5172, and we've got Gretchen Viver followed by Patti Shea.

GRETCHEN VIVER: I'm back.

REP. FONTANA: Welcome, Gretchen, please proceed.

GRETCHEN VIVER: Oh, thanks. So good evening to all of you. I'm not quite sure why I stayed this long. Am I passionate, stubborn or whatever? Actually there is some language in HB 5172 that's one of my pet peeves that talks about affordable health insurance. And since there isn't very much language in this bill, and we don't know exactly what it means, I just felt a very strong need to be on record even though it was the last bill up.

Affordable health insurance does not guarantee affordable health care and, as a matter of fact, it often does not. If you don't pay very much for a premium, if you have high out-of-pocket costs, there are often things that are not covered or that people just won't access because it's not affordable. What I



Statement of the
Radiological Society of Connecticut
before the
Insurance and Real Estate Committee
in support of SB 46 and SB 47
February 5, 2009

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Sen. Crisco, Rep. Fontana and members of the committee:

My name is Linda Kowalski. I am executive director of the Radiological Society of Connecticut, which is comprised of Medical Doctors who engage in the practice of radiology. The Society would like to offer comments on two bills before you today.

Senate Bill 46, AAC Transparency in Medical Loss Ratio Information

RSC believes this legislation will provide valuable information to consumers about the financial status of health insurers and managed care plans. Specifically, it will require that reports list the amount of medical claims that have been paid by the policy issuer compared to the revenue received from premiums and other income. This "medical loss ratio" will be a valuable piece of information for consumers to have in deciding whether or not they want to do business with a given company.

Senate Bill 47, AAC Health Care Provider Contracts

RSC also strongly supports SB 47. This legislation will "level the playing field" when it comes to medical provider relationships with managed care organizations and insurers. It would prohibit such organizations from unilaterally changing terms of an agreement in areas such as fee schedules, provider panels and negotiating rights. These are very reasonable limits on unilateral action and we would urge the committee to approve them. Importantly, it would establish a 90 day "lookback" period on recouping payments for services that were duly authorized, delivered and paid for.

In conclusion, Connecticut's radiologists are dedicated professionals who play a major role in ensuring that patients benefit from state-of-the-art radiological and imaging services. They are asking that you create a higher degree of fairness to the administrative process that exists with their payors. Both SB 46 and SB 47 do this.

Thank you for considering our position on this legislation. We look forward to working with you on these important issues during the 2009 session.

RICHARD BLUMENTHAL
ATTORNEY GENERAL

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Office of The Attorney General
State of Connecticut

TESTIMONY OF
ATTORNEY GENERAL RICHARD BLUMENTHAL
BEFORE THE INSURANCE AND REAL ESTATE COMMITTEE
FEBRUARY 5, 2009

I appreciate the opportunity to support Senate Bill 47, An Act Concerning Health Care Provider Contracts.

This proposal prohibits a number of unfair provisions in any contract between health insurers and health care providers: unilateral health insurer changes in fee schedules or provider panels, limitations in negotiability of contract terms, delays in payment exceeding 90 days and reductions in payment amounts for particular coded services.

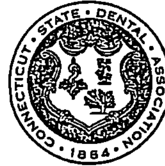
Managed care organizations are large, multi-million dollar corporations, often with hundreds of thousands of enrollees. Health care providers are generally individual practitioners or small group practices. This imbalance in economic power has impacted contracts between providers and HMO's, with provisions that could reduce the quality of health care provided to patients. The interests of the patients are vitally affected.

Senate Bill 47 will address some of the more onerous, unfair provisions commonly found in insurer/health care provider contracts -- unilateral changes in compensation and other key provisions and arbitrary decisions to recode the health care provider services reducing insurer payments.

I urge the committee to consider extending the prohibition on unilateral changes in contracts to all material aspects of such contracts. A contract should not allow insurers to substantially alter any material term unilaterally.

At some point soon, there needs to be consideration of revision in our antitrust laws to address this bargaining power imbalance. The current bar to joint bargaining by providers puts them -- and potentially their patients -- at a severe disadvantage. Our legislature can change state antitrust laws, but the U.S. Congress must address this issue in federal antitrust statutes.

I urge the committee's favorable consideration of Senate Bill 47 with the suggested amendment.



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Legislative Testimony
SB 47 An Act Concerning Health Care Provider Contracts
Committee on Insurance and Real Estate
February 5th, 2009
Dr. Stephanie A. Urillo DDS
Vice-President, Connecticut State Dental Association

Good afternoon Senator Crisco, Representative Fontana, and members of the Committee on Insurance and Real Estate. I am Dr. Stephanie Urillo, Vice-President of the Connecticut State Dental Association. I thank you for the opportunity to provide written testimony to you today on this bill.

I would like to first applaud the introduction of this bill as I feel it is long overdue. Very often in my own practice I have had insurance codes reduced or changed despite the language that was in a contract. Because of this I have had to fight for my patients to get them the benefits that are rightly their due. I have asked these insurance evaluators, who are not dentists and do not provide oral health care, if they would like to fly my patient and me to their office for an explanation as to why, despite a contract, procedures have been changed to the procedure originally billed.

Additionally, the Connecticut State Dental Association has instituted a lawsuit against Anthem Blue Cross alleging that Anthem arbitrarily changed the procedure for which they use to reimburse for procedures. This was done without notifying participating dentists, and while also changing the method with which this was done. For instance, instead of reimbursing at the 90th percentile, Anthem changed this to the UCR (usual and customary fee). As a result, participating dentists did not receive the entire benefit to which they were entitled, and could not balance-bill. For participating dentists the reimbursement is sent directly to the dentists' office. For non-participating dentists, the patient receives the check directly. This results, oftentimes, in the patient simply keeping the check and the dentist having to spend time and money in recovering it.

