LEGISLATIVE COMMITTEE MINUTES

SB157

Bill as Introduced

2017 SESSION

17-0968
01/10

SENATE BILL ***157***

AN ACT relative to network adequacy and consumer rights under the managed care law.

SPONSORS: Sen. Feltes, Dist 15; Sen. Fuller Clark, Dist 21; Sen. Hennessey, Dist 5; Sen. Kahn, Dist 10; Sen. Lasky, Dist 13; Sen. Soucy, Dist 18; Sen. Watters, Dist 4; Sen. Woodburn, Dist 1; Rep. Luneau, Merr. 10; Rep. Williams, Hills. 4; Rep. Butler, Carr. 7

COMMITTEE: Health and Human Services

ANALYSIS

This bill adds rulemaking for persons with substance use disorder for the purposes of the managed care law. This bill also requires health carriers to notify covered persons of their rights as a managed care consumer.

Explanation: Matter added to current law appears in ***bold italics.***
Matter removed from current law appears [~~in brackets and struckthrough.~~]
Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

SB 157 - AS INTRODUCED

17-0968
01/10

STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Seventeen

AN ACT relative to network adequacy and consumer rights under the managed care law.

Be it Enacted by the Senate and House of Representatives in General Court convened:

1 Managed Care Law; Network Adequacy. Amend RSA 420-J:7, II(b) to read as follows:

(b) Choice of and access to providers for specialty care, specifically addressing the needs of the chronically ill, mentally ill, ***persons with substance use disorder,*** developmentally disabled or those with a life threatening illness.

2 New Section; Managed Care Law; Notice of Managed Care Consumer Rights. Amend RSA 420-J by inserting after section 7-d the following new section:

420-J:7-e Notice of Managed Care Consumer Rights. A health carrier shall, at least annually, in conspicuous and stand-alone correspondence, notify each covered person of his or her rights under this chapter as a managed care consumer, including, but not limited to, appeal rights and the ability to access services out-of-network in the event covered services are not available in-network. A health carrier shall notify covered persons of these rights when a covered person contacts the health carrier directly requesting assistance finding clinically appropriate care.

3 Effective Date. This act shall take effect 60 days after its passage.

Committee Minutes

Senate Health and Human Services Committee

Kyle Baker 271-2609

SB 157, relative to network adequacy and consumer rights under the managed care law.

Hearing Date: February 14, 2017

Time Opened: 1:30 p.m. **Time Closed:** 2:00p.m.

Members of the Committee Present: Senators Bradley, Avard, Gray, Fuller Clark and Hennessey

Members of the Committee Absent : None

Bill Analysis: This bill adds rulemaking for persons with substance use disorder for the purposes of the managed care law. This bill also requires health carriers to notify covered persons of their rights as a managed care consumer.

Sponsors:

Sen. Feltes	Sen. Fuller Clark	Sen. Hennessey
Sen. Kahn	Sen. Lasky	Sen. Soucy
Sen. Watters	Sen. Woodburn	Rep. Luneau
Rep. Williams	Rep. Butler	

Who supports the bill: Sen. Watters, SD# 4; Sen. Kahn, SD# 10; Sen. Lasky, SD# 13; Sen. Feltes. SD#15; Michele Merritt, New Futures; Ken Norton, NAMI NH

Who opposes the bill: None

Who is neutral on the bill: Tyler Brannen, NHID; Paula Rogers, Anthem

Summary of testimony presented in support:

Senator Feltes – Senate District 15

- This bill continues to ensure that there is parity for mental health treatment and medical surgical services.
- This bill seeks to rectify some consumer rights in the managed care program.
- If you cannot find services in network you are supposed to be able to access them out of network but many people do not know this.
- This bill would require that carriers notify the insured that they can go out of network for services in the event that services are not available in network.

- The bill also requires the notification of appeal rights when they get denied.
- We need to make sure people can get access to the mental health and substance abuse treatment they need.
- Modest step to make sure people know what their rights are.
- Many carriers are already doing this and this bill would make it a requirement across all of the carriers.

Michelle Merritt – New Futures

- Supports
- Passage of this bill would increase consumer awareness of their rights and improve access to critical behavioral health services.
- If a carrier does not have capacity for a particular service in network the carrier is required to provide the service from out of network but many people do not know their rights.
- When a patient calls their insurance company they are provided a list of providers that they can go to for treatment but they are often not informed of their rights for out of network services if there is no capacity in network.
- Common sense bill to increase awareness for consumers.
- Does not impose any new obligations for insurance carriers to cover services.

Ken Norton – NAMI NH

- Lack of out-patient care plays a big role in the long waits in the ER for care.
- People often call providers for help but many of the providers are no longer taking new patients and the wait times can be months to get an initial appointment.
- NAMI released a report outlining the disparity between getting prompt healthcare for mental health and people getting care for medical and surgical services.
- When someone is in need of mental healthcare it is often a critical moment and patients and families will do whatever they need to do. They might pay out of pocket for out of network services because they are not aware

Sen. Fuller Clark – Does out of network mean someone can go out of state.
Norton – Would defer to the insurance department for that question.
Sen. Fuller Clark – There is an increase in the need for mental health services in colleges across the country. Can you speak to this?
Norton – Yes this is being documented and that is why it is important to make sure that there are the appropriate services available for people that need them.

