PA 11-038

HB6310

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CONNECTICUT
GENERAL ASSEMBLY
HOUSE

PROCEEDINGS
2011

VOL.54
PART 4
1040 – 1385

Will the Clerk please call Calendar Number 191.

THE CLERK:

On page 14, Calendar Number 191, Substitute for House Bill Number 6310, AN ACT CONCERNING CONTRACTS WITH OPHTHALMOLOGISTS AND OPTOMETRISTS, favorable report of the Committee on Insurance.

DEPUTY SPEAKER RYAN:

Representative Megna.

REP. MEGNA (97th):

Thank you, Mr. Speaker.

Mr. Speaker, I move the committee's joint favorable report and passage of the bill.

DEPUTY SPEAKER RYAN:

The question is acceptance of the Joint Committee's favorable report and passage of the bill.

Will you remark?

REP. MEGNA (97th):

Yes, Mr. Speaker.

This bill ensures that insurers contract with both ophthalmologists and optometrists and inform patients of the availability of both so the patient can choose freely what type of eye care provider to see, no pun intended, Mr. Speaker. It does this by requiring health care centers and preferred provider networks to

contract with ophthalmologists and optometrists in substantially the same manner.

Mr. Speaker, the Clerk is in possession of LCO 5566. I ask that it be called and I be permitted to summarize.

DEPUTY SPEAKER RYAN:

Will the Clerk please call LCO 5566, which will be designated House Amendment Schedule "A."

THE CLERK:

LCO Number 5566, House "A," offered by Representatives Aresimowicz and Olson.

DEPUTY SPEAKER RYAN:

The Representative seeks leave of the Chamber to summarize the amendment. Is there objection to summarization? Is there objection? Hearing none, Representative Megna, will you proceed?

REP. MEGNA (97th):

Thank you, Mr. Speaker.

Mr. Speaker, the amendment simply tightens up the language to make sure that this bill does what it's intended to do and nothing more. And with that I move adoption.

DEPUTY SPEAKER RYAN:

The question before the Chamber is adoption of

House Amendment Schedule "A." Will you remark on the amendment?

Representative Srinivasan.

REP. SRINIVASAN (31st):

Thank you, Mr. Speaker.

I rise in support of this bill.

DEPUTY SPEAKER RYAN:

Excuse me. Excuse me, sir. Is this on the amendment or on the bill?

REP. SRINIVASAN (31st):

Oh, I'm sorry. I thought it was on the bill.

DEPUTY SPEAKER RYAN:

Okay. Just a couple of seconds then.

REP. SRINIVASAN (31st):

Thank you. Thank you. I'm sorry.

DEPUTY SPEAKER RYAN:

Representative Coutu, on the amendment.

REP. COUTU (47th):

Thank you. Thank you, Mr. Speaker.

I just want to say I know there's been a lot of work behind the scenes to make this amendment acceptable for the different parties involved with this bill. And I believe it's a friendly amendment, and that's it.

Thank you for those who took the time and effort to make this a reality.

DEPUTY SPEAKER RYAN:

Thank you, Representative Coutu.

Will you remark further? Will you remark further on the amendment before us? If not, I will try your minds. All those in favor, signify by saying, aye.

REPRESENTATIVES:

Aye.

DEPUTY SPEAKER RYAN:

All those opposed, nay.

The ayes have it and the amendment is adopted.

Will you remark further on the bill as amended? Representative Srinivasan.

REP. SRINIVASAN (31st):

Thank you very much. Thank you, Mr. Speaker. I rise in support of this bill.

As I had mentioned earlier, the educational background of the health care provider is extremely important. Here this is not a scope of practice bill at all. Patients know that they are going to see an ophthalmologist. Patients are well aware that they're going to see an optometrist, and they know the difference as far as the educational backgrounds of

what both these professionals are. So that is not the issue here at all.

The bill talks about insurance companies that have the privilege of cherry-picking as to which services can be provided by whom, and more important, the insurance companies decide on the clubbing of services and what the compensation of what the clubbing of services is. And in that process the optometrists have not been treated adequately in this bill.

And therefore, I feel that this is a good bill. This is the bill that (inaudible) people do support because it makes sure that both of the ophthalmologists and the optometrists are on an equal footing as far as being listed by the health care provider. And the patient, the individual can always decide as to who they want to see and not leave it to the insurance companies to cherry-pick based on the compensation. So I request my colleagues on both sides of the aisle to support this bill.

Thank you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Thank you, Representative.

Representative Lavielle of the 143rd.

REP. LAVIELLE (143rd):

Thank you, Mr. Speaker.

I just have one question for clarification to the proponent of the bill. I would like to -- may I, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Please proceed.

REP. LAVIELLE (143rd):

Thank you.

In some of our smaller towns, certainly in Western Connecticut it is sometimes difficult to find an ophthalmologist easily when it's a question of having services performed that an optometrist also legally performs. And I wanted to ask if this bill will facilitate the exercise of going to an optometrist for people who need that kind of service. It will be easier for them to be insured.

DEPUTY SPEAKER RYAN:

Representative Megna.

REP. MEGNA (97th):

Through you, Mr. Speaker.

I believe so. I don't think it impacts services at all from either the optometrist or the ophthalmologist.

DEPUTY SPEAKER RYAN:

Representative Lavielle.

REP. LAVIELLE (143rd):

I thank the Representative for that answer.

