

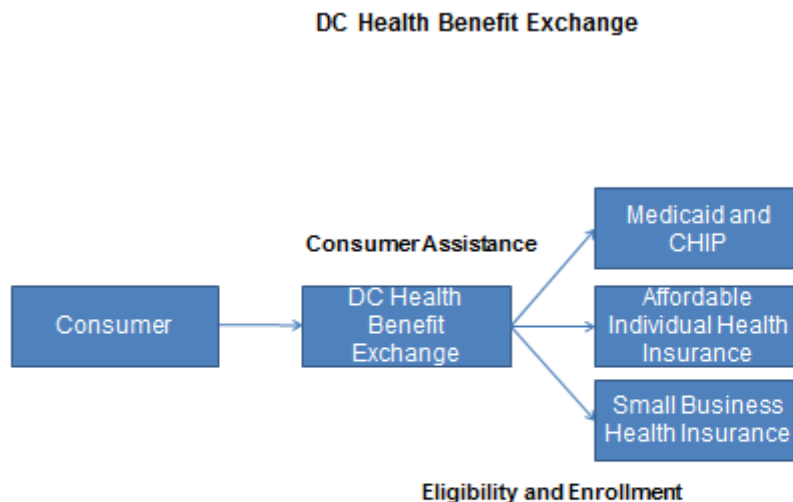
# The District of Columbia Health Benefit Exchange Authority: Network Adequacy Working Group

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February 14, 2013

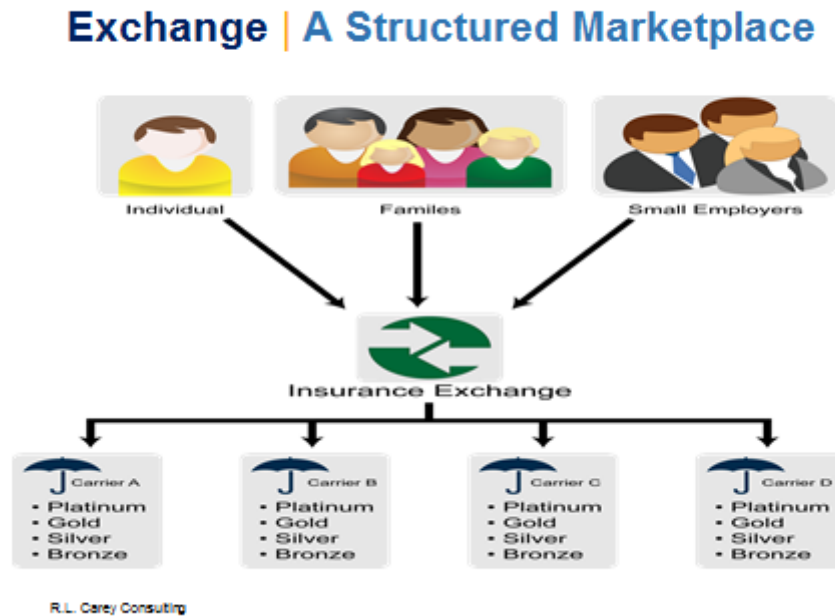
## Exchange-Marketplace Background

The District of Columbia (the District) established a State-based Exchange (HBX) through legislation as required by the Affordable Care Act (ACA) and assigned a working group to address the issue of network adequacy. Health benefit exchanges are being compared to websites such as Travelocity or Orbitz, enabling consumers and employers to assess different health insurance options. Starting October 1, 2013, employers and individuals, wanting to review insurance options for families and individuals, will be able to use these exchanges to assess plan benefits, provider networks, and costs from a menu of options for policies that become available January 1, 2014.



Insurance plans will vary—from providing comprehensive coverage with limited cost sharing to less comprehensive with more extensive cost sharing but each plan must include basic, comprehensive medical coverage and prescription drug benefits. As with the online travel services, this exchange will provide information to assess health plans costs and benefits using

head-to-head comparisons. These health plans must not deny coverage for pre-existing conditions and must comply with the new consumer protections. The cost of policies is not yet known, but policies will have annual limits on how much can be expended for deductibles and copays. Subsidies will be available to individuals with low or moderate income and tax credits will be available to small employers for the first two years.



## Federal Requirements for Network Adequacy

The Affordable Care Act requires exchanges to ensure network adequacy as a condition of qualified health plan certification. Exchanges have some latitude in how they develop their requirements, but they must meet the minimum requirements established in federal regulations.

The minimum requirements, as defined in the Federal regulations (45 CFR 156.230), include requirements that the health plan:

- Has a network for each plan with sufficient number and types of providers to ensure that all services are accessible without unreasonable delay.
- Has a network that must include providers which specialize in mental health and substance abuse services.
- Has a network with sufficient geographic distribution of providers for each plan.
- Has sufficient number and geographic distribution of essential community providers, where available, to ensure reasonable and timely access to a broad range of such providers for low-income, medically underserved individuals in the service area.

- Makes its provider directory available to the exchange for publication online in accordance with guidance from the exchange and to potential enrollees in hard copy upon request. This directory must identify providers that are not accepting new patients.

## Network Adequacy Context

The ACA allows for State-based Exchanges to establish their own standards for network adequacy to meet the unique status of each state, recognizing the variability in provider networks at the local level. These exchanges will also be responsible for maintaining consistency between the regulatory requirements for plans sold inside and outside the exchange.

Network adequacy is one of many important factors to be considered in certifying plans to be sold on the exchange. States and exchange-like entities have undertaken a number of different approaches to network adequacy to balance the needs of access while attracting the greatest number of insurers to establish a robust health insurance market.

In 2008, the District of Columbia commissioned<sup>1</sup> a working paper to assess health access and health outcomes in the District. This paper referenced studies that highlighted the difficulties that many residents face in accessing health care. Network adequacy regulations alone cannot fully address problems underlying access to health care and if overly stringent could even be detrimental to increasing access and improving health outcomes by reducing the number of insurers that participate in the market. If network adequacy requirements do not reflect the actual availability of providers in a community, they could result in disqualifying plans from participating. For example, if there is a requirement that there be a physician to population ratio of 1:1000 and the actual physician to population ratio for a given area is 1:1500, the standard might have the effect of disqualifying all plans from participating because of the difficulty in meeting the standard.

## Background -Review of How Other States and Exchange-Like Entities Have Approached Network Adequacy

This section summarizes a range of policies other states and exchange-like entities have adopted to address network adequacy in different markets.

One of the key considerations exchanges need to consider in establishing network adequacy requirements is what is currently required in the commercial market.

- HMO Market: The National Association of Insurance Commissioners (NAIC) has a model act for network adequacy requirements. Most states (47) have some regulatory

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<sup>1</sup> Laurie, Nicole et al. "Assessing Health and Health Care in the District of Columbia" Prepared for the Executive Office of the Mayor, District of Columbia. January 2008.

requirements for network adequacy for HMOs, including some that have adopted the NAIC model act or something similar. There is variability in what states require and there are no uniform quantitative state standards. The District of Columbia does not have a network adequacy requirement for the commercial HMO market.

- Non-HMO Market: There are fewer states (27) that have requirements on non-HMOs related to network adequacy and even less standardization in the requirements as compared to HMOs. The District of Columbia does not have network adequacy requirements for the non-HMO market.

While some states do not establish regulatory standards for network adequacy, many require HMOs or non-HMOs to be accredited.

Both the National Committee on Quality Assurance (NCQA) and URAC have established network adequacy requirements that evaluate issuers' policies and procedures to include measurable standards for the number of each type of provider, including primary, specialty and behavioral health care. Most plans self-define network adequacy by setting standards based on membership which is also checked by an accrediting agency. Some state regulators require accreditation by NCAQ or URAC.

There are network adequacy requirements in other markets that may serve as models for exchanges to consider. However, there are important distinctions among the markets that may limit the applicability of these models to the commercial exchange market.

- Medicaid – Many state Medicaid programs have network adequacy requirements that reflect the unique needs of their Medicaid program. The District of Columbia has established standards in their contract with managed care organizations. These include standards that are significantly more stringent than state exchanges or exchange-like structures.
- Medicare Advantage (MA) and Federal Employees Health Benefits (FEHB) undertake different strategies to address network adequacy. The MA program is voluntary, for both beneficiaries and health plans. There are counties that do not have a MA plan offering, and consumers can still receive Medicare services through traditional fee-for-service coverage if no MA plan is available. The MA program uses a very rigorous data collection process before policies are sold through the program. The program has a robust process for monitoring network adequacy with fully developed standards that consider provider-enrollee ratios for 34 different provider types and 23 types of facility providers. The MA program allows plans to request an exemption from the standards, and many plans do so. By contrast, the FEHB program, which must ensure that plan options are available for its members in all counties in the country, takes a more flexible approach to assure network adequacy by using retrospective monitoring of plan adherence to network requirements.

## Review – Other State-Based Exchanges Approach to Network Adequacy

State based exchanges have taken different approaches to network adequacy reflecting both their different market environments and their goals for the first year of exchange operation.

Table 1 below highlights different approaches selected states are taking to address various aspects of network adequacy. These state exchanges were selected for their relevance to the unique characteristics of the District’s health market.

**Table 1. Network Adequacy Regulations in Selected States**

State/Exchange Structure	General Network Adequacy requirements	Exchange Network Adequacy Requirements
California	HMO and non-HMO health insurance policies are subject to stringent regulations under the Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI).	Health insurers must submit provider contracts to have their networks evaluated. In addition to providing provider contracts, plans must attest that they meet DMHC and CDI regulations.
Maryland	<p>For HMOs: Provisions for assuring that all covered services, including any services for which the health maintenance organization has contracted, are accessible to the enrollee with reasonable safeguards with respect to geographic locations.</p> <p>Non-HMOs: An insurer shall implement an availability plan describing: the quantifiable and measurable standards for the number and geographic distribution of providers; the method used to annually assess the carrier's performance against the standards specified in the availability plan; the method used to ensure timely access to health care services, as identified by the carrier; and the issuer's process for monitoring and assuring on an ongoing basis the sufficiency of the provider panel to meet the health care needs of enrollees.</p>	Maryland Health Benefit Exchange (MHBE) will allow carriers to “self define” network adequacy standards for benefit plan year 2014. For benefit plan year 2015, MHBE will determine if standardized network adequacy requirements across all carriers are appropriate. The MHBE staff will utilize network adequacy software to monitor carrier networks, compare networks across carriers, and publicly report on accessibility of providers to the Exchange population.
Massachusetts	For HMOs: An HMO shall annually notify the commissioner of any material change to the information submitted.. Said materials shall include, but not be limited to: a	The Massachusetts’ health insurance exchange selects “Preferred plans” in which network adequacy is evaluated and includes time and distance

	<p>provider inventory, including a listing of providers by specialty, a calculation of physician to population ratios, and an inventory of owned, operated, contracting and participating provider facilities, including, but not limited to, hospitals, skilled nursing facilities, home health care and medical care services.</p> <p>Massachusetts does not have regulations for non-HMO policies.</p>	standards.
Rhode Island	Rhode Island has defined network adequacy standards for all health insurance products sold within the state. Starting in 2014, Network Adequacy requirements defined by the Department of Health must be met inside and outside of exchange.	Exchange regulations specify geography, time, and distance standards for 2014 and will be reevaluated on an annual basis

### Key Issues and Questions

Outlined below are some of the key issues and questions the Network Adequacy Working Group may wish to consider:

1. How does the unique characteristics of the District's current market environment impact network adequacy?
2. Consistency of market rules inside and outside the exchange
3. Are the likely Qualified Health Plans (QHPs) in the District accredited and already subject to some network adequacy review?
4. Should the District establish consistent network adequacy regulations for health plans offering products both inside and outside the exchange?
5. Which insurers are likely to apply to offer what types of health plans through the District Health Benefit Exchange? Have these insurers been subject to the District or other state network adequacy requirements?
6. Are the insurers accredited (NCQA or URAC) and if so, to what extent do these accreditations ensure that network adequacy requirements are met?
7. Should the District establish a phased approach for assessing how plans meet network adequacy standards? A phased approach could rely on attestations in the initial years and collect baseline network data so that future requirements could be considered. Does the District have available data to develop specific benchmarks that balance the unique needs of the District and are achievable for QHPs?
8. Should network adequacy be evaluated as a condition of participation or should this review be done retrospectively?

9. What strategies other than network adequacy standards should the District HBX consider to ensure consumer access to adequate networks (for example, consumer satisfaction)?
10. What are the resource implications of network standards for both the District HBX and health plans and how will these requirements fit the timeline of standing up an exchange by the end of 2013?

## Possible Options

The following are possible options that could be utilized to address the issue of network adequacy:

1. Regulator verifies directly through prospective evidence that requirement is met.
  - Accomplished by data collection through an access plan and retrospective monitoring (e.g. complaints to Department of Insurance)
  - Accomplished by NCQA or URAC accreditation
2. Regulator will accept verification by company officer that requirement has been met.
  - Accomplished through QHP attestations and retrospective monitoring
3. Regulator will accept verification by company officer that company is taking steps to meet the requirements prior to a predetermined date.
  - Phase -in process using attestations and/or accreditation in the first few years and moving to prospective data collection with standards