Summary of testimony presented in opposition: None

Neutral Information Presented:

Tyler Brannen – NHID

- The department is neutral on this bill but they do feel that the increasing notification of network adequacy, especially for substance use disorders is likely to support the goals of the department as they rework their network adequacy rule to fit the new model the department is going forward with.
- One thing that insurance carriers need to be careful of is adverse selection.
    - Adverse selection is where a carrier that provides the best information about certain services will most likely attract the most people needing that service. This means that a carrier that provides the most information about SUD services will tend to attract the most people needing those services. This can be costly for a carrier because this particular population may be more expensive on a number of different fronts
    - Worried about how adverse selection can determine the amount of information a carrier shares on initial contact with their insured.
- NH has had network adequacy laws on the books for a long time
- Network adequacy does not mean adequate coverage it simply means that a certain number of providers on in the network.
- The department did a report that looks at the payment levels for SUD treatment.
    - Report concluded that all the private carriers are paying less than Medicare for these services
- The department thinks this bill would support the new model the insurance department is moving forward with to increase access and coverage for mental health and substance use disorders.

  Sen. Bradley – Are there any costs associated with this?

  Brannen – If you are forcing insurance companies to contract with people they have not contracted with before there would be higher payments paid for this population which could lead to an increase in premiums.

Paula Rogers – Anthem

- No issue with adding persons with substance use disorders to those covered under RSA 420-J:7,IIb
- Concerned with the new section because we are not sure where Anthem is as far as compliance with the new section.
- Concerned with the comments from the Insurance Department that the payment from carriers for substance abuse disorders is substantially less than Medicare. Anthem has taken exception to the report put out by the department

and has been in talks with the Commissioner and the report developers with no positive outcomes so far.

- Anthem will get back to the committee with more information.

Future Action: Pending

KRB
Date Hearing Report completed: February 15, 2017

Speakers

Senate Health and Human Services Committee

SIGN-IN SHEET

Date: 2/14/2017 **Time:** 1:15 p.m.

SB 157-FN AN ACT relative to network adequacy and consumer rights under the managed care law.

Name/Representing ***(please print neatly)***

Name/Representing	Support	Oppose	Speaking?	Yes	No
Watters Dist 4	☑	☐	Speaking?	☐	☐
Sen Kahn Dist 10	☑	☐	Speaking?	☐	☐
Sen. Bette Lasky SD #13	☑	☐	Speaking?	☐	☑
Sen Dan Feltes SD #15	☑	☐	Speaking?	☐	☐
Tyler Brannen NHID	☐	✓ ☐	Speaking?	☑	☐
Paula Rogers	☐	✓ ☐	Speaking?	☒	☐
Senator Fuller Clark SD21	☐	☐	Speaking?	☐	☐
Michele Merritt New Futures	☒	☐	Speaking?	☒	☐
Ken Norton NAMI, NH	☑	☐	Speaking?	☑	☐
	☐	☐	Speaking?	☐	☐
	☐	☐	Speaking?	☐	☐
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Testimony

NAMI New Hampshire

National Alliance on Mental Illness

February 14, 2017

Honorable Chairman Jeb Bradley
Senate Health and Human Services Committee
Room 101 Legislative Office Building
33 N. State Street
Concord, NH 03301

Dear Chairman Bradley and Members of the Committee,

Thank you for the opportunity to testify today. My name is Kenneth Norton and I serve as Executive Director of NAMI NH, the National Alliance on Mental Illness. I also have several family members with a serious mental illness. On behalf of NAMI NH, I am here to speak on behalf of SB 157.

NH is in the midst of a mental health crisis characterized by an inability to access timely mental health treatment. While the most obvious symptom of this is the number of people being boarded in emergency departments waiting for inpatient treatment, yesterday there were 53 adults and children waiting. Timely access to outpatient treatment is also a critical part of the picture and likely a significant contributor to the emergency department boarding situation.

As part of our move as a state to a Medicaid Managed Care model, network adequacy is an essential component of the managed care contracts and was a key determining factor in the decision to "go live" with managed care in New Hampshire. Network adequacy means that there are a sufficient number of health care providers, including mental health and substance use disorder providers within a certain distance from their homes. Managed care companies then contract with providers in order to insure that they have an adequate network of providers.

The challenge that has emerged is that providers become full or stop accepting new patients or have long waiting lists to be served. A colleague last week told me she called her local community mental health center to get an appointment for her 18 year old son who was depressed and anxious only to be told the first available appointment was in four months. Many people call multiple providers within "the network" without being able to access timely care. Some then seek care out of network (from a provider who is not approved) which then results in the insurer refusing to pay for treatment because it is "out of network".

NAMI has tracked this issue nationally and during the past year completed a national survey and in November of 2016 issued a summary titled, *"Out of Network, Out of Pocket, Out of Options"*, which provides details about the challenges faced by consumers when accessing mental health care. One result of the survey was that people were much more likely to encounter difficulty accessing mental health or substance abuse treatment within their network than for physical disorders and subsequently, many ended up paying for services out of their own pocket.