And through you, Mr. Speaker, just to confirm this, this just does actually make access easier for patients who might have to go farther to find an ophthalmologist to have those services insured.

REP. MEGNA (97th):

Through you, Mr. Speaker.

I imagine so.

REP. LAVIELLE (143rd):

I thank the Representative for his answer.

Thank you very much.

DEPUTY SPEAKER RYAN:

Thank you, Representative.

Representative Alberts of the 50th.

REP. ALBERTS (50th):

Thank you, Mr. Speaker.

If I may, a question to the proponent of the bill now amended before us?

DEPUTY SPEAKER RYAN:

Please proceed.

REP. ALBERTS (50th):

Thank you, Mr. Speaker.

I think there's a little bit of confusion as it relates to this bill in terms of whether it may or may not be an insurance mandate that may not be covered by the Affordable Care Act's essential benefits package. So I would like some clarification from the proponent, if we are looking at the potential here, that the State may have to expend some coverage and his understanding of that.

Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Representative Megna.

REP. MEGNA (97th):

Through you, Mr. Speaker.

From what I understand this is in conforming with the Federal Health Care Act.

Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Representative Alberts.

REP. ALBERTS (50th):

Thank you, Mr. Speaker.

And so, in today's world, it is conforming, but beginning in 2014, if for some reason that Act changes, then my understanding is then the State would be obligated to pick up any costs associated with this.

Is that not correct?

Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Representative Megna.

REP. MEGNA (97th):

In terms of this year, the federal government will tell us what types of policies are to be offered on exchanges. We don't know what mandates will be required and what mandates will not be required in those policies on the exchange.

Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Representative Alberts.

REP. ALBERTS (50th):

Thank you, Mr. Speaker.

So then I'm to understand that we believe that this will be a benefit that will remain and be a covered benefit. We can't be positive of that at this time, but the confidence factor is very high that it will be part of that. If for some reason if it's not, then it could be a cost that the State would have to pick up. Is that not correct?

Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Representative Megna.

REP. MEGNA (97th):

Yeah. Through you, Mr. Speaker.

This isn't a mandatory coverage that will be required or not required under the Affordable Health Care Act when we find out what coverages will be in those basic policies. So this is simply enabling the optometrist to contract with the carriers.

So I don't believe there's going to be any impact. I believe it's conforming with federal legislation at this point.

Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Thank you, Representative Megna.

Representative Alberts.

REP. ALBERTS (50th):

Thank you, Mr. Speaker.

I thank the gentleman for his responses.

DEPUTY SPEAKER RYAN:

Thank you, sir.

For the second time, Representative Srinivasan of the 31st.

REP. SRINIVASAN (31st):

Thank you, Mr. Speaker.

If I would be allowed to make just a comment on health care access which was raised by a previous Representative.

This bill makes sure that the health care access is there. That is the importance of this particular bill. In a small town where an optometrist may be practicing and an ophthalmologist may be quite far away, in terms of reaching out to the ophthalmologist, this bill will make sure that the patient can see the optometrist, A, and more important, the optometrist will want to see the patient as well. So that it goes both ways because both the ophthalmologist and the optometrist are all treated on an equal footing.

So from a health care access point of view, this is a phenomenal bill, a bill that will support and make sure that our patients are well informed and have easy access to the health care that they need. So I would urge everyone, from a health care access point of view, to please support this bill.

Thank you.

DEPUTY SPEAKER RYAN:

Thank you, Representative.

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 the members please take your seats. The machine will be open.

THE CLERK:

The House of Representatives is voting by roll call. Members to the chamber. The House is voting by roll call. Members to the chamber, please.

DEPUTY SPEAKER RYAN:

Have all members voted? Have all members voted? Will the members please check the board to determine if the vote is properly cast? If all members have voted, the machine will be locked and the Clerk will take a tally.

The Clerk will please announce the tally.

THE CLERK:

House Bill 6310 as amended by House "A."

Total Number voting	144
Necessary for adoption	73
Those voting Yea	144
Those voting Nay	0
Those absent and not voting	7

DEPUTY SPEAKER RYAN:

The bill as amended is passed.

Will the Clerk please call Calendar Number 34.

JOINT
STANDING
COMMITTEE
HEARINGS

INSURANCE AND
REAL ESTATE
PART 8
2295 – 2657

2011

care to many individuals. However, they cannot select me to be their primary care provider; they can only choose the physician. However, there's insurance plans in this state that can automatically assign me to be their provider, even though they're patients I've never seen. And I get calls in my office that say, so-and-so's plan assigned you to be my primary care provider.

So there are plans that assign me. There are plans that my patients aren't able to choose me. And I believe that individuals should be able to choose among all the available primary care providers.

As Connecticut moves forward to improve health care access, we must get rid of ineffective rules. Advanced practice registered nurses are providing health care to individuals and should be able to be found listed in their directories.

I thank you for your consideration, and will answer any questions.

SENATOR CRISCO: Thank you, Pat.

Any questions? Any questions? Okay.

Thank you very much.

Proceeding to House Bill 6310, Doctor -- is it McCain? McMunn? Doctor McMunn? No? Doctor Emmel?

DAVID EMMEL: Excuse me.

SENATOR CRISCO: That's all right, Doctor. If it's -- if it's an emergency, okay. If not, then you're disqualified.

