Georgia Consumer and Provider Protection Act Senate Study Committee Hearing
November 9, 2015
Comments from
America's Health Insurance Plans

Thank you for the opportunity to be part of today's meeting to discuss network adequacy and provider directories. My name is Allan Hayes and I represent America's Health Insurance Plans, a national association for health insurers offering coverage directly to individuals and groups, and through state programs like Medicaid and CHIP, and federal programs like Medicare Advantage. AHIP's members cover more than 200 million people throughout our nation.

We've been invited to speak today on behalf of our member plans in Georgia, which include most, if not all, of the insurers offering health insurance here. And we're here because the focus of today's hearing is a matter of significant importance to consumers and insurers. In my comments today, I will review the numerous network adequacy standards that apply to health plan networks and highlight how plans design provider networks to meet these benchmarks and serve consumer needs.

We'll start by highlighting some **key considerations** to keep in mind as we approach network issues – **Flexibility, Choice and Shared Responsibility**.

- **Flexibility** - to allow health plans to innovate and create network designs that meet the needs of consumers and employers. High value provider networks, for example, give consumers access to high quality and effective care, and can maximize consumers' health care dollars.

- **Choice** - to provide consumers and employers with an array of choices, including more affordable, tailored network products.

- **And Shared Responsibility** - taking a holistic approach and looking at health plan and provider requirements in tandem, with the goal of enabling transparency, access and affordability.

With respect to provider directories, shared responsibility is especially relevant. For example, as health plans regularly update their provider directories, health plans rely on providers to inform them if the provider has changed locations or is no longer accepting new patients.

With these considerations in mind then, let's look at **what is Network Adequacy?**

The benchmark for network adequacy in the current National Association of Insurance Commissioners' Model Act (adopted in 1996) is:

- A network that is "sufficient in number and types of providers to assure that all services will be accessible without unreasonable delay."

The current definition in Georgia law (G.A.C. 120-2-80-.03, 1998) is similar:

- A network that is sufficient in numbers and types of providers to assure that all required services will be accessible without unreasonable delay."(Georgia GID-PPA-1)

The NAIC Model Act is now under revision, and is expected to be finalized by Executive Committee and Plenary Action at the NAIC Fall National Meeting later this month. The benchmark for network adequacy in the revised model has been updated, and as approved by the NAIC B Committee on November 3rd, is a network that is:

- "Sufficient in numbers and appropriate types of providers, including those that serve predominately low-income, medically underserved individuals, to assure that all covered services to covered persons, including children and adults, will be accessible without unreasonable travel or delay."

Forty-three states and DC have network adequacy laws on the books, and state approaches to evaluating networks vary. Network adequacy laws are intended to establish standards for the creation and maintenance of networks by health carriers, with provisions aimed at assuring the adequacy, accessibility and quality of health care services offered under a plan.

Many state network adequacy laws establish requirements for written agreements between health carriers and participating providers, and ensure there are sufficient numbers and types of providers to assure that all covered benefits are accessible. State laws typically address:

Access to Providers: Thirty-three states, **including Georgia** (GA Form GID PPA-1) require specific access to providers. For example, the laws require a plan to maintain a provider network; ensure a specified ratio of providers to enrollees; and/or ensure access to specified providers -- such as behavioral health specialists, cardiologists, etc.

Access to Non-participating Providers: Eighteen states have provisions for access to non-participating providers. For example, when a carrier has no participating providers in its network to provide certain covered benefits, many states require carriers to arrange for a referral to an appropriate provider to obtain the covered benefit at no greater cost to the covered person than if the benefit were obtained from a participating provider. Non-participating providers are generally reimbursed at the usual and customary rate, with no additional financial liability to the enrollee.

Certification/Filing of Access Plan: Twenty-one states, **including Georgia** (GA Form GID PPA-1), require carriers to file an access plan with the applicable state agency demonstrating the adequacy of the provider network.

Emergency Services: Twenty-four states require emergency health care services to be available and accessible within the service area 24/7. This is also a federal requirement.

And Geographic Areas: Twenty-one states have provisions requiring covered services to be readily available and accessible to each of the plan's enrollees.

Many states also incorporate accreditation into their network adequacy laws. The National Committee for Quality Assurance (NCQA) and URAC are two nationally recognized managed health care accreditation entities that have robust standards for network management. In addition to the elements in state laws that I just outlined, accreditation standards also contemplate factors such as:

- consumer complaint and appeals processes,
- quality assurance and improvement programs,
- ongoing health plan monitoring of networks to ensure that the clinical needs of enrollees are being met,
- timely access to care,
- the cultural needs of enrollees,

- ability of members to get regular appointments, urgent care appointments, after hours care, and
- member services by phone.

The Affordable Care Act (ACA §156.230) also establishes network adequacy requirements to ensure all consumers have access to a broad array of physicians and hospitals in health plans' provider networks, and it requires qualified health plans to maintain a network that is sufficient in number and types of providers. For example, a Qualified Health Plan (QHP) issuer must ensure that each of its QHPs' provider networks:

- Includes essential community providers in accordance with the ACA; and
- Maintains a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay.

The ACA also has **provider directory requirements** that apply to QHPs offered on exchanges. A QHP issuer must make its provider directory for each QHP available to the Exchange for publication online and to potential enrollees in hard copy upon request. In the provider directory, a QHP issuer must identify providers that are not accepting new patients.