Although the report found that the Medicaid recipients were slightly more likely than their privately insured counterparts to find in network care, there was still a considerable gap when compared to accessing health care for physical disorders. The report offered five recommendations including that consumers be fully reimbursed for the cost of out of network providers if they are unable to access appropriate care within their network. I have provided copies of the report along with my written testimony.

One of the biggest challenges with network adequacy is that consumers are not aware of their rights. When faced with a mental health crisis for themselves, a family member or a loved one, they will do whatever it takes to access timely treatment. SB 157 is proposed as a way of insuring that Medicaid Managed Care recipients are informed of their rights for treatment to be paid for if they have tried and been unable to access treatment within their network.

On behalf of NAMI NH, I ask that you vote SB 157 as ought to pass. Thank you for your time and consideration.

Respectfully,

Kenneth Norton, LICSW
Executive Director

Out-of-Network, Out-of-Pocket, Out-of-Options

The Unfulfilled Promise of Parity

NAMI
National Alliance on Mental Illness

National Alliance on Mental Illness

About NAMI

NAMI, the National Alliance on Mental Illness, is the nation's largest grassroots mental health organization dedicated to building better lives for the millions of Americans affected by mental illness.

Acknowledgements and Gratitude

This report was prepared by NAMI staff including Dania Douglas, Sita Diehl, Ron Honberg and Angela Kimball. For survey data analysis, NAMI expresses sincere gratitude to Deb Medoff, Ph.D., from the University of Maryland School of Medicine, Department of Psychiatry. We also thank policy interns Kayla Prince, Elena Schatell, Krystal Canare and Katharine Carter for assistance with the survey and data analysis. This report is made possible by the leadership of Mary Giliberti, Chief Executive Officer. We deeply appreciate the 3,081 individuals and family members affected by mental health or substance use conditions who responded to the survey, sharing their experience of health insurance coverage.

This report was made possible by support from Otsuka America Pharmaceutical and other generous donors.

www.nami.org

NAMI HelpLine: 800-950-NAMI (6264)

Twitter: @NAMICommunicate

Facebook: facebook.com/NAMI

NAMI 3803 N. Fairfax Drive, Suite 100 Arlington, VA 22203

INTRODUCTION

"I don't even try to use mental health benefits anymore provided by my insurance company. It requires pre-authorization by one of their providers. My psychiatrist isn't in any network. I have been going to her for over 20 years. She is part of the reason I'm still on this earth. I spend roughly $175/month to see her, and it's worth it. I would spend less money on food, if I had to, rather than stop seeing her."

For many Americans, finding quality, affordable mental health care is like navigating an obstacle course. High costs, difficulty finding providers and attempting to understand insurance documents can make accessing mental health care difficult for many, and impossible for some.

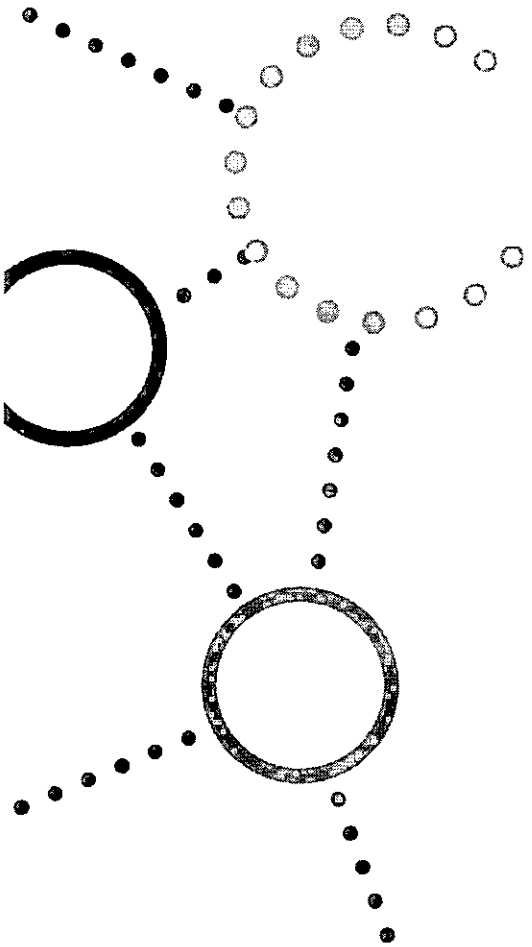
In 2014, NAMI issued a report, "A Long Road Ahead: Achieving True Parity in Mental Health and Substance Use Care," which described the results of a survey on the experiences of people with mental health conditions and their families with private health insurance. The survey revealed that, despite the requirements of federal parity legislation, people encountered significant barriers to receiving services.

NAMI updated the survey in 2015 and found that people were continuing to confront these obstacles to care. *Out-of-Network, Out-of-Pocket, Out-of-Options* highlights the findings of this survey, which echoes the same truth about the status of mental health parity: we're not there yet.