DAVID EMMEL: Good afternoon, Senator Crisco, and

other members of the Insurance and Real Estate Committee. My name is David Emmel. I'm a board certified ophthalmologist practicing in Wethersfield and I'm also the president of the Connecticut Society of Eye Physicians.

I'm here today representing over 1200 physicians in various medical specialties, in opposition to RB 6310, AN ACT CONCERNING CERTAIN HEALTH CARE PROVIDER NETWORK ARRANGEMENTS.

We appreciate the intent of this bill and understand that our optometric colleagues are not happy with the insurers, and neither are we or any of the other providers. But we are opposed to this bill for several reasons.

First and foremost, our professions are not identical, regardless of what you think about their individual merits. They are based on different degrees, different training, different paradigms, and often, different modalities of treatment.

It is understandable that insurers might choose to deal with them differently. In a progressively more monopolistic environment, this bill is potentially anti-competitive, creating a hurdle to market entry and limiting (inaudible) -- and limiting competition by preventing a smaller insurance payer from selecting a small group of highly trained providers that can -- that supply the full spectrum of care from office to surgery.

To ensure the best care value, we should always aim to broaden, not narrow competition among our payers.

Further more, right now, even within each profession, our providers are treated differently. I do not get the same contract as

my ophthalmic colleagues at Yale, or at Grove Hill, or even from another solo practitioner. Different ophthalmologists are different -- treated differently by payers based on their training and expertise if they have special training, to which ophthalmologist would the optometrist be regarded as identical. It would probably be impossible for insurers to actually comply with this bill because of that problem.

This bill, furthermore, does nothing to promote patient choice. If all types of providers are to be lumped together, transparency becomes even more of a challenge. A given patient may have reasons for choosing one type of provider over another. In order to allow patients to make informed decisions about their care, the system must let them identify providers by degree, by their training, and by their scope, and not simply lump them all together. Studies have shown that patient empowerment can help control health care costs.

This bill will create problems for patients and for health care in general, and even for insurers. It will be difficult to administer, and it will be unfair in its effect on providers. We urge opposition to RB 6310. Thank you.

SENATOR CRISCO: Well, thank you, Doctor.

Any questions? Any questions for the doctor?

Thank you very much.

Debbie, are you testifying? No? No, okay. It just said -- it said or, you know, I wasn't sure.

Doctor Lynch.

BRIAN LYNCH: Senator Crisco, members of the

HB6310

Insurance Committee, thank you for allowing me to testify today.

My name is Dr. Brian Lynch. I am the legislative and legal affairs director for the Optometric Association, as well as a private practicing optometrist in -- in Bradford.

In 1993, the Legislature passed an act attempting to preserve a patient's right to select the eye care provider that he or she wished to use. The freedom of choice in Eye Care Provider Act enacted the patient -- protected the patients of both optometrists, as well as ophthalmologists, from being directed by health care centers to -- to a provider they didn't choose to use.

Not only did the act ensure that both professions would be part of the panel, but it also assured that the provider's scope would not be limited to less than what is statutorily defined by yourselves, insurers would inform patients of the availability of both providers, as well as insurers would enroll a sufficient number of both providers to meet patients' needs.

The statute has -- has served the public well until recently. Some HMOs have chosen to exploit a loophole within the statute and circumvent its legislative intent by requiring an optometrist to join -- and only an optometrist -- to join a vision care carve-out in order to be on their medical provider panel.

This provision is only placed upon optometrists -- not ophthalmologists. It is designed to discourage optometrists from participation in their plan, thus denying patient's access to the provider of their choice.

The Harkin Amendment to the Patient Protection

and Affordable Health Care Act is very clear that no group, health plan, or health insurer will be allowed to discriminate against a group of providers based upon licensure.

By supporting HB 6310, you will be bringing our current Freedom of Choice Act into alignment with the soon to be enacted federal statutes. Please support HB 6310. It serves -- it helps to preserve a patient's right to choose the eye care provider that he or she desires.

In response to -- to Dr. Emmel's testimony, he's correct. Both providers are dissimilar and, yet, we are similar. We're similar when we're providing the same level of service, which might be a routine eye examination. And when providing that routine eye examination, the insurer should impose the same credential requirements upon both professionals.

I'm not saying don't -- don't require us to be part of an eye care carve-out. We're -- what we're requesting is that both groups have to be required to be part of an eye care provider, or carve-out. That's what fosters competition within the marketplace by leveling the playing field for both groups of providers.

Thank you.

SENATOR CRISCO: Thank you, Dr. Lynch.

Any questions?

Representative Schofield.

REP. SCHOFIELD: Okay. Thank you, Mr. Chairman. Thank you, Dr. Lynch.

I -- I'm just a little confused by this bill. Maybe you can just help me understand.

DR. LYNCH: Sure.

REP. SCHOFIELD: And when they carve out this vision care benefit --

DR. LYNCH: Uh-huh.

REP. SCHOFIELD: -- is it part of a -- a regular full health plan? Because, usually, vision correction is not a benefit within a regular health plan.

DR. LYNCH: It oftentimes is. Depending upon the way the particular plan is structured, some will -- some HMOs will say routine eye examinations are available every one or two years, and that's just part of the total benefit package.

REP. SCHOFIELD: Uh-huh.

