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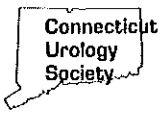

Testimony on Senate Bill 433
An Act Concerning Standards and Requirements for Health Carriers' Provider Networks and Contracts between Health Carriers and Participating Providers
Presented to the Insurance and Real Estate Committee
March 15, 2016

Senator Crisco, Representative Megna and other distinguished members of the Insurance and Real Estate Committee, on behalf of the physicians and physicians in training of the Connecticut State Medical Society (CSMS) and the specialty organizations on this testimony, thank you for the opportunity to provide this testimony to you today on Senate Bill 433 An Act Concerning Standards and Requirements for Health Carriers' Provider Networks and Contracts Between Health Carriers and Participating Providers.

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 Affordable 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, insurers are increasingly limiting, narrowing, or tiering their provider networks, particularly in those plans offered through the Connecticut Exchange (AccessCT) in which multiple variations of tiered and narrow networks exist. 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 increasingly difficult time identifying the networks in which insurers consider them networked providers. The prevalence of these narrow, limited, and tiered networks is why Connecticut needs adequacy standards in order to provide more transparency and safeguards for patients.

Senate Bill 433 begins to address these concerns. Given the ACA and the prevalence of tiered plans, the time has come for substantial and substantive legislation regarding network adequacy. We thank this Committee and its members for bring forward this bill and recognizing the very real problems that exist without adequate network standards in place. However, CSMS has several concerns that we believe need to be fully vetted in order to avoid unintended consequences of this legislation. We will address those concerns one at a time.

Telemedicine/Telehealth

Last year, this legislature passed comprehensive standards regarding the practice of telemedicine and telehealth in Connecticut. At the heart of that legislation was the recognition that if telemedicine and telehealth is to be of value to the patients in Connecticut, it must be conducted in such a way that the patient's medical records are available to the remote telemedicine physician and the patient's primary care physician must be made aware of the encounter and the results of such encounter. Raised Bill 433 has many references to telemedicine and telehealth, and appears to give the Commissioner the ability to take into consideration a health insurer's telemedicine/telehealth network when determining network adequacy. CSMS strongly believes that network adequacy should be determined by the number of physicians practicing in Connecticut; those that are physically present and available to examine patients. We do not believe that the availability of a retired physician to provide a telemedicine visit, perhaps while sitting at his/her kitchen table in Florida should be a criterion for determining the adequacy of a network. Telemedicine and telehealth are still in their infancy stages and we do not know yet how effective these methods will be in patient care. Also, by their nature there are significant limitations on the kinds of patient care that can be delivered through telemedicine and telehealth. As such, we would respectfully ask this Committee to remove any reference to telemedicine and telehealth as criteria for establishing network adequacy. Alternatively, we would ask this Committee to define telemedicine and telehealth, for the purposes of this legislation, as limited to encounters with physicians physically located in the state of Connecticut. We are happy to work further with this Committee on this issue.

Change in Network

Senate Bill 433, specifically in Section 1(h)(1)(C) provides that the health carrier must notify the Commissioner of any material changes to an existing network within 15 days of that change. The proposed language goes on to define "material change" as a change in twenty-five percent or more in the participating providers in the carrier's network. CSMS believes that the twenty-five percent trigger for such notification is considerably too high. Under this proposed standard, a health carrier would not have to provide notice to the Commissioner until there is a change in nearly 1 in 4 of its network providers. In other words, under this proposed standard, the health carrier could remove up to 24% of its provider network and not have to provide notice to the Commissioner. We are hard pressed to imagine a situation where modification of 24% of a health carrier's network would not give rise to significant concern and patient access issues in this state. As such, we would ask for a considerable reduction in the threshold to trigger "material change" and we are happy to work with this Committee to develop a more reasonable standard.

Tiered Networks

This Bill begins to address the concerns with tiered networks. First, it provides a definition of what a tiered network is and recognizes that health insurers are using such networks today in their plan design and implementation. The Bill also calls for some increased transparency on the design and composition of tiered networks. However, CSMS does not believe that this bill goes far enough in defining network adequacy as it relates to tiered networks. We believe that each tier of a network should be required to demonstrate adequacy **as a standalone network**. The reality of the health insurance market is that many plan designs restrict patients to using one tier of a network. Patient care should not be compromised because insurers elect to use tiered networks. True network adequacy standards require that each and every patient have access to

an adequate network for their medical care. As such, we respectfully request this Committee to modify the language of this Bill to require that each tier of a multi-tiered network be required to meet sufficient network adequacy standards.

Provider Contracting Standards

At the outset, CSMS questions why contracting standards between providers and health insurers would be combined into a Bill where the primary focus is network adequacy. We do not see these issues as co-dependent and strongly believe that they should be bifurcated. That said, we will address each of the provider contracting standards one at a time.