SURVEY DESCRIPTION

NAMI conducted an online survey in winter 2015 to answer the question, "What do insurance beneficiaries experience when they seek mental health care?" The survey drew responses from 3,081 individuals. To be eligible, a person had to have either private health insurance or public health coverage, such as Medicaid. Respondents were asked a series of questions elicit information about their experiences accessing care for mental health and substance use disorders relative to their experiences accessing care for primary and specialty medical care.

Survey respondents could answer for themselves or for another person for whom they could provide reliable information. The majority of people responded for themselves (61.1%) or their child (30.9%). Of the respondents, 65% were female, 87% were Caucasian and 44.5% were ages 26–49. Incomes were low: 65.8% earned less than $25,000, and 40% were working full or part-time.



SURVEY FINDINGS

Consistent with nationally-reported trends, NAMI's survey found that people with insurance had more difficulty locating in-network providers and facilities for mental health care compared to general or specialty medical care. This was true of both inpatient mental health care (hospitals and residential facilities) and outpatient mental health care (therapists and prescribers of mental health medications). Because out-of-network providers were often the only reasonable option, many respondents incurred greater costs for mental health compared to other types of specialty medical care.

Outpatient Mental Health Care

Survey results showed that people were far less likely to find or use an in-network mental health provider compared to other types of medical specialists. For the purposes of the study, outpatient mental health providers included mental health prescribers (psychiatrists and other practitioners who prescribe mental health medications) and mental health therapists (therapists and counselors). These results are consistent with other studies, which found that people have particular difficulty finding in-network psychiatrists.[3] The results showed that the difficulty in finding in-network mental health providers also extended to other mental health professionals, such as psychologists and social workers.

In-Network Mental Health Therapists

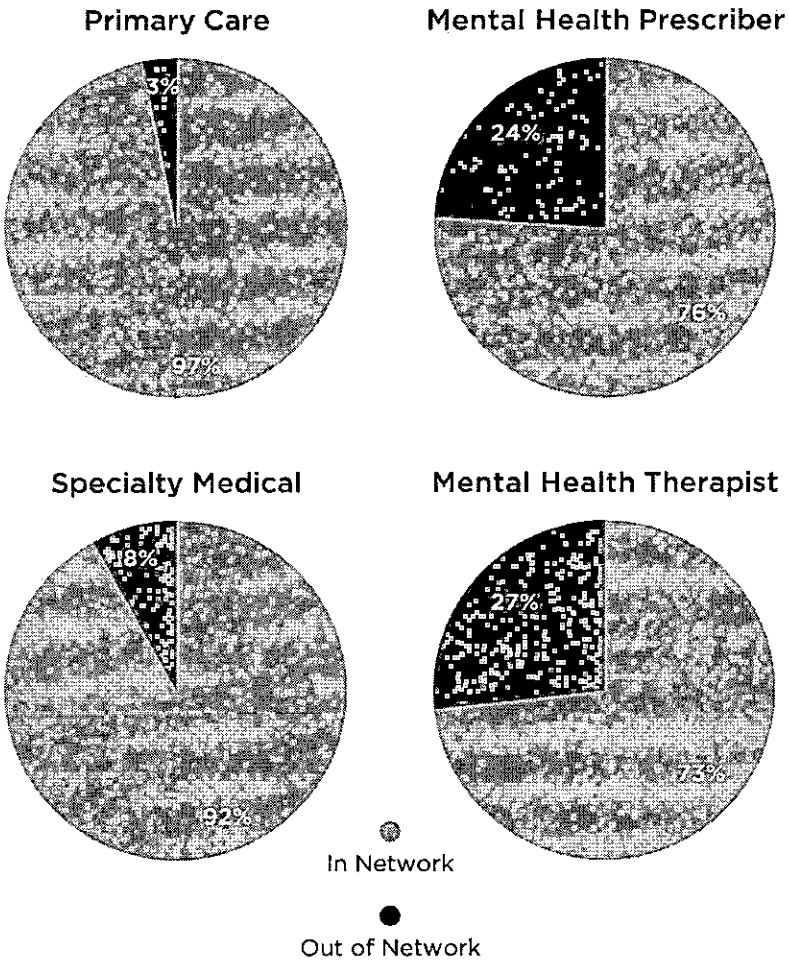
Three out of four (73%) respondents reported that they had an in-network mental health therapist, whereas nine out of 10 (91%) reported that they had an in-network medical specialist. This means that one in four respondents did not have a mental health therapist in their health plan's network, while only one in 10 did not have an in-network medical specialist. In addition, respondents were about 80% more likely to report having difficulty finding a therapist who would accept their insurance (32%) compared to other types of specialty medical care (18%).

In-Network Mental Health Prescribers

Results for finding in-network mental health prescribers were very similar to results for therapists. Among respondents, 76% had an in-network mental health prescriber compared to 91% having an in-network medical specialist. In other words, about one in four respondents did *not* have a mental health prescriber covered by their plan's network, while only one in 10 did not have an in-network medical specialist. Survey participants were about 70% more likely to report having difficulty finding a prescriber who would accept their insurance (30%) compared other types of specialty medical care (18%).