DR. LYNCH: Others will carve it out to a separate entity. Maybe to name a few; Davis Vision Group, Vision Service Plan, AETNA One, Blue Care, there's a whole bunch of different ones. And a few of the HMOs have required that optometrists, and only optometrists, be a member of this carve out in order to be placed on their medical provider panel.

Now, our patients rely upon us for both levels of service. They reply -- they rely upon us for routine vision care, but may also rely upon us to treat their glaucoma, or to treat their eye infections, or to remove a foreign body.

In order to bill the patient's insurance plan for those levels of service, one has to be on the medical plan. And the problem we're running into is, in order to be part of that medical plan, you're saying, okay, you want to be on that plan, you have to join this carve out. Fair enough.

What we're saying is both groups of providers -- if you're providing routine vision care as a routine service to the patients you're serving, you happen to have that insurance. Both groups should be required to do the same.

REP. SCHOFIELD: So you're an optometrist.

BRIAN LYNCH: That is correct.

REP. SCHOFIELD: And so, I'm assuming you're already in that carve out.

BRIAN LYNCH: I am.

REP. SCHOFIELD: Okay. And --

BRIAN LYNCH: And actually I'm not. I have to give you both. This is where it really gets convoluted. Those of us who have been in -- within particular plans for quite some time, aren't even being required to do that. Some of your new enrollees, i.e., if I just graduated optometry school and I'm opening up a practice, this will be a requirement.

Some of the statutes that you have passed in the -- in the past, have prohibited them from imposing that upon me, since I was already on the medical plan. But again, as a new (inaudible) or a new optometrist go to join some of these particular plans, they're required to be a part (inaudible).

REP. SCHOFIELD: To be in the carve out. And that carve out is for purposes of vision correction and --

BRIAN LYNCH: -- and only vision correct.

REP. SCHOFIELD: Okay. So the ophthalmologists are

still in the plan if you have cancer of the eye or a surgical problem or a -- an infection, or something.

BRIAN LYNCH: That is correct. But yet, that patient will still access them for routine vision care. And I don't know how that's being handled. Because my understanding is that the only way you can provide the routine vision care would be to be part of the carve out. So if the patient is there for a well care visit in a plan that doesn't have well care, only medical eye care unless it's provided via the carve out, how that's actually being coded, I don't know.

REP. SCHOFIELD: And -- and so you, also, are opposed to the bill or supportive of the bill?

BRIAN LYNCH: I support the bill.

REP. SCHOFIELD: Supporting the bill.

BRIAN LYNCH: I support that an even playing field for both groups of providers. If they want to have a carve out for all new providers entering the plan, then it should be a restriction for both groups if they're going to provide that level of services.

REP. SCHOFIELD: So you want to welcome the ophthalmologists into this special network?

BRIAN LYNCH: I don't know how -- how much they want to be welcomed into it. But the answer to your question is yes.

REP. SCHOFIELD: Okay, thank you.

SENATOR CRISCO: Any other questions?

Dr. Lynch.

BRIAN LYNCH: Great.

SENATOR CRISCO: Thank you very much.

Debbie Osborn.

BRIAN LYNCH: Thank you -- thank you for your time.

SENATOR CRISCO: You're welcome.

DEBBIE OSBORN: Good afternoon, Senator Crisco, Representative Megna. Thank you for the opportunity to give some testimony. For the record, my name is Deb Osborn. I'm the executive director for the Connecticut Society of Eye Physicians for the Connecticut ENT Society, the Connecticut Urologists and the Connecticut Dermatologists. We been up here a lot, so I thank you for allowing me to testify. HB6310

I just wanted to clarify Representative Schofield's question. The ophthalmologists in this state do have to contract in the same exact way as the optometrists. These carve outs that Dr. Lynch referred to, that the ophthalmologists do not have to go through that process, they do.

So if my doctors want to do routine eye care, they have to join that carve out. So there is no difference here. But I think that what we have to keep in mind is that we want to keep the highest standard of care in this state. And if the insurers feel that there are providers out there that they want to give better rates to because they may have better fellowship training or expertise, I think we should allow them to do that.

So that's my testimony. If you have any questions about the carve outs, I have seen every single one of them.

SENATOR CRISCO: Uh-huh. Well, I'm glad. Okay.

Any questions of Deb?

If not, you could also supply the committee with -- provide with information if you have it.

DEBBIE OSBORN: We also gave two sheets on the training differences for everyone.

SENATOR CRISCO: Okay, good. Okay.

Thank you. Thank you so much, Debbie.

DEBBIE OSBORN: You're welcome.

SENATOR CRISCO: Appreciate it.

Proceeding now to House Bill 6307. Brooks.

BROOKS GOODISON: Good afternoon, Senator Crisco and Representative Megna, and the members of the Insurance and Real Estraight -- Estate Committee for allowing us to present our testimony today.

My name is Brooks Goodison. I'm the president of Diversified Group Brokerage Corporation doing business as Diversified Administration Cooperation, a third party administrator in Marlborough, Connecticut.

We have provided professional third party health plan administrative services for single employer groups such as claims processing, enrollment, eligibility, consolidated billing, customer service, as well of -- was wellness, disease management to self-funded employers in the state for the last 44 years. I think we're a good TPA, and -- and we do have contracts with all of our customers.

Do they --

RENEE PROVOST: Oh, sure.

REP. SCHOFIELD: Seem to have any problem with you being -- being listed in the directories?

RENEE PROVOST: No, absolutely not.

