CPPP Center for Public Policy Priorities

Testimony

May 5, 2011 Stacey Pogue, pogue@cppp.org Senate State Affairs Committee

CSSB 1430 – EXCLUSIVE PROVIDER ORGANIZATIONS

The committee substitute for Senate Bill 1430 (CSSB 1430) authorizes a new type of fully insured health benefit plan, an exclusive provider organization (EPO), that combines features from preferred provider organization (PPO) plans and health maintenance organizations (HMOs). EPOs have the potential to lower premiums, which can increase access to coverage for small employers and families. However, lower EPO premiums come with tradeoffs for consumers—less access to out-of-network care than a PPO and higher and less predictable out-of-pocket costs (deductibles and coinsurance) than an HMO. As filed, the center was concerned that SB 1430 lacked needed consumer protections. But the center is satisfied with the language of the substitute, which ensures access to out-of-network care when a service is not available in-network, improves disclosure, and extends relevant balance billing protections that exist today for HMOs.

Consumer Tradeoffs related to EPOs

Exclusive provider organizations are a hybrid between PPO plans and HMOs. From a consumer's perspective, EPOs share some of the upsides and some of the downsides of both PPOs and HMOs.

EPO Trade-Offs for Consumers

	EPO Upsides	EPO Downsides
Like an HMO	**Cost:** Lower premiums	**Access:** Limited to care from in-network providers (with limited exceptions)
Like a PPO	**Access:** Do not need to designate a PCP or get referrals for specialists	**Cost:** Face higher and less predictable out-of-pocket costs when you get care (deductibles and coinsurance)

Costs

Because EPOs do not have out-of-network coverage, they should have lower premiums than PPO plans, a big benefit for consumers. Although EPOs will have lower up-front (premium costs) like HMOs, EPO enrollees will face larger and less predictable out-of-pocket costs than HMO enrollees because EPO enrollees will be subject to deductibles and coinsurance. HMO enrollees generally have low and predictable out-of-pocket costs when they get health care, subject to just a copayment (for example, $20 for an office visit), with no (or low) deductibles and no coinsurance.

Access to Providers

Like HMOs, EPOs limit coverage to in-network providers and do not cover out-of-network care (with limited exceptions). In HMOs and EPOs, enrollees' out-of-network care is covered only in emergencies and when a covered service is not available in network. Otherwise, the enrollee must pay the full cost of care received from an out-of-network provider. Like PPOs, EPOs do not require enrollees to select a primary care physician or get referrals for specialists.

Health Plan Features Related to Access to Providers

	Covers Out-of-Network Care (with higher out-of-pocket costs)	No Out-of-Network Care (limited exceptions)
Must Designate PCP to Coordinate Care	**POS** Point of Service Plan	**HMO** Health Maintenance Organization
No PCPs Designated	**PPO** Preferred Provider Organization Plan	**EPO** Exclusive Provider Organization

Consumer Protections Included in CSSB 1430

The committee substitute for SB 1430 extends basic but important consumer protections to EPO enrollees, by ensuring access to out-of-network care when a service is not available in-network, improving disclosure, and extending relevant balance billing protections that exist today for HMOs.

Protection from Balance Billing

Balance billing can occur when an enrollee gets out-of-network care. In these cases, the provider and health plan have not agreed on a reimbursement rate for services. If the health plan's standard payment does not cover the provider's charge, the provider may bill the enrollee for the balance. Balance billing is a significant concern for consumers, who are often surprised that despite paying premiums, deductibles, and coinsurance, they may still owe more for health care.

EPO enrollees would only have the potential to face balance bills in the two limited circumstances in which their out-of-network care is covered: (1) emergencies, and (2) when a medically necessary covered service is not available in network. In both cases, the circumstances that caused the enrollee to get out-of-network care was beyond the enrollee's control. In an emergency, people need to seek the most immediate care, which may be in an out-of-network hospital. In other cases, the enrollee goes to an in-network hospital but is seen by an out-of-network ER physician, surgeon, etc. In an emergency, patients do not have the ability to ensure that hospital-based physicians are in their network.

The only other circumstance in which out-of-network care is covered in an EPO is when the enrollee has to get a covered service out-of-network because the service is not available in network. This is clearly beyond an enrollee's control, and in fact, is a direct result of a health plan failing to maintain an adequate network for covered services as required by law. EPO enrollees pay premiums with the promise of access to preferred providers for covered services. Enrollees should not be subject to balance billing when the health plan's network is insufficient to deliver covered services.

EPO and HMO enrollees can only get covered out-of-network care in the same two circumstances: in an emergency or when a covered service is not available in network. Texas HMO enrollees are <u>not</u> balance billed in these circumstances. Instead, the HMO makes the out-of-network provider whole, either by negotiating an agreeable rate with the provider or paying the provider's billed charge.

The committee substitute contains the same language related to balance billing as currently applies to HMOs, extending the same balance billing protections to EPO enrollees. The center supports this important addition.