



Testimony presented by Ken Yanagisawa, M.D.

In Insurance and Real Estate Committee

On

March 3, 2015

HB6867AN ACT CONCERNING HEALTH CARE PROVIDER NETWORK ADEQUACY.

Good Afternoon Senator Crisco, Rep Megna and other distinguished members of the Insurance and Real Estate Committee. I am Ken Yanagisawa, MD, a board certified otolaryngologist practicing in Hamden, Milford, Ansonia and the New Haven area. I am here to represent the thousands of physicians and physicians in training who are in the state medical society and the over 1000 physicians in the medical specialties of Dermatology, Ophthalmology, Otolaryngology and Urology. On behalf of this group of dedicated physicians, we thank this committee for bringing this important issue of Network Adequacy to public hearing.

Last week, Sharon Barrett, MD, a dermatologist from Clinton, testified on HB 751, noting that our organizations have struggled over the past few years with terminations by Connecticut insurers that have left provider networks grossly inadequate. In fact, several bills on "network adequacy" have been proposed for consideration this year. These bills require more transparency on the types and numbers of providers in their networks and to provide the credentials of these providers to consumers through the consumer report card administrated by the Department of Insurance. Even after many providers were recently terminated by an insurer, their names remained on the network's list of participating providers, giving the impression to the public that they could see these physicians, when in fact, they could not. These misled patients were upset and even angry when they were ultimately notified that they would need to seek their medical care elsewhere.

Simply stated, patients in this state must be offered accurate and up-to-date information about provider participation in the insurance plan they are either considering, or enrolled in.

HB 6867 needs to identify critical details of network providers: what type of providers, how many, and what geographic regions are covered at the time of enrollment. It should be updated monthly to remain current in a searchable online format as well as other communications to potential and current consumers. We strongly recommend that this information be updated at least monthly if not bi-weekly, probably best on the internet since this has become the primary Exchange source.

To incorporate these clarifications in HB 6867, we request the following amended language for consideration in (3) amending line 36-43 as follows:

(3) Each provider network shall be adequate to meet the
28 comprehensive needs of the enrollees of the insurer, health care center,
29 managed care organization or other entity and provide an appropriate
30 choice of health care providers sufficient to provide the services
31 covered under the policies or plans of such insurer, health care center,
32 managed care organization or other entity. The actuarial analysis

33 required under subdivision (1) of this subsection shall determine (A)
34 whether a network includes a sufficient number of geographically
35 accessible participating health care providers for the number of
36 enrollees in a given region, provider's credentials and categorization of providers by specialty and geographic location. (B) whether enrollees have the opportunity
37 to select from at least five primary care health care providers with provider's credentials and geographic location within
38 reasonable travel time and distance, taking into account the conditions
39 for provider access in rural areas, (C) whether a network includes
40 sufficient health care providers with provider's credentials and categorization of providers in each area of
41 specialty practice and if the provider is taking new patients to
42 meet the needs of the enrollee population, and (D) that such network
43 does not exclude health care providers as set forth in subdivision (2) of
44 this subsection.

In addition, it is important for patients to know how frequently medical claims are being denied by the insurer for reasons of "not being medically necessary or experimental". This benchmark will provide valuable performance information to the consumer, who can use this ratio to compare with other insurers. We believe HB6867 could address this important issue with the following amendment:

(4) In assessing provider network adequacy, the commissioner and

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45 the Healthcare Advocate shall consider (A) the availability and
46 accessibility of appropriate and timely care provided to disabled
47 enrollees in accordance with the Americans with Disabilities Act of
48 1990, 42 USC 12101 et seq., as amended from time to time, (B) the
49 network's capability to provide culturally and linguistically competent
50 care to meet the needs of the enrollee population, and (C) the number
51 of grievances filed pursuant to sections 38a-591c to 38a-591g, inclusive,
52 related to waiting times for appointments, appropriateness of referrals, denials for "not medically necessary or experimental
53 and other indicators of limited network capacity or performance.

Patients depend on accurate and up-to-date listings of provider networks to make critical decisions for themselves and their families. Many will change their healthcare insurance plans just to ensure that certain doctors can remain their caregivers – physicians whom they trust, respect, and listen to. HB6867 will ensure that these important physician-patient relationships can be maintained and that the insurer's performance can be monitored.

Thank you for your consideration and if there are any questions please contact us at Phone: 860-567-3787,

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