REP. SCHOFIELD: Has it taken business away from them?

RENEE PROVOST: No, actually not. And I've always worked collaboratively as, of course, I need to. But I can tell you that in -- in some of the practices I've worked in, we really knew by the kind of patient what their -- their issues were. What kind of attention they needed. People would say, oh, that's a -- that's somebody for Renee, or, oh, that's somebody for Dr. So-and-So. We -- we just knew. We do different things. We're very, you know, we're very advanced but we don't do the same thing, and they knew it. And it really wasn't a territorial problem at all.

REP. SCHOFIELD: All right, thank you.

RENEE PROVOST: Thank you. Anything else?

SENATOR CRISCO: Thank you and that was very good.

RENEE PROVOST: Thank you so much.

SENATOR CRISCO: Thank you very much. Well, that concludes our testimony. We will go back.

Doctor McMunn. And it -- is Doctor McMunn here? On 6310?

ELIZABETH MCMUNN: Hi, I'm Dr. Elizabeth McMunn. I'm the president elect of the Connecticut Association of Optometrists, and I practice in

East Lyme, Connecticut.

I'm just here to say I -- Deb Osborn presented earlier about the credentialing criteria being equal between both optometry and ophthalmology. We know that is not the case but we're going to gather some information and get back to the committee on that, regarding how the HMOs are credentialing differently and how they're discriminating against optometrists.

Are there any questions or anything else I can --

SENATOR CRISCO: Hold on. Hold on, Dr. McMunn.

ELIZABETH MCMUNN: Sure.

SENATOR CRISCO: Any questions? No? No.

Thank you so much. And thank you for that information.

ELIZABETH MCMUNN: Thank you.

SENATOR CRISCO: Seeing no other individuals who are -- who's interested in testifying on these raised bills of the Insurance Committee -- and -- and -- the Insurance and Real Estate Committee, we'll conclude this public hearing. Thank you all for your participation.

Quality is Our Bottom Line

Insurance Committee Public Hearing
February 22 2011

Connecticut Association of Health Plans

Testimony in Opposition to

- **SB 923 AAC Health Insurance Coverage and Certain Cancer Screenings.**
- **HB 6306 AAC the Listing of Advanced Practice Registered Nurses in Managed Care Organization Provider Listings and Primary Care Provider Designations.**
- **HB 6310 AAC Certain Health Care Provider Network Arrangements.**

The Connecticut Association of Health Plans respectfully urges the Committee's rejection of SB 923, HB 6306 and HB 6310. While every mandate under consideration by the legislature is laudable in its intent, each must be considered in the context of the larger debate on access and affordability of health care and ***now must also be viewed in the context of federal health care reform and the applicability of the Patient Protection and Affordable Care Act of 2010 (PPACA).***

Please consider recent testimony submitted by the Department of Insurance relative to another proposed mandate under consideration which urges the Committee to understand the future financial obligations that new or additional health insurance mandates may place on the State of Connecticut and taxpayers stating that:

> ***In simple terms, all mandated coverage beyond the required essential benefits (as will be determined by HHS) will be at the State's expense. Those costs may not be delegated to the individual purchaser of insurance or the insurer.***

There are benefit mandates and then there are administrative mandates both of which add appreciable cost to the underlying premium. Both SB HB6306 and HB 6310 are administrative in nature and make specific demands on health insurers. With respect to HB 6310, we can only assume that the bill's intent is to require parity between ophthalmologists and optometrists and we would caution the legislature against setting such precedents in statute.

When considering benefit mandates, please note the unintended consequences of previous mandates that were considered or enacted by other states such as ABMT (autologous bone marrow transplant) for the treatment of breast cancer. Some states mandated its use and coverage and ABMT not only turned out be ineffective, it was actually hastening the deaths of women. Hormone replacement therapy is another example. In some states, mandates to cover it were

considered but the clinical trials now demonstrate that it is not a panacea and not benign, and should only be used in very limited circumstances for very short durations. Legislation can never keep up with science, which is always evolving and we would caution the legislature against adopting additional mandates at this time.

Both the General Assembly and the Administration have pledged this year to address the needs of the approximately 400,000 Connecticut residents who lack health insurance coverage. As we all know, the reasons people go without insurance are wide and varied, but most certainly cost is a major component. In discussing these proposals, please also keep in mind that:

- Connecticut has approximately **49 mandates, which is the 5th highest** behind Maryland (58), Virginia (53), California (51) and Texas (50). The average number of mandates per state is 34. (OLR Report 2004-R-0277 based on info provided by the Blue Cross/Blue Shield Assoc.)