Outpatient Provider Networks

Percentage of respondents with in-network vs. out-of-network providers



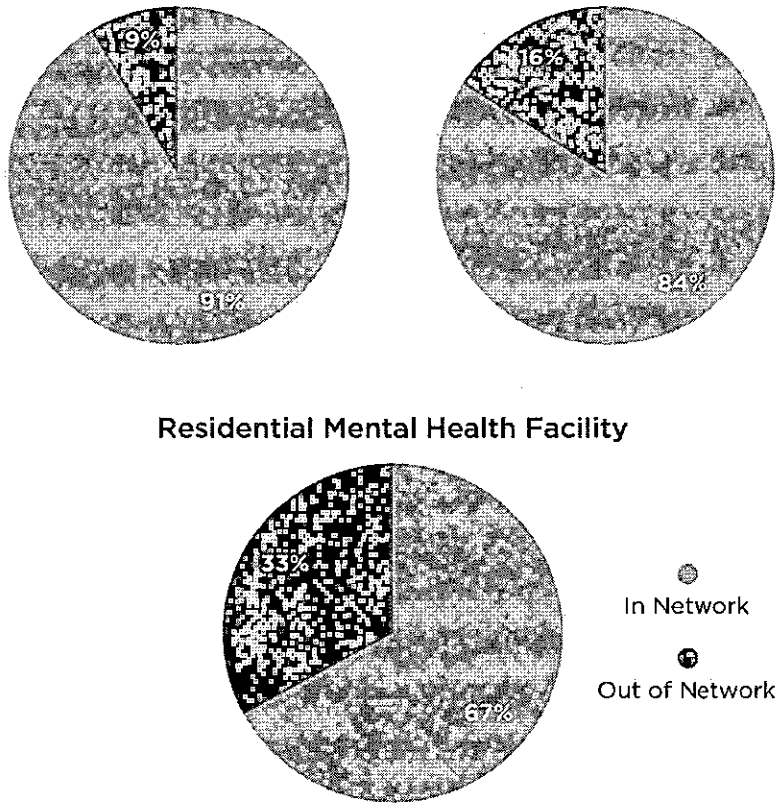
"The majority of the mental health professionals in my area do not participate in any insurance plans. The in-network providers do not have the same level of quality. My insurance plan has an $8,000 deductible for out-of-network benefits. The psychiatrist charges $215 and the insurance reimburses $60 because that is what they determine to be a Usual and Customary Reasonable (UCR) rate. We have depleted our savings and incurred much debt to get the quality mental health care we need."

Inpatient Mental Health Care

Survey respondents were also more likely to go out-of-network and incur high expenses for psychiatric hospital care and psychiatric residential treatment than for hospital care to treat other medical conditions. Psychiatric hospitals include state-operated psychiatric hospitals, private free-standing psychiatric hospitals and psychiatric units within general hospitals.

Inpatient Networks

Percentage of respondents who received care in in-network facilities vs. out-of-network facilities



In-Network Inpatient Mental Health Care

The study showed that only 87% of people needing psychiatric hospitalization (inpatient care) received treatment in an in-network psychiatric hospital, while 92% of people needing hospitalization for other medical conditions were able to receive services in an in-network hospital. In addition, people were more than twice as likely to have trouble finding a psychiatric hospital that would accept their insurance (19%) compared to other types of hospital care (8%).

In-Network Residential Mental Health Care

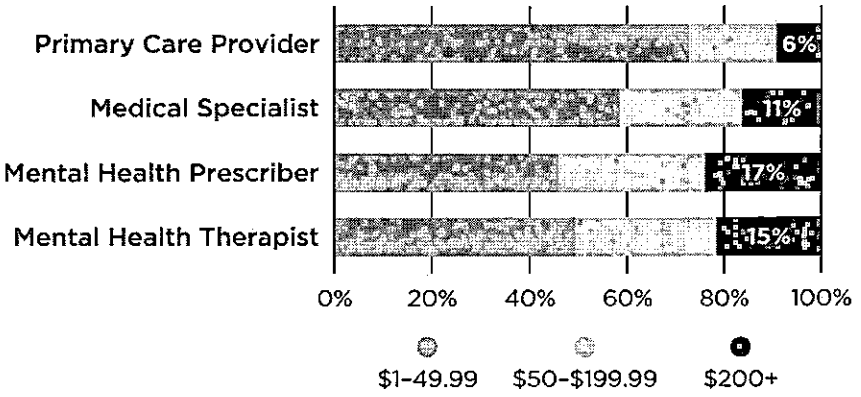
Residential mental health care involves treatment in a facility for people who need more intensive services, but who do not meet criteria for hospital care. Survey respondents had even more trouble finding in-network residential mental health treatment than psychiatric hospital care. They were far less likely to use in-network residential mental health facilities (67%) compared to other types of inpatient medical care (92%). This means that one in three respondents did not receive care in an in-network residential mental health facility, and one in four had difficulty finding one that would accept their insurance.

