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**Connecticut State Medical Society Testimony in Support Senate Bill 392 An Act
Concerning Health Care Provider Network Adequacy
Insurance and Real Estate Committee
March, 12, 2014**

Senator Crisco, Representative Megna and members of the Insurance and Real Estate Committee, on behalf of the physicians and physicians in training of the Connecticut State Medical Society, thank you for the opportunity to present this testimony to you today in support of Senate Bill 392 An Act Concerning Health Care Provider Network Adequacy. This bill will increase the transparency required by health care insurers regarding the networks they offer to enrollees and more importantly ensure that an adequate number of physicians are available to provide comprehensive and efficient access to health care services.

Currently, network adequacy requirements contained in state statute simply require an insurer to be accredited by one of two entities: the National Commission on Quality Assurance (NCQA) or the Utilization Review Accreditation Commission (URAC). However, this requirement is woefully inadequate and does not guarantee a network is adequate based on both geographic needs and the need for specialty or sub-specialty care. In addition, accreditation does not guarantee that 100% of adequacy requirements have been met. It is a pass/fail process.

The passage of the Accountable Care Act (ACA) has increased the number of citizens with health insurance coverage. It has also increased the number of plans and products under which one can receive coverage. However, at the same time, examples are increasing in which insurers are limiting, narrowing or tiering their provider networks. In many situations, it is difficult for enrollees to obtain accurate information regarding physicians available to them within a network. Conversely, physicians are having an increasing difficult time identifying the networks in which insurers consider them networked providers.

Senate Bill 392 begins to address several concerns. First, it requires insurers to provide comprehensive information to the Connecticut Insurance Department (CID) regarding the number of enrollees in its plans and/or policies and the number of participating physicians. It then requires CID in consultation with the Healthcare Advocate to assess networks to ensure that they are actuarially sound and meet an established set of criteria to ensure appropriate access to primary care services as well as needed specialty and sub-specialty care. Finally, it establishes reasonable requirements for those insurers that CID identifies as not meeting adequacy standards.

An important element of adequate health care coverage is that a health insurer offers an adequate network of contracted physicians and other health care providers, (e.g., the “provider network”). The provider network must be clearly identified. Critical to the network is that consumers can receive specialized and sub specialized care within the “in-network” environment. If a consumer has to obtain care in an “out of network” environment, there may be significant financial disincentives for that patient to receive care. Inadequate provider networks deprive consumers of the benefit of the money they have paid for health care coverage. Additionally, the entire public health and welfare system is undermined by forcing consumers to look out of network for services, consequently reducing utilization of appropriate preventive services and forgoing necessary medical care. Inadequate networks do not contain access to highly specialized care. As a result, this lack of necessary care has the effect of driving the sickest patients - those who need health insurance the most - out of that network, and therefore potentially benefitting the health insurance issuer’s profit margin with fewer risky patients. To meet consumers’ reasonable expectations and maximize their welfare, health insurance benefits, including all medically necessary and emergency care, must be available at the preferred, in-network rate on a timely and geographically accessible basis to all enrollees. Consumers and state insurance regulators need meaningful measures of network adequacy covering all aspects of the network, including emergency and other hospital-based physicians, taking into account any tiering or other network restrictions that may exist.

In addition to subjective satisfaction data, there is a need for objective data on critical access metrics, such as the number of visits to out-of-network providers per thousand enrollees, the percentage of services received from in-network providers as a percentage of total services received by enrollees, and the percentage of total costs for in-network and out-of-network services received by enrollees which were paid for by the health insurer. As health insurers’ actuaries must evaluate the provider network to make premium determinations, these actuaries are positioned to provide reliable network reports to insurance regulators relatively efficiently.

The CSMS supports adequate provider networks that ensure insurance regulators and consumers have access to the information necessary to determine whether the provider network includes a sufficient number of primary care, specialty and subspecialty physicians and other health care providers, who are not substitutes for well trained, well qualified physicians, so that all enrollees will be able to receive all covered services in a timely and geographically accessible basis at the preferred in-network rate.

We look forward to the opportunity to work with Committee members on the issue of network adequacy to ensure that the best possible language is passed by the General Assembly.

Please support Senate Bill 392.