- For all mandates listed, the total cost impact reported reflects a range of **6.1% minimum to 46.3% maximum.** (OLR Report 2004-R-0277 based on info provided by the Dept. of Insurance)

- State mandated benefits are not applicable to all employers. Large employers that self-insure their employee benefit plans are not subject to mandates. **Small employers bear the brunt of the costs.** (OLR Report 2004-R-0277)

- The National Center for Policy Analysis (NCPA) estimates that **25% of the uninsured are priced out of the market by state mandates**. A study commissioned by the Health Insurance Assoc. of America (HIAA) and released in January 1999, reported that "...a fifth to a quarter of the uninsured have no coverage because of state mandates, and federal mandates are likely to have larger effects. (OLR Report 2004-R-0277)

- **Mandates increased 25-fold over the period, 1970-1996, an average annual growth rate of more than 15%.** (PriceWaterhouseCoopers: The Factors Fueling rising Healthcare Costs- April 2002)

- National statistics suggest that **for every 1% increase in premiums, 300,000 people become uninsured.** (Lewin Group Letter: 1999)

- "According to a survey released in 2002 by the Kaiser Family Foundation (KFF) and Health Research and Educational Trust (HRET), employers faced an average **12.7% increase in health insurance premiums** that year. A survey conducted by Hewitt Associates shows that employers encountered **an additional 13% to 15% increase in 2003**. The outlook is for more double-digit increases. **If premiums continue to escalate at their current rate, employers will pare down the benefits offered, shift a greater share of the cost to their employees, or be forced to stop providing coverage."** (OLR Report 2004-R-0277)

Thank you for your consideration.

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Ln. 6

Testimony of
The Connecticut Society of Eye Physicians
The Connecticut ENT Society
The Connecticut Urology Society
The Connecticut Dermatology and Dermatologic Surgery Society
On February 22, 2011
For the Committee of Insurance and Real Estate Committee
In OPPOSITION to
RB 6310 AAC Certain Health Care Provider Network Arrangements

Good afternoon, Senator Crisco, Representative Megna, and Members of the Insurance and Real Estate Committee My name is David Emmel, M.D, I am a board certified ophthalmologist, practicing in Wethersfield, CT, I am also the president of the Connecticut Society of Eye Physicians and I am here representing over 1200 physicians in various medical specialties in **opposition** to RB 6310, AAC Certain Health Care Provider Network Arrangements.

We appreciate the intent of this bill, and understand that our optometric colleagues are not happy with the insurers; neither are we or any other providers. But we are opposed to this bill for several reasons. First and foremost, the professions are not identical, regardless of what you think about their individual merits. They are based on different degrees, different training, different paradigms, and often, different modalities of treatment. It is understandable that insurers might choose to deal with them differently.

In a progressively more monopolistic environment, this bill is potentially anti-competitive, creating a hurdle to market entry and limiting competition by preventing a smaller payor from selecting a small cadre of highly trained providers that can provide the full spectrum of care, from office evaluation to surgery. To ensure the best health care value, we should aim to broaden, not narrow, the competition among payors.

Furthermore, right now even within each profession, providers are not treated identically by payors; I do not get the same contract as my ophthalmic colleagues at Yale, Grove Hill, Pro Health, or even my solo practice friend in Trumbull, and different ophthalmologists are treated differently by payors based on special expertise or the extra training they have undertaken. To which ophthalmologist will they be regarded as 'identical"? It would be impossible for insurers to comply with this language.

This bill does nothing to promote patient choice. If all types of providers are to be lumped together, transparency becomes even more of a challenge. A given patient may have reasons for choosing one type of provider or another. In order to allow patients to make informed decisions about their care the system must let them identify providers by degree, training level, and scope, and not simply lump them all together. Studies have shown that patient empowerment may help control health care costs.

This bill will create problems for patients, for health care in general, and even for insurers. It will be difficult to administer, and unfair in its effects on providers. We urge opposition to RB 6310. Thank you.

Optometry/Ophthalmology
Educational Training Comparison Chart

Degree/Qualifications	Optometrist (OD)	Ophthalmologist (MD)
	Optometry School	Medical School
Education	♦ 4 years in length ♦ Average hours of coursework based on comparison SUNY Optometry School are **597.3** hours of basic	♦ 4 years in length ♦ Average hours of coursework based on average across medical schools are **1,436** hours.
	Optometry Residency	Ophthalmology Residency
Mandatory Post – Graduate Training	♦ There is **no mandatory post graduate training**. About 15% go on to an optional 1yr training program. ♦ Additional optometry lab and instruction on ocular disease and management are **335.5** hours.	♦ Additional **4** years in training ♦ Must complete **1** year of general medical or surgical internship. ♦ **3** years of an ophthalmology residency training program. ♦ **40%** of ophthalmologists participate on a 1 or 2 year fellowship program ♦ Additional ophthalmology lab and instruction on ocular disease and management of a minimum **626** hours.
Clinical Experience During Mandatory Education and Training	♦ On average of **1,910** hours of clinical experience. ♦ Optometrists have no minimum requirements for number of patient visits with ocular diseases or ocular surgical operative experience.	♦ Estimate of an average **60** hours per week. ♦ At least **17,280** hours are for clinical experience. ♦ [1]ACGME requires that Ophthalmologists have a minimum of **3,000** outpatient visits.
Profession Regulation	♦ State licensure ♦ Several national boards with highly variable standards. None qualify for membership in the American Board of Medical Specialties.	♦ State licensure ♦ National board certification by the American Board of Ophthalmology, a member Board of the American Board of Medical Specialties. ♦ Recertification every **10** years for Ophthalmologists certified in 1992 or later.

