

Written Statement for the Record
By Claire McAndrew, Families USA
U.S. House of Representatives
Committee on Energy and Commerce
“The President’s Health Care Law Does Not Equal Health Care Access”
Thursday, June 12, 2014

Since 1982, Families USA has worked to promote access to affordable, high-quality health coverage and care for all Americans. With the enactment of the Patient Protection and Affordable Care Act in 2010 and its subsequent implementation, monumental progress toward that goal has been achieved. The Affordable Care Act provides access to health care provider networks for millions who previously had no access to health coverage at all, while taking initial steps to address long-standing network adequacy problems.

This statement will:

- Review the difficulties consumers faced in accessing care before the passage of the Affordable Care Act;
- Discuss new federal protections for network adequacy put in place by the Affordable Care Act;
- Suggest policy solutions for improving network adequacy and provider network information.

Before the Affordable Care Act, Millions Were Locked out of the Health Care System

The Affordable Care Act guarantees access to health coverage and care for millions of Americans. But before the law was in place, millions went without insurance and without needed medical services. This was because health insurance company practices shut them out of coverage or because coverage was too expensive.

Individuals whose employers did not offer affordable health insurance had to shop for coverage in the individual market, where in most states they could be denied coverage because of a pre-existing condition. For customers who were healthy enough to receive an offer of coverage, they frequently faced an additional hurdle: the prohibitive cost of many plans in the individual market. Low-income adults have had even more difficulties obtaining coverage. Many states did not provide Medicaid coverage to childless adults, even when they had little or no income. As envisioned by the Affordable Care Act, about half of the states have expanded Medicaid coverage to everyone below 138 percent of the federal poverty level. But in many of the remaining states, people living in poverty do not qualify for any health coverage.

Prior to the Affordable Care Act, the covered benefits of plans in the individual market were also often insufficient. In 2013, nearly 40 percent of individual market plans did not cover evaluation and treatment of mental health conditions, and more than 45 percent did not cover substance use disorder services. Additionally, more than 65 percent of individual market plans did not cover maternity and newborn care and nearly 20 percent did not cover prescription drugs.ⁱ Even when pre-Affordable Care Act individual market health plans covered needed services, the costs consumers would incur to obtain these services could be enormous. Individual market insurers in most states commonly offered plans with annual deductibles of \$10,000 or more for individuals and \$20,000 or more for couples, and these plans often had no out-of-pocket spending caps.ⁱⁱ

Individual market consumers also struggled to find providers who could meet their needs once enrolled in coverage. Insurers' provider directories have been notoriously inaccurate for decades,ⁱⁱⁱ with little accountability required of the plans to ensure their accuracy and little recourse for consumers in most states who rely on inaccurate provider listings. Networks themselves have long been inadequate,^{iv} with consumers often having to travel too far or wait too long for an appointment with a provider for necessary care. In the worst-case situations, consumers have been unable to find an in-network provider who can meet their needs at all.

The Affordable Care Act Improves Access to Coverage and Care for Americans

Under the Affordable Care Act, all Americans, including vulnerable sick and low-income individuals, are experiencing improved access to health coverage and care. Since the start of the first Affordable Care Act enrollment period in October 2013, the uninsured rate has decreased rapidly. The most recent Gallup-Healthways Well-Being Index ("Gallup Poll") release indicates an uninsured rate of 13.4 percent for the second quarter of 2014, down from an uninsured rate of 17.1 percent during the fourth quarter of 2013.^v This significant decrease in the rate of uninsurance would not have occurred without the Affordable Care Act's premium tax credits, prohibitions on discriminatory insurance practices against people with pre-existing conditions, and expansion of Medicaid.

Once enrolled in coverage, Affordable Care Act protections now guarantee that insurers cannot unfairly rescind consumers' insurance when they get sick, or place annual or lifetime limits on their coverage. The Essential Health Benefits package that is part of the Affordable Care Act guarantees consumers access to critical services that before were often left out of individual market insurance plans, such as prescription drugs and mental health care. Gone, too, are the days of deductibles reaching \$10,000 or more. Plans must now have out-of-pocket spending caps for consumers that guarantee that individuals will not pay more than \$6,350 a year for not just deductibles, but for all cost-sharing, including copayments and co-insurance.

