UNIVERSAL HEALTH CARE
FOUNDATION OF CONNECTICUT

Testimony in Support of
SB 433: An Act Concerning Standards and Requirements for Health Carriers' Provider Networks and Contracts Between Health Carriers and Participating Providers
Submitted by Rosana Garcia, Policy Associate
Universal Health Care Foundation of Connecticut
March 15, 2016

We support SB 433: An Act Concerning Standards and Requirements for Health Carriers' Provider Networks and Contracts Between Health Carriers and Participating Providers, and would like to provide some recommendations to strengthen consumer protection.

There is a reason that this legislation is needed. Well designed, with protections for accessibility and quality in place, narrow networks could possibly be an important method for cost containment, while still meeting some patients' needs. But they are also fraught with the possibility of one more "gotcha" approach to overly complex insurance design, which in the end shifts risk and costs onto all-too-often unsuspecting consumers.

Most health insurance plans have separate deductibles and out-of-pocket maximums for in-network and out-of-network care.* Given the problems of surprise medical bills, already being addressed by Public Act 15-146, and the higher costs that consumers bear when seeing an out-of-network provider, this legislation is crucial to further protect consumers from paying for insurance that does not meet their needs. If narrow networks are truly to be an instrument for saving money *and* improving quality, they must be carefully and skillfully regulated.

We recognize that this bill is based on the National Association of Insurance Commissioners (NAIC) Model Act on Network Adequacy, which is meant to be responsive to the post-ACA insurance marketplace and protect consumers. We applaud Insurance Commissioner Wade for introducing this important legislation. This bill will fortify consumer protections, and actually allow insured people the access to health care providers that they pay for with their premiums.

There are critical consumer protections in this bill, including:

- Ensuring a sufficient health plan network so that consumers have access to care they need, when they need it;
- Measures for ensuring continuity of care when providers leave a network for patients in active treatment, including pregnant women;
- Recourse for consumers to make their health plans play fair and follow these new provisions;
- Inclusion of essential community providers (ECPs) in all health plans, not just qualified health plans (QHP's) on the exchange (Access Health CT);
- Provisions to prevent discriminatory practices in tiering or building a network;

- Transparency on plan structure, including providers included in-network, coupled with accessibility for consumers to be able to choose a plan when shopping;
- Improved accuracy, currency and accessibility of provider network directories.

While this bill has commendable provisions for consumer protection, we have some recommendations to further strengthen this bill, and respectfully submit them to you for your consideration:

- Currently this bill does not explicitly define "unreasonable travel or delay" in regard to provider availability. While this may vary depending on the area (urban/metro, suburban, rural or other regional designation), we believe it is important to **set quantitative standards for "unreasonable travel or delay."**
    - Unreasonable travel could be defined by miles or time it takes to travel to a provider (taking into account public transit accessibility).
    - Unreasonable delay should consider the acuity of the medical condition, as well as a consumer's reasonable expectation to access a provider's services in a timely manner.
    - We realize that this bill includes the ability for the Insurance Commissioner to craft regulation to support this bill, and hope that "unreasonable travel or delay" will be defined in regulation, if not in this legislation.
- As the bill stands, insurers need to submit "access plans" that detail their networks for review by the Insurance Commissioner—yet does not require active approval by the Commissioner before going to market. We recommend that the **Insurance Commissioner be required to both review *and* approve a network plan, to ensure that non-compliant narrow network plans are not sold to consumers**.
- While this bill addresses discriminatory practices in tiered networks, it should go further and **require that consumers have adequate in-network access to all covered services through providers in the lowest cost-sharing tier in tiered network plans**.
- While continuity of care measures in this bill are laudable, we suggest **providing greater certainty and a longer transition period for continuity of care measures** for those consumers actively undergoing treatment for life-threatening or serious physical, mental or behavioral conditions.
- It is unclear if, as in the model act, the protections for surprise bills during medical emergencies extend to planned procedures at an in-network facility, but where a non-participating, or out-of-network, provider is used. If this bill does not address this, **we recommend the "surprise billing" protections be applied to out-of-network providers at an in-network facility.**
- Lastly, we suggest that **insurer standards for tiering providers include quality metrics and patient outcomes**. It is imperative that consumers have access to high-quality providers.
- We are glad to see strict standards for insuring provider directories are up-to-date and accurate, but also caution that availability of this information may not be sufficient to help consumers make informed decisions. **More education needs to be done to make it**

easier for consumers to truly understand the tradeoffs they are making when they choose a narrow network.

Universal Health Care Foundation of Connecticut (UHCF) is an independent, nonprofit foundation working to shape our state's health care system to provide quality, accessible, affordable care and promote good health for all state residents. We work with a diverse array of partner organizations, as well as with individual consumers from throughout Connecticut.

**For example, this is Access Health CT's 2016 standard silver plan design:*

	In-network	*Out-of-Network*
Individual deductible	*$ 2,900*	*$ 6,000*
Family deductible	*$ 5,800*	*$12,000*
Individual out-of-pocket maximum	*$ 6,850*	*$12,500*
Family out-of-pocket maximum	*$13,700*	*$25,000*

Source: http://www.ct.gov/hix/lib/hix/Standard_Silver_Plan_--_70.pdf