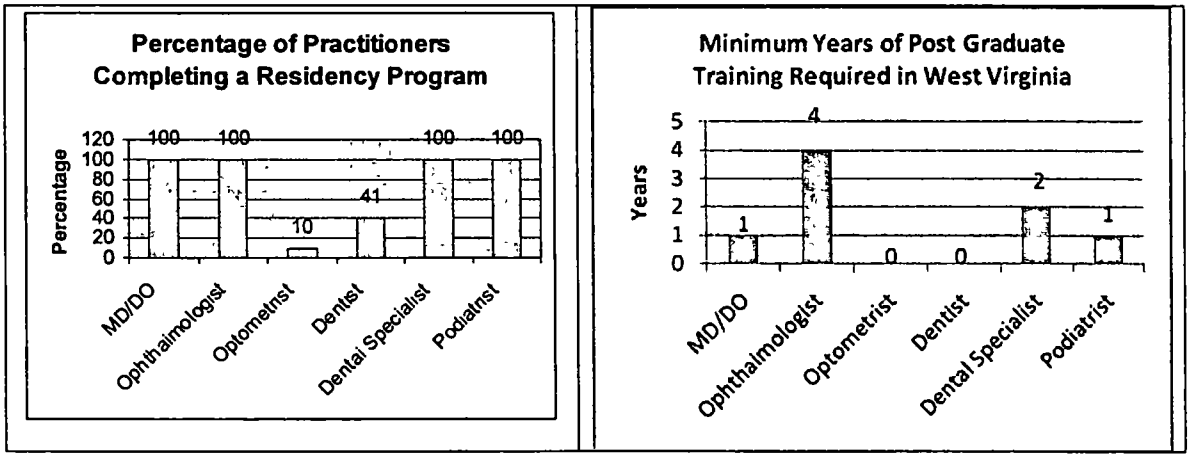
[1] Accreditation Council for Graduate Medical Education

Post Graduate Training Comparison Between Optometrists and Selected Professions

Ophthalmologists are medical doctors or doctors of osteopathy who specialize in the treatment of eye disease after three to four years of training after medical/osteopathic school and hospital residency. In arguing for expanded scope of practice to treat eye disease, optometrists, on the other hand, compare their education and training to podiatrists and dentists. However amongst the many significant differences between optometrists and these other professions is post-graduate training.

Since we are discussing eyes - not feet or teeth, the more reasonable comparison is between the education and training of an ophthalmologist and that of an optometrist. The question at hand is whether optometrists, without seeking the approval of or consulting with the state medical or osteopathic board, any medical or osteopathic schools, or any ophthalmology residency program, have devised a unique method to learn to perform surgical procedures with just enough fragments and bits of knowledge to not harm patients in this state. The answer is that they have not. Optometry school is not a substitute for four years of medical or osteopathic school, a hospital residency, and three years of ophthalmology residency training.

It should be pointed out that optometry education is not comparable to even podiatry or dentistry education. To be licensed in this state, podiatrists must complete a one-year podiatric surgical residency program. To be licensed as a dental specialist, these specialists must complete at least a two-year postgraduate program, depending on the specialty. Although there is no residency requirement for dental school graduates, 41 percent of dental school graduates immediately enter a post-graduate training program. In contrast, only about 10 percent of optometrists complete a residency program nationally. Furthermore, the completion of a residency is not required as a part of any optometry school program and is not a requirement to be licensed in this state.



MD/DO

All medical doctors and doctors of osteopathy must complete at least a one year residency program upon graduation from medical school or osteopathic school.
http://www.wvbom.wv.gov/medpracact.asp

Ophthalmologists

In addition to the same one year residency program that all medical doctors and doctors of osteopathy must complete, to become an ophthalmologist, the MD/DO must also complete an additional three to four year residency training program that specializes in medical and surgical treatment of the eye. http://www.acgme.org/acWebsite/downloads/RRC_progReq/240pr106.pdf

Optometrists
Nationally, **approximately 10 percent** of all optometrists complete a one year residency program. **Moreover, optometric *residencies are not required in West Virginia or elsewhere by law or by professional standard.*** http://www.opted.org/teampublish/uploads/SpringStudentInterest.pdf

Dentists
Nationally, approximately 41 percent of dental school graduates immediately enter into post-graduate training program. About 27 percent of all dentists enter a general dentistry residency program and an additional 14 percent enter a dental specialty program. www.adea.org/DEPR/Assocreptjune01.pdf

Dental Specialists
Completion of at least a two year post graduate program is a prerequisite to be licensed as a dental specialist. http://www.wvdentalboard.org/30-4.pdf
http://www.ada.org/prof/ed/specialties/specialty_certifying_report.pdf

Podiatrists
West Virginia requires podiatrists to complete a one-year podiatric surgical residency program. Today, virtually all podiatry school graduates in the US complete a podiatric residency. It is now a licensing requirement in 41 states. http://www.wvbom.wv.gov/medpracact.asp

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Connecticut Association of Optometrists

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Testimony HB6310 Equity in Vision Care
Brian T. Lynch, OD
February 23, 2011

In 1993, the legislature passed an act attempting to preserve a patient's right to select the eyecare provider he/she wished to use. The Freedom of Choice in Eyecare Provider Act protected the patients of both optometrists and ophthalmologists from being directed by healthcare centers to a provider they didn't want to see.

Not only did the act ensure that both professions would be part of the panel, but it also assured:

1. The provider's scope wouldn't be limited to less than what is statutorily defined
2. Insurers would inform patients of the availability of both providers
3. Insurers would enroll a sufficient number of both providers to meet patients' needs

The statute has served the public well until recently. Some HMOs have chosen to exploit a loophole within the statute and circumvent its legislative intent by requiring an optometrist to join a vision plan carve-out in order to become a medical provider. This provision is placed only upon optometrists; not ophthalmologists. It is designed to discourage optometrists from participation in their plan, thus denying patients access to their provider of choice.