Out-of-Pocket Costs

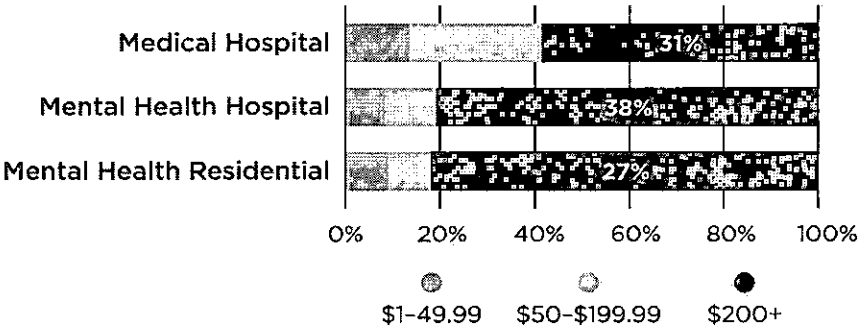
Survey respondents faced greater out-of-pocket costs (costs not covered by insurance) for outpatient and inpatient mental health care than for other types of specialty medical care. This result is not surprising given the difficulty respondents faced in finding in-network mental health care. However, it is particularly concerning that out-of-pocket costs were significantly higher for both mental health prescribers and therapists compared to medical specialty care. There were no significant differences in out-of-pocket costs between respondents with private insurance compared to respondents with Medicaid.

Out-of-pocket costs for psychiatric hospital stays and residential mental health care were much higher than out-of-pocket costs for hospital care for other types of medical conditions. Eight in 10 respondents had out-of-pocket costs of over $200 for psychiatric hospital or residential mental health care compared to fewer than six in 10 for general hospital care. There were no significant differences in out-of-pocket costs between private insurance and Medicaid.

Outpatient Out-of-Pocket Costs



Inpatient Out-of-Pocket Costs



Medicaid

Medicaid recipients were more likely to have an in-network mental health prescriber or therapist than those with private insurance. Medicaid recipients were also more likely to use an in-network psychiatric hospital or residential treatment versus out-of-network facilities. These results run counter to the common perception that private insurance provides more readily-available in-network care than state Medicaid programs.[4]

Provider or Service	Medicaid In-Network Rate	Private Insurance In-Network Rate
Mental health prescriber	86%	70%
Mental health therapist	82%	68%
Psychiatric hospital	88%	80%
Residential mental health	80%	57%

DISCUSSION

With passage of the Affordable Care Act and the decision by 32 states (including the District of Columbia) to expand Medicaid, millions of Americans who previously had no health insurance now have access to health coverage. Combined with the federal parity law requirements, Americans should have better access to mental health care than at any time in history. Yet, studies have consistently shown that, despite improvements, people with mental health conditions who have health insurance still struggle to find mental health providers and services in their health plan networks.

One reason for the difficulty finding in-network mental health care is the critical nationwide shortage of mental health professionals, including psychiatrists and licensed therapists.[5] In 2012, there were 3,669 Mental Health Professional Shortage Areas (HPSAs) containing almost 91 million people. At least 1,846 psychiatrists and 5,931 other practitioners would be needed to fill the gap.[6] Shortages are most severe for specialties such as children's mental health, in rural areas and underserved communities.[7]

Adding to the problem, many mental health providers—particularly psychiatrists—do not accept health insurance. A recent study published in the Journal of the American Medical Association found that only 55% of the nation's psychiatrists accepted insurance compared with 88% of physicians in other medical specialties.[8]

Mental health providers often cite low reimbursement rates and heavy administrative burden as the main reasons they have chosen not to participate in health plans.[9] Mental health providers spend more time with a patient than a typical primary care practitioner (PCP) or other medical specialist. In addition, mental health providers often operate small or solo practices, which leaves many without the infrastructure to complete paperwork and negotiate treatment authorization with insurance personnel.[10]

Another significant contributing factor is that insured individuals appear to be having difficulty finding accurate information about participating providers in their health insurance plans.

"[My relative] has had terrible trouble finding a psychiatrist in our community. He has been traveling 50 miles each way to see a psychiatrist. The wait lists for all psychiatrists locally are between six months and two years."

"I have a psychiatrist who also handles my psychotherapy. Insurance will only reimburse him $75 for an hour of services. He is out-of-network—he has to be—at $225 an hour. My current insurance has no deductible limit on out-of-network services. I have to pay 100% and have had to cut back on psychiatry visits. This has caused a lot of problems and threatens my ability to maintain my job."

Survey respondents complained about making multiple calls only to discover that the health plan directory listed providers who were no longer practicing, were deceased or did not accept their health plan. In addition, callers often found that practitioners were not accepting new patients, or the first available appointment was weeks or even months out.

Secret shopper surveys and reports show that insurance networks are failing to keep up-to-date, comprehensive provider directories.[11] Finding mental health care while experiencing symptoms is difficult enough. Making phone calls to non-working numbers or providers who are no longer practicing further delays care. In addition, frequent changes in provider networks can lead to disruptions in care, confusion and unexpected medical bills.