The first standard is contained in Section 2(b)(1)(A) and requires contracts between health carriers and providers to contain a hold harmless provision whereby the provider agrees "in no event... including nonpayment by the health carrier, insolvency of the health carrier ... shall the provider bill, charge... a covered person." While CSMS understands the concerns that led to the inclusion of this provision, there is a fundamental unfairness to the physician community, many of whom struggle to operate small businesses. In the event that a health carrier fails to pay a required payment to a physician, there must be a mechanism for the physician to recoup against the health carrier. Simply saying, as this bill does, that it does not prohibit the provider from "pursuing any legal remedy" is not enough. The legal costs entailed in seeking such remedies for nonpayment against a health carrier would, in many cases, significantly exceed the amount of the nonpayment. These concerns are also mirrored in language contained in the proposed modifications to §19a-904a that provides that no "health care provider shall collect... from an insured patient any money owed to such health care provider by such patient's health carrier." We would respectfully ask that this Committee take a close look at these sections and balance the language of these sections so that it is fundamentally fairer to all parties involved and physicians are not the parties left holding the bag when a health carrier fails to pay.

Another concern with this section is the "grace period." We applaud the provisions of this bill that require greater transparency as to when a patient is in the "grace period." However, we would ask for clarification that nothing in the contracting standards language prohibits a physician from seeking payment from a patient when such patient incurred costs while in the "grace period" and subsequently failed to pay the required insurance premiums.

Paragraph (B) of this section speaks to health carrier insolvency. The implication of this paragraph appears to be that in the event of a health carrier insolvency, physicians must provide services to covered individuals (outside of the coinsurance, copayment, deductible or otherwise incurred out-of-pocket costs) at no cost to the patient. There are two stop-dates to this provision: the termination of the covered person's coverage under the network plan or the date the contract between the health carrier and the participating provider would have otherwise terminated. This section raises several questions for CSMS. First, the Connecticut Insurance Department requires all licensed health insurers in Connecticut to maintain an insolvency fund. CSMS questions how this insolvency fund would work with the language above. Isn't the point of the insolvency fund to protect against health carrier insolvency and still have funds in reserve to pay outstanding claims and claims that might be incurred at the time of the insolvency? While the language in this section is not clear, it would seem that a physician could be required to provide free medical care until the time that a covered person is officially "terminated" from coverage. In the case of an oncologist, for example, this medical care could amount to hundreds of thousands of dollars in just one visit. Is it the intent of this provision that the physician be required to provide this service free of charge? If so, even one uncovered visit would financially bankrupt a community oncologist practice.

We would ask this Committee to look at the provider contracting standards contained in this proposed legislation separately from the network adequacy legislation. We stand ready to work with this Committee to craft language that protects covered persons from unfair insurance practices without putting the financial burden on the physician community.

Additional Provider Concerns

Section 1(e)(1)(A) provides that health carriers must "establish and maintain procedures by which a participating provider will be notified on an ongoing basis of the specific covered health care services for which such participating provider will be responsible, including any limitations on or conditions of such services." The language in this paragraph seems to state that a heath carrier has the ability to put restrictions on the services for which a participating provider will be responsible. Connecticut scope of practice law clearly defines the scopes of practice for physicians and other participating providers. CSMS is concerned that if this language were to be included in the final iteration of this bill, health carriers could place restrictions on how, where and what types of medicine physicians are able to practice. Physicians are the only individuals who should be implementing and defining any such restrictions put on services provided to patients. This provision could allow health carries to greatly interfere and influence the physician-patient relationship, and could significantly compromise the quality of care provided to patients. Under this provision, it would appear that a health carrier could inform a gastroenterologist who also practices primary care that he/she is only responsible for gastroenterology care for patients and is not responsible for primary care. As health carriers should have no ability to restrict the scope of covered health care services provided by a physician to his or her patients, CSMS would ask that this provision be removed from the proposed legislation.

Additionally, Section 1(g)(1)(A) provides that if a participating physician receives notice of removal from a health carrier, it is the obligation of the physician to provide to the health carrier "a list of such participating provider's patients who are covered persons under a network plan of such health carrier." This is a tremendous burden on behalf of the physician, and may not even be possible. For physicians without electronic health records (EHR), this would entail going record by record to search for health insurance carriers. The health carrier is in a much better position to ascertain this information. We would ask that this section, that imposes an unreasonable burden on physicians, be removed from the Bill.

Online Provider Directory

The provisions of this legislation relating to online directories will bring much-needed transparency to the often-inaccurate and confusing provider directories. CSMS, however, would like to see clarification in this section related to tiered plans. We believe that health carriers should be required to provide in their online directories clear delineations as to which providers participate in which tiers of a given network. It must be obvious to patients that many plans have tiered networks and not all providers are available on an in-network basis to a patient if a tiered plan is purchased by the patient.

CSMS appreciates the tremendous work that was put into crafting this proposed legislation. We believe that many of the provisions requiring stricter standards for network adequacy and greater transparency in network construction are beneficial for patient care in Connecticut. The concerns we have outlined above we believe can be rectified by working in collaboration with this Committee. We thank you for the opportunity to present this testimony and for bringing forth the legislation that provides much-needed network adequacy standards.