Again, the dentist has much better ways to spend his/her time, as well as that of their staff. All benefit checks, regardless of provider participation, should be sent to the provider, unless the patient requests that the benefits be sent directly to him/her, as per previous arrangement. Such procedures would streamline an office's ability to provide patient care, which is what our profession is all about!

Thank-you for allowing me the opportunity to provide testimony for this bill. One party should absolutely not be able to arbitrarily change, erase, modify or delete provisions of a contract unilaterally. I am in favor of this bill and would request that the committee support it.

Stephanie A. Urillo, DDS
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February 5, 2009

Statement
Of
Anthem Blue Cross and Blue Shield
On
SB 47 An Act Concerning Health Care Provider Contracts

Good afternoon Senator Crisco, Representative Fontana and members of the Insurance Committee, my name is Christine Cappiello and I am the Director of Government Relations for Anthem Blue Cross and Blue Shield. I am here today to against **SB 47 An Act Concerning Health Care Provider Contracts.**

We are strongly opposed to SB 47 because while we realize the goal of the bill is to establish a set of standards for health insurance plans and the providers that they contract with, this bill has numerous and financially crippling problems in the implementation of that goal. Coupled with the fact that this legislation will do nothing to help the consumer and will only raise the cost of their premium.

To begin, requiring us to obtain a signature for any change to the contract between ourselves and the provider is completely unrealistic. There are changes that are made to the contract that we have no control over, things like changes in Medicare methodology, etc. Currently, our contracts allow us to make changes to the contract with a 90 days written notice to the provider. With thousands of providers – we have over 5000 physician providers and 12,000 ancillary providers - it is not practical to require signatures from both parties to make changes to the contract.

To continue, requiring us to perform an investigation on claims that are improperly coded will cripple our claims processing system and again raise costs substantially. The concept of properly coding health insurance claims is not about patient care or denial of care, it is about payment for services already provided. At Anthem Blue Cross and Blue Shield we process over 6 million claims a year. Some of those claims come to Anthem improperly coded for a variety of reasons and first receiving approval would cripple the system, which

In Connecticut: Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans, Inc.
In Maine: Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans of Maine, Inc.
In New Hampshire: Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans of N
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pays many of those claims in less than 30 days. We have worked hard to get our claims processing to a place where providers are paid quickly and efficiently, this section would remove that efficiency by requiring us to perform an investigation on improperly coded claims. As I said earlier, the concept of properly coding health insurance claims is ***not about*** patient care or denial of care, it is about payment for services already provided. Allow me to take a moment to speak about the process that takes place with coding health insurance claims.

Doctors' submit claims to us once the service has been performed on the patient. Doctors' bill with codes that are located in the CPT code book. The CPT codebook is a nationally recognized book that is put out by the American Medical Association. The codes are based on procedures. There are codes for single procedures and codes for a combination of procedures. When a combination of services take place, doctors are supposed to use the codes for the combination procedures; however, occasionally this does not take place and single codes are used in order to get a higher payment. When that occurs, we correctly code the claim and send payment that reflects that change.

This section would not allow us to properly check codes and subsequently will increase the cost of health care. In recent years, we realized $22 million dollars attributed to improperly coded procedures. This certainly is a significant amount of money in an area that finds it facing pressure to provide more coverage while keeping costs to a minimum.

SB 47 will severely impact our ability to provide the highest quality of service to our members and we strongly urge the Committee to defeat this legislation.

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Legislative Testimony
SB 47 AN ACT CONCERNING HEALTH CARE PROVIDER CONTRACTS
Committee on Insurance and Real Estate, Thursday, February 5, 2009
Bruce Tandy D.M.D.
President-Elect, CT State Dental Association

Good afternoon. My name is Bruce Tandy. I am a practicing dentist in Vernon and Coventry and currently serve as President-Elect of the Connecticut State Dental Association (CSDA). The CSDA represents 83% of the dentists in our state. As a private practitioner, I support SB47.

First, I commend the legislatures' efforts to find solutions to the lack of standards in and the failure to abide by contracts between insurers and health care providers, health care centers, hospital or medical service corporations or other organizations providing health care to the residents of this state. In 30 years of practice, I have signed contracts with a limited number of insurance companies. The provisions were followed initially but over time, as costs escalated, the companies failed to increase fees according to the provisions of the contract, changed coding of treatment to less expensive procedures, bundled fees, and continually failed to live up to the signed agreements. A practitioner such as me had little recourse in these circumstances as my patients were of primary concern and had become part of my dental family. They, too, were constantly frustrated by changes in their agreements that they were unaware of and which limited their access to the care they needed. We must learn from these past and present experiences. This bill may finally provide an equitable result for all concerned. A contract is just that, a contract and the failure to abide by it becomes a legal issue which as a small businessman, would be difficult to pursue. We have already seen judgments against these practices in New York where the Attorney General ruled that United Healthcare had violated its contracts. Passage of this bill may make things more equitable for all involved and a large, costly lawsuit unnecessary.

I respectfully request your favorable vote on this bill.

Respectfully Submitted.

Bruce Tandy, D.M.D.

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Statement in support of Proposed Bill 47 –

An Act Concerning Health Care Provider Contracts

Insurance & Real Estate Committee
February 5, 2009

This statement is being submitted on behalf of the nearly 700 Connecticut Family Physician members in support of Proposed Bill 47.

As physicians we are committed to providing the highest quality healthcare to our patients. Unfortunately, caring for our patients no longer just requires a physician's time to address health concerns. Instead, we must negotiate contracts with MCO's, multibillion-dollar companies that have dozens of contract attorneys on their side. In contrast, we are usually small practices, sometimes solo physicians who need to hire an attorney, but usually attempt to negotiate these contracts ourselves. Some physicians utilize their local Physician-Hospital Organization (PHO) or Independent Practice Associations (IPA) to negotiate for them. Unfortunately, some of these organizations are not experienced enough to negotiate on their own or simply do not have enough resources to negotiate. Finally, not only do we have to negotiate contracts we must also sort through through restrictive drug formularies, hire extra staff to resubmit "denied or downcoded" claims, and we must be businessmen before we can even begin to doctor.

Of course the days of simple fee for service billing are gone. We are not sure that we would like to go back. Unfortunately the current environment fosters animosity between the companies that have the money and the doctors who want to get fair reimbursement for their service. As usual the patient is caught in the middle.

In the past few years Medicine has asked for and unfortunately did not receive any relief from professional liability premiums. As a consequence our overhead increases steadily without any increase in income or reimbursement. The only way to make up for this loss is to increase patient volume or increase the ordering of tests or procedures. This ultimately raises the cost of health care. The final winners: the MCO's with record profits. The losers, initially physicians and finally the patients of Connecticut.

The MCO's executives have told us that if we don't like the contracts then we should simply not sign them. Given that most if not all of our patients are covered by an MCO through their employer, we have no choice but to sign such agreements. In addition, the strong market hold of the MCO combined with antitrust laws that prohibit physicians from negotiating together leave us powerless.

These contracts usually allow for unilateral contract changes on the MCO's part, do not give the financial information that is needed to determine the amount of reimbursement, and allow for the downcoding and bundling of claims, and other unfair practices.

Current anti-trust laws that prevent physicians from entering into "cooperative agreements" must be changed. Such agreements would allow physicians to join together in order to provide health care services, negotiate pricing, share patients, personnel, support services, laboratory facilities and/or procedures. As a result physicians would be able to improve quality of care, help to contain costs, and improve access to health care especially in rural areas. The only way to combat unfair contract provisions and negotiate with an MCO is through the

formation of a cooperative health care arrangement. Without changes to current antitrust laws, MCOs will be able to continue dictating the terms and conditions they offer physicians

We must level the playing field between physicians and MCOs in order to guarantee that our patients are able to receive the health care they deserve. We hope to be able to work together with this Committee in order to bring fairness in contracting between Managed Care Organizations and physicians.

For more information, please call:

Craig Czarsty, MD, Legislative Chair

Mark Schuman, Executive Vice President

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Testimony of Joseph Engel

On behalf of the Connecticut Association of Ambulatory Surgery Centers

on

On Senate Bill 47, An ct Concerning Health Provider Contracts

Before the Insurance Committee

February 5, 2009

Good afternoon, Representative Fontana, Senator Crisco and distinguished members of the Insurance Committee. I am Joe Engel, the Legislative chair of the CT Association of Ambulatory Surgery Centers and an administrator of an ambulatory surgery center in Fairfield County. I am here today to speak on SB 47, **Senate Bill 47, An Act Concerning Health Provider Contracts.**

In the fall, we participated in a Public Health Committee working group to look at the issue of Site of Service Differentials. More and more insurance companies across the country are turning to what they call *Site of Service Differentials* as a primary mechanism for reducing their overall reimbursement rates to providers. Following the committee meeting, the co-chairs of the working group suggested that this issue could be addressed through Standards in Contracting legislation.

Conceptually HMOs and insurers use *site of service differentials* as a way to shift health care away from more expensive settings (and more expensive procedures) to settings and procedures that they deem to be less expensive. Typically, providers who perform their procedures in their offices (or outside of hospitals) are rewarded with a bonus payment or higher percentage reimbursement, while reimbursement rates are cut for those medical personnel who continue to utilize hospitals or surgery centers.

While there is not doubt that reducing costs for patients is very important, doctors – but unfortunately not many insurance companies - understand that medical decisions must always be based on best medical practices. The recent developments in "non-Hospital based endoscopies" are a prime example of how site of service differentials can lead to inappropriate medical outcomes.

A few years ago, the Connecticut General Assembly recognized patient safety concerns and appropriately acted to ensure that procedures requiring more extensive anesthesia must be done in safe and appropriate environments and no longer in the physician office. As part of this effort, Connecticut established detailed regulations improving patient safety by eliminating unregulated, unlicensed surgical settings and also requiring surgery centers and hospitals to contract with patient safety organizations. Unfortunately, insurers are now using this legislation to penalize providers for complying with state statute and providing care in the hospital or surgery center.

In some cases, insurers have actually recognized the benefit of supporting the utilization of surgical centers as the most effective way to provide patients with high quality care outside of the traditional hospital settings. However, in other situations, insurers have lumped surgical centers in with hospitals and have proposed cuts in reimbursement rates as a way to limit patient access to care in these appropriate settings.

A few years ago Anthem Blue Cross / Blue Shield proposed a site of service payment system for selected procedures only to reverse itself after discussions with medical leadership in the state. A similar scenario occurred in Massachusetts.

More recently, Oxford/United announced a new policy that reimburses physicians at a much lower level when they provide ambulatory surgical procedures in a setting now required by CT law rather other than their office. Of course, this new policy flies in the face of the recent legislative patient safety mandate and actually incentivizes physicians to violate the patient safety legislation and punishes physicians for following Connecticut law.

I don't know if any of you have had a colonoscopy before, but today it can be done very comfortably under anesthesia and with better outcomes. Oxford believes it should be done in the physician office with light sedation and this policy reflects that position. That is no longer the standard of care and in the interest of patient safety; Oxford should not be allowed to establish this kind of policy.

Our Association has met with state officials on these developments. We have explained that the Oxford policy has put physicians in an untenable situation. We have further explained the value of Connecticut's recent steps to ensure that patient safety be the main focus of care and that there is an obligation on insurers to provide appropriate reimbursement rates to support that goal.

It is our hope that by passing standards in contracting legislation as proposed in SB 47, we will prevent insurers from arbitrarily changing contractual provisions and inappropriately reducing payments. Thank you for the opportunity to speak here today and I would be happy to answer any questions you might have.

Quality is Our Bottom Line

Connecticut Association of Health Plans

Insurance Committee Public Hearing
February 5, 2009

Testimony in Opposition to
SB 47 AAC Health Care Provider Contracts.