Some positive efforts are underway to require health plans to maintain accurate provider directories. For example, the California Insurance Commissioner issued regulations[12] to strengthen mental health provider network requirements, appointment wait time criteria and provider directory standards. A provision in these regulations requires health plans to apply in-network costs to consumers for out-of-network care when in-network providers are not available. Maryland has also recently enacted legislation to strengthen network adequacy and provider directory standards.[13]

RECOMMENDATIONS

Health plans are responsible to maintain provider networks sufficient to deliver care for plan enrollees, yet survey respondents had greater difficulty finding an in-network mental health provider in their community than for other medical care. Many were forced to pay higher out-of-pocket costs or to travel long distances for care. To address disparities in accessing mental health care, NAMI recommends the following:

1. **Maintain accurate, up-to-date directories.** America's Health Insurance Plans is testing a "one-stop" method to update provider directories on behalf of all health plans in a given state. Providers are contacted quarterly to verify their directory listing. If there are any changes, providers can update their information for all insurers through a single portal rather than having to report to each plan separately.[14] Health plans should adopt this method or other measures to ensure they maintain up-to-date directories.

   Recent regulations allow the Centers for Medicare and Medicaid Services to fine some types of health plans[15] for provider directory errors. An increasing number of states—including California, Maryland, Illinois and New York—require insurers to update provider directories at frequent intervals. States should adopt these accountability measures throughout the country.

2. **Provide easy-to-understand information about mental health benefits.** Health plans should provide detailed and user-friendly information about covered mental health and substance use services, prescription drug coverage, treatment limitations and exclusions and out-of-pocket costs. Information should be available to consumers prior to purchasing or enrolling in a health plan, when re-enrolling and upon demand.

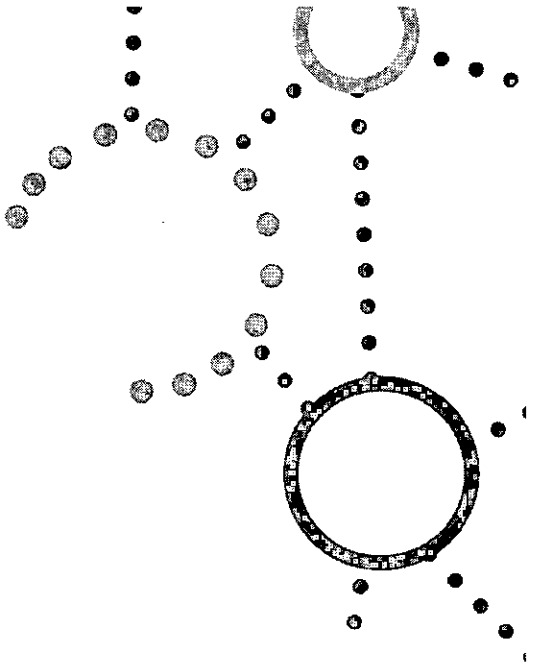
3. **Promote integration of care.** Health plans should promote integration of mental health and primary care to expand availability of mental health care, including covering psychiatric consultation to primary care providers, peer professional training and telehealth technology to deliver mental health care.

4. **Expand provider mental health networks.** Health plans should set provider reimbursement rates for mental health and substance use care that cover the cost of doing business and are sufficient to attract qualified professionals to provider panels. Additionally, administrative requirements should be streamlined and simplified and loan forgiveness programs and other incentives adopted to motivate practitioners to enter mental health fields and practice in underserved areas.

5. **Cover out-of-network care to fill provider gaps.** Health plans should be required to cover the full cost for medically necessary mental health care provided by an out-of-network provider when no appropriate in-network provider is available or accessible.

CONCLUSION

Despite the federal parity law, the promise of parity remains elusive. Consumers continue to face significant challenges finding a provider, getting an appointment and paying the bill for mental health care compared to other types of specialty medical care. For the sake of millions of children and adults affected by mental health conditions, NAMI calls on health plans—and state and federal lawmakers—to address these disparities and improve access to quality, affordable mental health care.



REFERENCES

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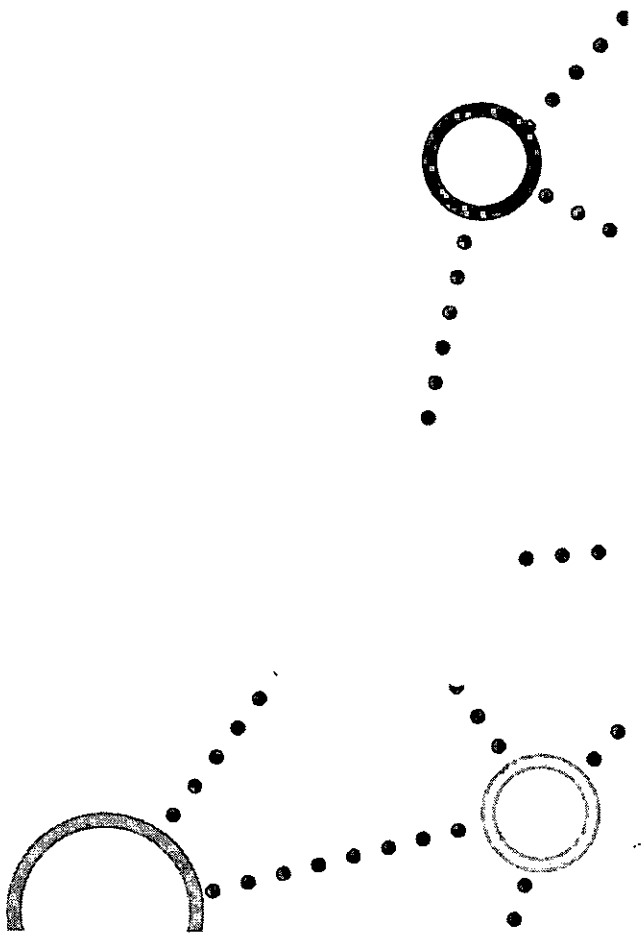