The provider directory requirements have been further strengthened for 2016 (Final Notice of Benefit and Payment Parameters for 2016, 45 CFR § 156.230b, February 2015). Beginning in 2016, a QHP issuer must publish an "up-to-date, accurate and complete provider directory" in a manner that is easily accessible to shoppers, enrollees, the public and states – via a publically accessible website and clearly identifiable link. The information must be updated at least monthly and must include:

- whether providers are accepting new patients,
- the provider's contact information and location, and
- the provider's specialty, medical group, institutional affiliations

QHPs in the federally facilitated marketplace on healthcare.gov must provide this data in a "machine readable format" to facilitate the creation of user-friendly aggregated information sources that may serve as consumer tools.

The established accreditation organizations also set standards for provider directories that health plans must meet in order to earn accreditation. These standards address,

for example, written policies and/or documented procedures for directory updates and timeframes for when providers must be included or removed from provider directories.

Health plans comply with these regulatory requirements and meet robust standards for network adequacy and access to care as part of the accreditation process. Health plans also contract with hospitals and physicians that have met standards set by established accrediting organizations such as NCQA and URAC, ensuring that patients have access to high-quality and effective care. Additionally, industry-wide standards set by health care provider credentialing organizations, such as the Joint Commission on Health Care Accreditation, ensure that network physicians and facilities are licensed within their appropriate field or specialty and meet basic standards for quality.

As they comply with network adequacy metrics, **health plans are committed to** providing consumers with affordable products that offer adequate networks of quality, cost-efficient providers. They continue to create new and innovative provider service models that are changing the way care is delivered while improving quality, lowering costs for patients, and reforming the provider network landscape.

For example, while consumers should be ensured that networks are adequate in terms of the scope and availability of providers within a network, health plans also believe consumers should at the same time be offered access to proven, quality providers that are cost efficient. Health plans are addressing this in many ways, including offering coordinated care systems and high-value networks which include contracts with select hospitals and physicians that meet specific high quality standards. These approaches focus on the quality of providers that consumers can access through their networks and seek to provide consumers with the most cost effective and efficient care. Data shows a wide variation in prices charged by providers without higher prices being linked to quality. With a greater focus on coordinated care systems and high-value networks, health plans are seeking to provide consumers access to high quality, efficient providers that want to partner with health plans in this pursuit of higher quality and lower costs.

A 2013 McKinsey analysis shows that policies with high-value networks resulted in premiums that were up to 26 percent lower than comparable options with broader networks. In addition, the analysis also found that consumers have expanded choice of coverage options with nearly three times the number of polices offering high-value

networks compared to the previous year.[1] Most important however, is that a study by Milliman found looking at both physician and hospital networks in Exchanges found that there were “no meaningful differences between broad and narrowed Exchange networks based on key CMS hospital metrics.”[2]

Health plans are also using tiered provider networks by recognizing providers who offer cost-effective quality care while still allowing access to other providers at a different cost-sharing level. This is meant to not only recognize high-value quality providers, but to also incent other providers to become more efficient to be included in the preferred tier. Using market competition instead of regulatory mandate, change comes from within the provider community.

It should be noted that these network approaches do not contemplate accepting any willing provider into provider networks – as that can be costly, and does nothing to promote quality improvement for enrollees. Enabling insurers to create high-value networks comprised of select providers that meet certain quality and cost requirements ensures more competition and thus lower prices for consumers.

The health care landscape is also evolving with health plan innovations such as telemedicine, increased utilization of urgent care centers instead of emergency rooms, and value-based purchasing. These innovations all necessitate flexibility when looking at how an adequate network is determined. Accreditation organizations such as NCQA and URAC understand how these, and other innovative network designs are beneficial to consumers and are working with health plans to have their network adequacy metrics account for these new service delivery models. This will allow health plans to innovate and adapt to consumers’ needs in the future.

The current revisions to the NAIC Model Act also contemplate the evolving health care delivery system. The robust process of updating the model involved numerous interested parties, and stakeholders ranging from insurers to medical providers to patient and consumer advocates have weighed in on revisions to the model act. Issues addressed during the process include continuity of care, provider directory standards, telemedicine, out-of-network payment responsibilities, tiered networks, filing requirements and ongoing monitoring activities. AHIP supports the current model

[1] McKinsey Center for U.S. Health System Reform/McKinsey Advanced Healthcare Analytics analysis of publicly available rate filings and carrier information; AHA database

[2] O’Connor, James and Spector, Juliet, Milliman Report: “High-Value Healthcare Provider Networks”, prepared for America’s Health Insurance Plans, July 2, 2014.

revisions, as approved by the NAIC B Committee, and will recommends its adoption by the full NAIC later this month.

The Model Act sets forth a framework for states to develop network adequacy standards and monitor health carriers' networks. It updates the previous model to be flexible, relevant and effective in the context of current coverage and to remain relevant for future health care innovation and provider networks. It preserves the states' ability to balance cost, access and geographic considerations in evaluating networks while still allowing for market flexibility, affordability of coverage, and consumer choice. It does not take a one-size fits all approach, recognizing states' needs to address their unique geographic and health care market /provider availability challenges.

In Closing…

AHIP appreciates the opportunity to present this information to the Consumer and Provider Protection Act Senate Study Committee today.

AHIP and its members are very committed to ensuring that consumers have access to the best networks of providers available and believe that the state and federal standards in existence and accrediting organizations create beneficial consumer protections while allowing health plans flexibility to create quality, efficient networks.

We are also committed to providing helpful information for consumers, and we have published an online guide to help consumers understand their health plan's provider network. It's available at www.ahipfoundation.org. The guide includes eight guiding principles to assist consumers in using their health care coverage, and is especially aimed at consumers with low health literacy and those that have health insurance coverage for the first time.

Thank you again. And I'm happy to answer any questions you may have.