The Connecticut Association of Health Plans respectfully urges the Committee's opposition to SB 47 AAC Health Care Provider Contracts.

With respect to the requirements around fee schedules, legislation is already in effect regarding this matter - PA 06-178 AA Requiring the Disclosure of Fee Information by Health Insurers. Health plans have implemented the provisions of the Act which represented a compromise on the "standards in contracts" issue. As such, each organization is now required to make available upon the request of any contracted physician, the reimbursement amounts for the top 50 procedure codes performed. Based on information we've received from one of our largest plans, the new process is being used fairly consistently with no reported problems.

If past history is any indication, the real intent of SB 47 is to codify portions of the legal settlements that several of the large health insurers have entered into on a national basis with medical societies from across the country - the Connecticut State Medical Society being one the most active and vocal organizations in the discussions. Such settlement policies apply to all practicing physicians including eye physicians and dermatologists.

While it is true that the settlements address some of the components under consideration, it is not true that the agreements are identical across the board. They differ by health plan in application, definition and timetable for phase-in purposes. Each health plan spent untold months and millions of dollars negotiating these settlements as they relate to their own specific business models and bargained with the medical societies in what they believed was "good faith" on both sides to address provider concerns.

The benefit of national settlements - for both insurers and providers - is precisely the fact that they're national. It is enormously difficult and expensive for all parties involved to develop claims systems and contracting standards specific to one state. The costs would be exorbitant if Connecticut were to pass legislation that deviates from the negotiated agreements. Consider our testimony from year's past:

Health plans contract with providers in a variety of ways. Many plans enter into agreements with large physician groups called IPA's and/or PHO's. These are very sophisticated business

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entities that often employ staff, legal counsel and consultants to negotiate on the behalf of their providers. The market power that these entities bring to bear is significant and should not be discounted. Increased fees, dissolution of prior authorization requirements, coding and reporting standards have all been bargained at the table. With respect to the language in SB 47 which allows providers to discuss and negotiate terms of the contract, these are the appropriate entities within which to have such conversations. To do otherwise, outside the umbrella of these entities, constitutes antitrust.

As for unilateral contract changes, some health plans still contract with independent practitioners. At least one plan in Connecticut contracts with over 8,000 independent providers in the state. Contracts entered into by these practitioners are generally referred to as "evergreen contracts" meaning that once the contract is signed, it is in effect until one of the parties decides to terminate. Under such contracts, health plans typically reserve the right to change the terms unilaterally in order to maintain the integrity of the network and avoid re-contracting with thousands of providers over and over again. If health plans have to seek provider approval before instituting any change in contract, as provided for under similar proposals, it will be difficult to determine which providers are in or out of the network at any given time and the result will be chaos.

The negotiated settlements take into account these various distinctions in plan design.

The segment of the bill related to coding seeks to prohibit health plans from using software systems designed to catch fraudulent billing. Such systems rely on statistically valid programs based upon the AMA's own coding standards and are recognized by CMS, most state departments of insurance and Medicaid and are important quality assurance mechanisms. To deviate in any way from the very individual, complex and painstakingly developed coding protocols determined in the legal settlements is to open up Connecticut insurers to costly and potentially fraudulent provider billing practices. This is true as well for section (3) of the bill which limits to 90 days the time under which an insurer can repeal or rescind an authorization even when there may be circumstances which warrant such action such as a loss of eligibility during the time of service or even fraud.

All of these distinctions are no small matters.

PA 06-178 also requires that the Insurance Committee convene periodic meetings of physicians and managed care organizations to discuss issues relative to contracting, including those related to any national settlement agreements, as permitted. Health plans maintain their commitment to continuing the dialogue around these issues and would welcome the opportunity to continue such discussions in this context.

We respectfully submit that many of the elements of the bill before you today are already addressed in current statute and that the true intent of the legislation under consideration is strongly ill-advised and should be rejected.

Thank you, as always, for your consideration.

Testimony of the Connecticut Society of Eye Physicians
The Connecticut Ear, Nose and Throat Physician Society, and the Connecticut Dermatology And Dermatologic Surgery Society
On
SB 47 AN ACT CONCERNING STANDARDS IN CONTRACTS BETWEEN HEALTH INSURERS AND PHYSICIANS
Given to the Insurance and Real Estate Committee
by Steven Thornquist, M.D.

February 5, 2009

Good afternoon, Chairman Crisco, Chairman Fontana, and distinguished members of the Insurance Committee. For the record my name is Dr. Steven Thornquist. I am here representing over 700 physicians in the Eye, ENT, and Skin specialties to testify on the need for Standards in Contracting and in support of SB 47. First I would like to thank the chairs and this committee for once again bringing this significant issue to public hearing. Many of you may recall our testimony every year since 2000. We thank you for that required partial fee disclosure in 2006 and Act 07-75 which established a much needed definition of medical necessity for 2009. While we are grateful for these improvements, physicians are still having to sign "take it or leave it" contracts that provide no fee guarantees, partial and inadequate fee schedules (an absolute necessity for making sound business decisions), and reduced payments from the unjustified bundling of services. Physicians still have no bargaining power, and anti-trust laws restrict physicians from collectively negotiating. The need for Standards in Contracting legislation between physicians and the managed care industry is now beyond critical; it is code blue.

I can not imagine that there is anyone in this room that thinks the healthcare delivery system is better off than it was eight years ago. Many of my colleagues and patients question where the money in healthcare is going. Physician payments have remained flat or decreased, while premiums experience double digit inflation and co-pays go through the ceiling. Consumers also read that insurance companies are paying outrageous compensation packages to their CEOs and administrators, and are making record profits.