The Affordable Care Act Includes First-Ever Federal Network Adequacy Protections

Before the enactment of the Affordable Care Act, consumers had no federal protections pertaining to provider networks or provider directories in the individual or small group private insurance markets. For the first time, the Affordable Care Act puts *federal* protections in place guaranteeing that consumers in marketplace plans have a right to provider networks that are sufficient in the “number and types of providers, including providers that specialize in mental health and substance abuse services, to assure all services will be accessible without unreasonable delay.” Under the law, marketplace plans must also include in their networks essential community providers, like federally qualified health centers (FQHCs), Ryan White HIV/AIDS providers, and community hospitals, which serve predominantly low-income, medically underserved individuals. And, the Affordable Care Act creates the first-ever federal consumer rights to accurate provider directories in private insurance plans. Rules under the law state that in the marketplaces, plans must make information about which providers are in their networks and which are taking new patients available to consumers.

Having these federal rights in place is an important step. However, problems persist. Consumers continue to struggle to 1) get accurate information about which providers are in health plans’ networks, and 2) find in-network primary care providers, specialists, and other providers and facilities to meet their needs. Fortunately, policymakers can help address these longstanding problems.

Making Consumers’ Rights to Adequate Provider Networks and Directories Real

Consumers have long reported problems finding in-network health care providers and accurate information about their plans’ networks. Through first-person accounts logged in our consumer story bank, Families USA has heard concerns about inadequate networks long before the implementation of the Affordable Care Act. But media coverage of the topic is increasing, as recent news reports^{vi} assert that some marketplace plan networks are narrower than the networks available through plans sold in previous years.

Policymakers must take a holistic perspective when contemplating how to improve network adequacy. It is too simplistic to define a provider network as either “broad” or “narrow.” Instead, policymakers, regulators, and health care consumers should consider whether in a given network, consumers can get the right care, in a timely manner, without having to travel unreasonably far. A plan does not necessarily have to have all health care providers or hospitals in its area in-network to provide this access to consumers. But if a health plan has too few providers or facilities in its network to guarantee these rights, consumers will face barriers to

care. There are some policy changes that lawmakers who are truly interested in improving access to care should consider.

Plans Should Meet Specific Standards for Provider Directory Accuracy and Network Adequacy

Across the country, some states have laws and regulations in place that outline requirements for health plans to ensure that they provide accurate provider directories to consumers and that their provider networks are adequate to meet consumers' needs. Congress could consider enacting federal standards requiring all health plans to provide accurate information to consumers and provide adequate networks.

Congress could develop federal provider network standards that:

- Define the maximum travel time or distance that plan enrollees should have to go to reach an in-network provider;
- Define the maximum amount of time plan enrollees should have to wait to get an appointment with an in-network provider;
- Describe the necessary ratio of providers to plan enrollees to adequately serve the population's medical needs;
- Outline the different types of providers that must be included in each plan's network;
- Define the share of essential community providers in an area that must be included in a plan's network;
- Define the frequency with which plans must update their provider directories;
- Require a plan make it easy for the public to report directory inaccuracies and that the plan investigate these reports and modify directories accordingly in a timely manner.

Families USA has always been concerned with the predicaments faced by consumers who cannot obtain accurate information about the providers in their health insurance plans' networks or who cannot find a provider in-network to meet their needs. This problem existed long before the implementation of the Affordable Care Act, which in fact expands access to health care for millions who had previously no access to care at all. Policymakers genuinely concerned with provider network problems should act to implement standards to ensure that, regardless of whether plans have broad or narrower networks, all health plan networks can provide to consumers the right care, at the right time, without consumers having to travel unreasonably far. Families USA would welcome the opportunity to work with members of the

Committee to craft these standards and appreciates the opportunity to provide input on this important consumer issue.

ⁱ <http://www.healthpocket.com/healthcare-research/infostat/few-existing-health-plans-meet-new-aca-essential-health-benefit-standards/#.U5IGOSj5lFE>

ⁱⁱ <http://www.gao.gov/assets/660/656121.pdf>

ⁱⁱⁱ http://www.commonwealthfund.org/usr_doc/731_shelton_physician_directory_information.pdf;
<http://www.ag.ny.gov/press-release/health-plan-correct-inaccurate-physician-directories>;
http://www.oag.state.ny.us/sites/default/files/pdfs/bureaus/health_care/settlements/MultiPlan_10-006.pdf;

^{iv} <http://www.texmed.org/Template.aspx?id=4228>;

<http://www.mentalhealthpromotion.net/resources/untreated-and-undertreated-mental-health-problems-how-are-they-hurting-your-business.pdf>

^v <http://www.gallup.com/poll/170882/uninsured-rate-holds-steady.aspx>

^{vi} <http://www.latimes.com/business/healthcare/la-fi-healthcare-watch-20140601-story.html>