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February 14, 2016

Senate Health and Human Services Committee
Legislative Office Building, Room 101
33 North State Street
Concord, NH 03301

Re: Support for SB 157; Relative to Network Adequacy and Consumer Rights under the Managed Care Law

Dear Honorable Committee Members:

New Futures strongly supports SB 157, which modifies RSA 420-J: 7, II (b) to clearly identify individuals with substance use disorder as a population requiring timely access to specialty care services. SB 157 also includes a critical addition to NH's managed care law, requiring carriers to notify consumers of their rights to access services out-of-network in the event a covered service is not available in-network without unreasonable delay. If passed, SB 157 will undoubtedly increase consumer awareness of their rights and improve access to critical behavioral health services.

Under current NH Law and Insurance Rules, health insurance carriers must "maintain a network sufficient in numbers, types, and geographic location of providers to ensure that all services to covered persons will be accessible *without unreasonable delay*."[1] In the event a covered person is unable to access treatment from an in-network provider in a timely manner, the carrier has an existing obligation under Ins 2701.04 (e) to cover services provided by out-of-network providers at no greater cost to the beneficiary.[2]

Unfortunately, the right to reasonable and timely access to care is not well-known among beneficiaries or behavioral health providers. During New Futures' recent series of community presentations on the *Resource Guide for Addiction and Mental Health Care Consumers,*[3] this lack of knowledge became increasingly apparent. For the majority of consumers, the first step to locating covered treatment is to call their health insurance carrier. During these calls, consumers are often given a list of approved in-network providers, but are not informed of their right access out-of-network services in the event in-network providers are unable to provide treatment in a timely manner. This results in many consumers unnecessarily waiting weeks for needed (and approved) treatment services or forgoing their coverage for self-pay providers, at extremely high costs.

SB 157 does not impose any new obligations for insurance carriers to cover services; it merely requires carriers to notify consumers of their *existing* rights under the managed care law. New

[1] NH Rev Stat § 420-J:7 (2015)
[2] Ins 2701.04 (e) "(e) In any county or hospital service area in which compliance with Ins 2701.04(a) is required and in which a health carrier's network is insufficient to meet one of the access standards in Ins 2701.06 and in which the carrier has not been granted an exception pursuant to Ins 2701.06(e), *the health carrier shall cover services provided by a non-participating provider located within the applicable geographic area at no greater cost to the covered person than if the services were obtained from a participating provider.*"
[3] http://new-futures.org/NavigatingTreatmentGuide

Futures believes SB 157 to be a common sense solution to ensuring adequate consumer education.

If passed, SB 157 will help to inform consumers of their rights and out-of-network treatment options, removing a significant barrier to timely access to treatment for individuals with behavioral health conditions. For the reasons cite above, New Futures *strongly supports* SB 157 and encourages the Committee to vote SB 157 Ought to Pass.

Sincerely,

Michele D Merritt

Michele D. Merritt, Esq.
Senior Vice President/ Policy Director
New Futures

Committee Report

STATE OF NEW HAMPSHIRE

SENATE

REPORT OF THE COMMITTEE

Wednesday, March 22, 2017

THE COMMITTEE ON Health and Human Services

to which was referred **SB 157**

AN ACT relative to network adequacy and consumer rights under the managed care law.

Having considered the same, the committee recommends that the Bill

OUGHT TO PASS WITH AMENDMENT

BY A VOTE OF: 5-0

AMENDMENT # 1042s

Senator Martha Fuller Clark
For the Committee

Kyle Baker 271-2609

HEALTH AND HUMAN SERVICES

SB 157, relative to network adequacy and consumer rights under the managed care law.
Ought to Pass with Amendment, Vote 5-0.
Senator Martha Fuller Clark for the committee.

Other Referrals

COMMITTEE REPORT FILE INVENTORY

S3157 **ORIGINAL REFERRAL** _____ **RE-REFERRAL**

✓ AS INTRODUCED TO COMMITTEE

✓ **HEARING REPORT**

✓ **SIGN-UP SHEET(S)**

✓ **COMMITTEE REPORT**

✓ **PREPARED TESTIMONY AND OTHER SUBMISSIONS HANDED IN AT THE PUBLIC HEARING**

ALL AMENDMENTS (passed or not) CONSIDERED BY COMMITTEE:

____ - AMENDMENT # _____ ____ - AMENDMENT # _____

____ - AMENDMENT # _____ ____ - AMENDMENT # _____

____ **OTHER (Anything else deemed important but not listed above, such as amended fiscal notes):**

DATE DELIVERED TO SENATE CLERK **BY:**

_____ _____

COMMITTEE AIDE