We need to bring back a balance of power in the healthcare system by providing some badly needed protections to abused healthcare providers. It is time to make the insurance industry accountable to the consumer through increased transparency. Let consumers decide which carrier makes the best use of their healthcare premiums. It is our hope that this committee consider the transparency issue and some basic "Standards in Contracting" language:

1. Provide Payment Methodology and full fee schedule. This is desperately needed to make sound business decisions and for reference when the industry takes back payments they claim were erroneously made to the healthcare provider – sometimes three years after.
2. Provide the Medical Director's name for appeal purposes.

3. Prevent unilateral changes to a healthcare contract once a physician has signed the contract.
4. Allow the physician to discuss the fees and negotiate the terms of the contract.
5. Prevent the automatic down-coding of claims and insure fair payment for services rendered and prevent bundling of services which are not bundled in CPT Guidelines. The industry has historically tried to pay for one service when a physician has done two separate and billable services if they are performed on the same day. This is what we refer to as the bundling of services. The industry also sometimes automatically reduces the level of service performed by a physician without reviewing records. By adopting this clause it will improve both the quality and efficiency of healthcare. Concerns over inappropriate services and over-billing (both actually very rare) can be handled through quality assurance and practice patterns, just as they are now.
6. Limit carrier "Take Back" of reimbursements to 90 days after a clean claim is filed.

Some insurers have denied doing any of these things. If that is so, then they will not be affected by this legislation. Please give us the tools to address those that do. It is also difficult to comprehend that these large companies with legions of actuaries, accountants and analysts cannot what most other operations to: develop a contract they can live with for the contract period – typically only one year. Furthermore, it is impossible to ignore that while physicians, employers and patients are being squeezed by big insurance companies, they are shamelessly reaping record profits and some executives enjoy compensation packages most of us consider outrageous.

We ask for your support for this legislation that requires contracts that prohibit unilateral changes, the bundling and down-coding of services, limits the take back period on MCO administrative errors to 90 days and requires full fee disclosure to healthcare providers..Thank you and I will be happy to answer any questions from the committee

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Legislative Testimony
SB 47 AAC Health Care Provider Contracts
Committee on Insurance and Real Estate, Thursday, February 5, 2009
Jonathan Knapp, D.M.D.
President, CT State Dental Association

My name is Dr. Jonathan Knapp. I am a privately practicing dentist in Bethel and currently serve as the President of the Connecticut State Dental Association. Please accept this as my written testimony urging your support for Raised Bill SB47, An Act Concerning Health Care Provider Contracts.

I commend the committee for bringing this important legislation forward and recognize the significance of its goal. If one only reads the title, this legislation looks like it might simply benefit health care providers with measures to improve a business matter, and it definitely accomplishes that aim. However the issues at stake here run far deeper and much broader than what appears in the bill's title.

The reforms that would be mandated by this bill are long overdue here in Connecticut. As a matter of background, the practices of bundling (grouping multiple procedures together in order to pay a lesser benefit), and downcoding (reducing the benefit on a procedure to that of a lower cost alternative - regardless of what is most appropriate) have been going on in Connecticut for years. Until almost 8 years ago, dentists had never made any significant headway in changing these practices. In 2001, two Connecticut dentists, Dr. Martin Rutt and Dr. Michael Egan, filed a lawsuit against Anthem Blue Cross/Blue Shield of Connecticut.

This lawsuit addressed the inequity created when carriers make unilateral changes, and these unfair alterations are incorporated into their business practices, without the consent of the contracted providers or the patients covered by the plans. It is a case that parallels very closely the intent of this legislation. Unfortunately, due to some legal maneuverings, the lawsuit has been stuck in the federal court system and has not yet been heard.

This bill is also very much in harmony with the actions of Attorney General Cuomo in our sister state of New York against the problematic practices of United Healthcare. From the New York Attorney General's website:

"For the past ten years, American patients have suffered from unfair reimbursements for critical medical services due to a conflict-ridden system that has been owned, operated, and manipulated by the health insurance industry. This agreement marks the end of that flawed system," said Attorney General Cuomo. "As working families throughout our nation struggle with the burden of health care costs, we will make sure that health insurers keep their promise to pay their fair share. The industry reforms that we announce today will bring crucial accuracy, transparency, and independence to a broken system. During these tough economic times, this agreement will keep hundreds of millions of dollars in the pockets of over one hundred million Americans."

The underlying common thread between SB47 and the two mentioned cases is that they ultimately are all efforts to support consumer rights. If providers are subject to unilateral changes in contract arrangements with no avenue for recourse, fewer will participate in these plans, or patients will pay more out of pocket, which in turn will limit consumer's access to participating providers and/or end up costing them more.

For these reasons I urge you to vote in favor and move this bill out of committee, and I urge ultimate passage of this very good piece of legislation.

Respectfully submitted,
Jonathan B. Knapp D.M.D.

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Connecticut State Medical Society

Testimony Presented to the Insurance and Real Estate Committee on

Senate Bill 47 An Act Concerning Health Care Provider Contracts

February 5, 2009

Senator Crisco, Representative Fontana and Members of the Insurance and Real Estate Committee, my name is Matthew Katz, and I am the Executive Vice President of the Connecticut State Medical Society (CSMS). On behalf of our more than 7,000 members, thank you for the opportunity to testify before you today in support of **Senate Bill 47 An Act Concerning Health Care Provider Contracts.**

CSMS and many of our state medical specialty societies have been before this Committee for a number of years asking for the establishment of certain standards in contracts between physicians and managed care companies. We are here again today with the same request.

The bill as currently drafted has three major provisions. It (1) prevents unilateral changes to contracts, (2) prevents "downcoding" or reductions on the level of coded services and (3) limits retrospective audit time periods to ninety days.

In 2006 session, the General Assembly passed legislation to require beginning this last October basic disclosure of certain fees schedule information to physicians by health insurers. This was a great first step and physicians today now have access to fee schedule information. However, many more standards need to be enacted to require fair and just contracting between physicians and insurers. In fact, physicians may have the published, standardized or personalized fees that are posted or otherwise provided by health insurers, but they still do not know what they are getting paid and patients do not know how much they are responsible to pay for the care they receive.

The reason that confusion still persists despite having access to the fee schedule is that health plans continue to adjust physician coding of the actual services provided and bundle payments when more than one medical service or procedure has been provided by the physician. Despite the fact that physicians must and do comply with the codes, guidelines and conventions as clearly presented in the American Medical Association Current Procedural Terminology (CPT) code book when recording and reporting the provision of medical procedures and services, health insurers often ignore these standards.

It is critical that health insurers play by the same set of rules and standards that physicians must follow and that health insurers do not unilaterally or arbitrarily (or inappropriately) reduce the level of service or decrease payment when multiple medically necessary services or procedures are provided. CSMS believes that correct coding methodologies, such as adherence to CPT codes, guidelines and conventions control for improper coding that could lead to inappropriate payment associated with the provision of medical procedures and services. In fact, The Centers for Medicare and Medicaid Services (CMS) developed its coding policies based on coding conventions defined in the AMA's CPT book, in addition to certain national and local policies and related code edits, as well as certain coding guidelines developed by national medical society societies. CMS also evaluated standard medical and surgical practices and performed a review of current coding practices. We believe that there needs to be standardization and adherence to CPT if physicians are to accurately report the medical procedures and services they provide to patients and health plans are to appropriately reimburse.

In addition to code editing and bundling, health insurers also continue to fail to provide physicians with the methodology or justification for fee reductions. This same data is often used in the in-network setting to determine rates for physicians and payments by patients. There must be greater transparency in the data used by health insurers and the methodology employed by health insurers in determining the plan and patient responsibility for paying for the medical care provided. Patients should not be paying more than their share.

CSMS believes that standards in contracting that includes transparent information to both physicians and patients will go a long way in addressing the problems that presently exist for physicians and patients when it comes to health insurer payments.

Nationally, most major health insurers have already consented to these fairness standards during a long and complex lawsuit lead by Connecticut physicians. In fact, recently most of the nation's Blue Cross Blue Shield plans agreed to these standards in contracting. We ask that several of those agreed to provisions be enacted into state law to protect every physician and insured. We also call on these health insurers who have settled with Connecticut and the nation's physicians to stand with us and behind these agreements and their business practice standards that better allow for physicians to practice medicine and patients to receive medical care.

On standard include in all settlements is a limitation on the timeframe for retrospective audits, while all insurers who have entered into national settlement have agreed to varying lengths of recover time, there is no statute to limit such audits. Therefore, it is possible that insurer can seek to extract information, records, documentation and even repayment years after a service was provide. This often places an administrative burden on physicians that cannot be met.

So before you today is also legislation to establish standards in contracts between physicians and Managed Care Organizations. We ask that several of those agreed to provisions from the settlements be enacted into state law to protect every physician and insured. Connecticut physicians ask that the proposed language be amended to comprehensively include the following:

Disclosure of complete fee information to physicians showing applicable fee amounts as well as a disclosure of methodologies used to establish fee levels prior to acceptance of a contract.

Prohibit changes to a fee schedule during a contract period

Prohibit contractual changes during the contract period of non-fee related issues without the written approval of the physician

Require each plan to establish an independent external review process to address physician contract issues and disputes similar to one already in place to address patient issues and disputes.

Require each plan to prove compliance with the bill by submitting an independently conducted annual audit to the Department of Insurance.

Prohibit the contracting health organization to reduce the level of service coded on a claim submitted by a physician without conducting a reasonable investigation based on all available medical records pertaining to the claim and adherence to CPT codes, guidelines and conventions

These issues were developed through years of legal battles and legislative debate, and have been included in the settlements of national class action lawsuits between doctors all over the country many of the nation's largest managed care companies. The settlements will eventually expire, and many state residents obtain coverage from companies not involved in the national settlements. By incorporating these provisions in Connecticut Statutes, they will serve doctors and their patient's forever- making sure that physicians, medical doctors, are making medical decisions.

We ask the Connecticut General Assembly to support and pass legislation to affirm the rights of physicians and define the role of managed care companies for playing by a set of fair and balanced rules when contracting for medical services for patients. We must protect the patient and standardize how health plans contract with physicians in order to level the playing field and provide greater transparency and simplicity to how, what and who is paying for medical care and at what level of payment.

Thank you for the opportunity to present this testimony to you today. Please support Senate Bill 47.

Connecticut Business & Industry Association

TESTIMONY OF
ERIC GEORGE
CONNECTICUT BUSINESS & INDUSTRY ASSOCIATION
BEFORE THE
INSURANCE AND REAL ESTATE COMMITTEE
LEGISLATIVE OFFICE BUILDING
FEBRUARY 3, 2009

My name is Eric George and I am Associate Counsel for the Connecticut Business & Industry Association (CBIA). CBIA represents approximately 10,000 businesses throughout Connecticut, the vast majority of which are small companies employing fewer than 50 people.

I am here to register CBIA's concerns over SB 47, **AN ACT CONCERNING HEALTH CARE PROVIDER CONTRACTS.** As drafted, SB 47 advances the interests of health care practitioners at the cost of health care patients and consumers. This would have implications for both workers' compensation costs and health care costs.

SB 47 dictates contract provisions in the contracts between practitioners and health insurers, including prohibitions against unilateral contracts. SB 47 advances the interests of one independent contracting party in the health care system over another as it dictates the provisions that must be excluded from contracts between health plans and health care providers. SB 47 creates a situation where state statute usurps the will of private parties in determining contract terms and provisions, inappropriately intruding into the health care system.

It would be inappropriate for the state to weigh-in on the side of health providers in setting the terms of provider/plan contracts, particularly in light of their recent economic history. Data indicates that health care providers are already calling the shots in contract negotiations with health plans. In a January 2004 Issue Brief published by The Center for Studying Health System Change, the authors make these observations about health care providers negotiating power:

> A number of forces converged in the late 1990's to give certain providers . . . significant bargaining leverage over health plans. By 2000, many providers were pushing plans for large payment rate increases and more favorable contract terms . . . to recover ground previously lost to health plans . . . Providers' negotiating success emboldened other providers to push back . . . In 2002-03, . . . plans

> accommodated providers' demands to avoid the negative consequences of bitter and protracted disputes. The lull in showdowns reflects, in part, a *growing recognition by plans that the balance of power now clearly favors providers* [emphasis added].

Providers are not in need of state protection to further advance their leverage in contracts with health care plans.

Thank you for considering my remarks and concerns with **SB 47.**

Statement

Insurance Association of Connecticut

Insurance and Real Estate Committee

February 5, 2009

SB 47, An Act Concerning Health Care Provider Contracts

The Insurance Association of Connecticut opposes SB 47, An Act Concerning Health Care Provider Contracts.

Overall, Workers' Compensation rates have decreased over 50 per cent in the standard market since 1993. Connecticut's employers have benefited from these cost changes. Lower business costs mean a greater ability to compete in their respective marketplaces. The use of managed care plans has been one reason why Workers' Compensation costs have decreased, by helping to control the cost of medical services provided for work-related injuries.

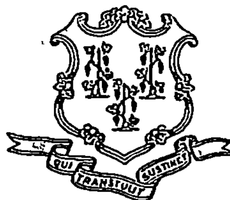
SB 47 seeks to statutorily restrict terms of contracts to be negotiated between freely contracting parties, and as such is contrary to the basic principle of freedom of contract. If a physician does not like a contractual arrangement, then the physician is free not to agree to it. If the physician doesn't like the terms of the arrangement after working under it, then the provider can terminate his or her relationship under the terms of that contract.

SB 47 would also require unspecified "investigations" before a coded service level on a claim could be reduced. Unfortunately, upcoding (charging for a level of service higher than that which was actually performed) by health care providers is an issue in Workers' Compensation. If entities are prevented from efficiently and effectively detecting overcharges due to such "investigation" standards, Workers' Compensation costs would be increased unnecessarily.

Legislation similar to SB 47 has been previously rejected by the General Assembly. Once again, the IAC urges rejection of SB 47.

SENATOR MARTIN M. LOONEY
MAJORITY LEADER

Eleventh District
New Haven & Hamden



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299, 47, 46

February 5, 2009

SB 457

Good Morning Senator Crisco, Representative Fontana and members of the Insurance and Real Estate Committee. I am here to testify in support of three bills that are on the agenda this afternoon: S. B. No. 299 AN ACT EXPANDING HEALTH INSURANCE COVERAGE FOR ROUTINE PATIENT CARE COSTS FOR CLINICAL TRIAL PATIENTS, S. B. No. 47 AN ACT CONCERNING HEALTH CARE PROVIDER CONTRACTS, and S. B. No. 46 AN ACT CONCERNING TRANSPARENCY OF MEDICAL LOSS RATIO INFORMATION

SB 299, AN ACT EXPANDING HEALTH INSURANCE COVERAGE FOR ROUTINE PATIENT CARE COSTS FOR CLINICAL TRIAL PATIENTS, would expand coverage of routine patient care costs for clinical trial patients to clinical trials for serious or life threatening diseases and ensure that third party payers retain their responsibility to patients. In 2001 the Connecticut General Assembly passed PA 01-171 which required insurers to sustain their responsibility to

Under President Clinton, Medicare made this common sense change to cover routine patient care costs for clinical trial patients. I believe that the Connecticut General Assembly should make this same change.

I would also like to express my support for SB No. 47 AN ACT CONCERNING HEALTH CARE PROVIDER CONTRACTS. This bill would address the need to prohibit insurance companies from making unilateral changes to contracts and the need to require insurance companies to disclose the full Current Procedural Technology (CPT) fee schedule disclosure. These represent important and necessary changes to our insurance statutes.

Last week I testified in support of and suggest some modifications to S.B. 457, AN ACT CONCERNING CONSUMER REPORT CARDS. I would like to offer similar comments in regard to SB 46, An Act Concerning Transparency of Medical Loss Ratio Information.

Transparency is always the best tool for educated decision making. Currently the MCOs must report medical loss ratio to the Insurance Department; the Department should include this information on its Consumer Report Card as would be required under SB 457. I believe that MCOs should also be required to report their Medical Loss Ratios to any employer or individual who is attempting

301

HB5093 SB299 SB638
SB46 HB6277 HB5172
SB47

Testimony of Kevin Lembo, State Healthcare Advocate
Before the Insurance and Real Estate Committee
In Support of S.B. 301
February 5, 2009

Good morning Senator Crisco, Representative Fontana, Senator Caligiuri, Representative D'Amelio and members of the Insurance and Real Estate Committee. For the record, I am Kevin Lembo, the State Healthcare Advocate. My office is an independent state agency with a three-fold mission: assuring managed care consumers have access to medically necessary healthcare; educating consumers about their rights and responsibilities under health insurance plans; and, informing you of problems consumers are facing in accessing care and proposing solutions to those problems.

I am here today to testify in favor of S.B. 301, AN ACT CONCERNING HEALTH INSURANCE COVERAGE FOR AUTISM SPECTRUM DISORDERS, the purpose of which is to provide comprehensive health insurance coverage for autism spectrum disorders. Last year, I testified in support of a bill promoted by Senator Crisco and Representative Abercrombie that required insurers to cover therapy services for children on the autism spectrum on par with therapy services provided to those with physical illnesses. That bill was a first step toward ensuring parity in treatment for people with an autism spectrum disorder. S.B. 301 will move the ball further down the field by acknowledging that Applied Behavioral Analysis (ABA), is not an experimental treatment, and must be covered if medically necessary.

Connecticut's mental health parity law requires coverage for the diagnosis and treatment of mental health disorders listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM) on par with medical surgical or other physical conditions. Autism spectrum disorders (ASD) are listed in the most recent edition of the DSM, and therefore, coverage for ASD should be on par other illnesses. Like many other mental disorders, the treatment for ASD involves more than psychological treatment. In most circumstances treatment also involves prescription medications and physical, speech and occupational therapies. It is not unlike many medical illnesses, which also require more than one modality of treatment.

While ABA has gained scientific acceptance and is recognized as a psychological treatment for ASD by the American Academy of Pediatrics, the insurers in our state still do not recognize ABA's validity and continue to deny legitimate mental health treatment to those with ASD. Our office has represented several of these consumers in front of managed care organization panels. While we were able to get coverage for ABA on a

the number of hours an employee would have to work to be eligible to purchase insurance from a small employer health plan.

HB 5172, AN ACT ESTABLSHING THE HEALTHY STEPS PROGRAM, should be studied. This bill was raised in both the 2007 and 2008 sessions as a detailed bill and was made part of a larger discussion on healthcare reform. Any major healthcare reform bill should be vetted through the Health First Authority and Statewide Primary Care Access Authority.

A bill as described by SB 47, AN ACT CONCERNING HEATLH CARE PROVIDER CONTRACTS, should make it through committee this year and onto the floor. The legislation has been offered for the last few years and would more clearly lay out the obligations of providers and insurers and offer some transparency to consumers. The proposed bill also offers consistency to providers and consumers across Connecticut regulated health plans.

Thank you for your attention, and I am happy to answer any of your questions.

JOINT
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HEARINGS

INSURANCE AND
REAL ESTATE
PART 4
957 - 1263

2009

SB47

Testimony of Ken Rosenquest
President of the Connecticut Association of Ambulatory Surgery Centers
Before the Insurance Committee
In Support of SB 74, An Act Concerning A Prohibition Against Site of Service Differential Rates.

February 10, 2009

Good Afternoon Senator Crisco, Representative Fontana and distinguished members of the Insurance Committee. My name is Ken Rosenquest and I am Vice President of Operations for Constitution Surgery Centers. I am here today as President of the Connecticut Association of Ambulatory Surgery Centers to speak in support of SB 74, **An Act Concerning A Prohibition Against Site of Service Differential Rates.**

In the fall, we participated in a Public Health Committee working group to look at the issue of Site of Service Differentials. More and more insurance companies across the country are turning to what they call ***Site of Service Differentials*** as a primary mechanism for reducing their overall reimbursement rates to providers. Following the committee meeting, the co-chairs of the working group suggested that this issue could be addressed through Standards in Contracting legislation.

A few years ago, the Connecticut General Assembly recognized patient safety concerns and appropriately acted to ensure that procedures requiring more extensive anesthesia must be done in safe and appropriate environments- surgery centers or hospitals- and no longer in physician offices. As part of this effort, Connecticut passed detailed regulations improving patient safety by eliminating unregulated, unlicensed surgical settings and also requiring surgery centers and hospitals to contract with patient safety organizations. Unfortunately, insurers are now using this legislation to penalize providers for complying with state statute.

In fact, some insurers have actually increased reimbursements to providers-if they provide care in their office rather than in the hospital or surgery centers. At the same time, almost cutting in half the reimbursement for providing care in the hospital or surgery center. In some instances, physicians actually modified their own offices to comply with safety regulations and state licensure requirements-all at great expense. Today, after all of the modifications, some providers will actually be reimbursed half as much.

When we broached the subject with the Insurance department and one of the insurers, the insurer actually indicated that they believed procedures like colonoscopy could actually be done in the office without anesthesia. (Clearly if you have ever had a colonoscopy, you would know that this is not the standard of care and not in the interest of the patient.) If patients are uncomfortable during this type

of procedure, perforations are more likely and the patient is likely to return for a follow up screening when appropriate.

It is our belief that the site of service differential flies in the face of the patient safety legislation passed by this very body. By passing SB 74 or Standards in Contracting legislation like SB 47, you will help to eliminate the "cookie cutter" approach to health care that some companies use in he name of controlling costs without regard to state statute or what is in the best interest of the patient.

Thank you for your consideration and I would be happy to answer any questions you might have.

JOINT STANDING COMMITTEE HEARINGS

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Connecticut Academy
of Family Physicians

Statement concerning

Senate Bill 47 – An Act Concerning Cancelled Doctor's Appointments

General Law Committee

February 5, 2009

This statement is being submitted on behalf of the members of the Connecticut Academy of Family Physicians on Senate Bill 47 – An Act Concerning Cancelled Doctor's Appointments.

Senate Bill 47 would prohibit physicians from charging a fee for a missed appointment, provided the patient or a representative of the patient contacts the doctor's office to cancel the appointment. While we take no issue with the idea that a patient not pay for a cancelled appointment, we do think that the bill must include at least a 24 hour time-frame for notifying the physician. A 24 hour notification would allow the physician's office to fill that time slot previously reserved for the cancelling patient with another patient who needs medical attention. With adequate notice, physicians' offices are better able to prioritize the delivery of health care to those who need it. We can see more people who call for a last minute appointment, we can offer care to new patients, reduce waiting room times and more. Those practices who do charge a fee for a missed appointment do not do so to be punitive but rather to manage their offices in an efficient manner.

Other professions also charge such fee. Chiropractors, psychologists, dentists, other health care providers, swim instructors, massage therapists and many others charge fees for last minute cancellations. If this bill moves forward we would encourage this Committee to consider

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adding in other professionals into this bill.

While not all offices or businesses charge a fee for cancelled appointments, those that do normally adhere to at least a 24 hour notice and even in those offices, a majority will waive the fee if a last minute cancellation is made provided that a reasonable explanation is provided.

We believe that a 24 hour notification is fair to both parties.

For more information, please call:

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