The Harkin Amendment to the Patient Protection and Affordable Care Act is very clear that no group health plan or health insurer will be allowed to discriminate against a group of providers based on licensure. By supporting HB6310, you will be bringing our current Freedom of Choice Act into alignment with the soon-to-be-enacted federal statutes.

Please support HB6310. It will help to preserve a patient's right to choose the eyecare provider he/she deserves.

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Testimony of
The Connecticut Society of Eye Physicians
The Connecticut ENT Society
The Connecticut Urology Society
The Connecticut Dermatology and Dermatologic Surgery Society
On February 22, 2011
For the Committee of Insurance and Real Estate Committee
In OPPOSITION to
RB 6310 AAC Certain Health Care Provider Network Arrangements

Good afternoon, Senator Crisco, Representative Megna, and Members of the Insurance and Real Estate Committee My name is Debbie Osborn, I am the executive director of the above listed medical societies and I I am here representing over 1200 physicians in these various medical specialties in **opposition** to RB 6310, AAC Certain Health Care Provider Network Arrangements.

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CONNECTICUT
GENERAL ASSEMBLY
SENATE

PROCEEDINGS
2011

VOL. 54
PART 7
2086– 2336

Without objection, so ordered.

SENATOR LOONEY:

Thank you, Mr. President.

Mr. President, on calendar page 12, Calendar 416, House Bill 6345, Mr. President, would move to place that item on the consent calendar.

THE CHAIR:

Without objection so ordered.

SENATOR LOONEY:

Thank you, Mr. President.

Mr. President, On calendar page 13, Calendar 419, House Bill 6310, Mr. President, move to place that item on the consent calendar.

THE CHAIR:

Without objection, so ordered.

SENATOR LOONEY:

Thank you, Mr. President.

Also on calendar page 13, Mr. President, calendar page -- Calendar Number 420, House Bill 6419, Mr. President, would move to place that item on the consent calendar.

THE CHAIR:

Without objection, so ordered.

SENATOR LOONEY:

Thank you, Mr. President.

Also on calendar page 13, Calendar 423, House Bill 6286, Mr. President, move to place that item on the consent calendar.

THE CHAIR:

Without objection, so ordered.

SENATOR LOONEY:

Thank you, Mr. President.

And additionally on calendar page 27, Calendar 92, Senate Bill 912, Mr. President, move to place that item on the consent calendar.

THE CHAIR:

Without objection, so ordered.

SENATOR LOONEY:

Thank you, Mr. President.

Mr. President, if the Clerk would call the items on the first consent calendar and if we might proceed to a vote on that consent calendar.

THE CHAIR:

Mr. Clerk.

THE CLERK:

Immediate roll call has been ordered in the Senate on the consent calendar. Will all Senators please return to the Chamber. Immediate roll call

has been ordered in the Senate on the consent calendar. Will all Senators please return to the Chamber.

Mr. President, those items placed on the first consent calendar begin on calendar page 11, Calendar Number 373, Substitute for Senate Bill 951; calendar page 12, Calendar 414, Substitute for House Bill 6299; Calendar 416, House Bill 6345; Calendar 417, Substitute for House Bill 6462; calendar page 13, Calendar 419, Substitute for House Bill 6310; Calendar 420, House Bill 6419; Calendar 423, Substitute for House Bill 6286; Calendar 425, Substitute for House Bill 5174.

Calendar page 19, Calendar Number 479, House Bill 5468; calendar page 26, Calendar Number 56, Substitute for Senate Bill 28; calendar page 27, Calendar Number 92, Senate Bill 912; and calendar page 32, Calendar Number 190, Substitute for Senate Bill 957.

Mr. President, that completes the items placed on the first consent calendar.

THE CHAIR:

This is an inquiry, was Calendar 416 on page 12 among those items that you called?

THE CLERK:

Yes, Mr. President. Calendar Number 416, which was House Bill 6345 was called and placed on the first consent calendar.

THE CHAIR:

Thank you.

THE CLERK:

The Senate is now voting by roll call on the consent calendar. Will all Senators please return to the Chamber. Immediate roll call has been ordered in the Senate on the consent calendar. Will all Senators please return to the Chamber.

THE CHAIR:

The machine is open.

Senators, please check the board to see that your vote is properly recorded. If all members have voted and if all votes are properly recorded the machine will be locked. Would the Clerk please take a tally.

THE CLERK:

Motion is on adoption of Consent Calendar Number 1.

Total Number voting 36

Necessary for adoption 19

Those voting Yea 36

Those voting Nay 0

Those absent and not voting 0

THE CHAIR:

The consent calendar is passed.

SENATOR LOONEY:

Mr. President.

THE CHAIR:

Senator Looney.

SENATOR LOONEY:

Yes. Thank you. Thank you, Mr. President.

I have some additional items to mark go at this time.

THE CHAIR:

You may proceed, sir.

SENATOR LOONEY:

Thank you, Mr. President.

Mr. President, first, on calendar page 6, Calendar 229, Senate Bill 205 might be marked go. Next, Mr. President, calendar page 36, Calendar 273, Senate Bill 1115 is marked go. And then, Mr. President, moving back to calendar page 9, Calendar 330, Senate Bill 3673 is marked go.

THE CHAIR: