



Network Adequacy Working Group Report

District of Columbia Health Benefit Exchange Authority

March 5, 2013

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Introduction

The District of Columbia (DC) established a state-based health benefit exchange (HBX) through legislation¹ as required by the Affordable Care Act (ACA) and assigned a Working Group to address the issue of network adequacy. Network adequacy is a requirement of certification for carriers to participate on the exchange. It requires qualified health plans (QHPs) to maintain provider networks that are sufficient in number and types of providers to ensure that all services will be accessible without unreasonable delays.² The ACA requires that all exchanges develop a process to ensure that carriers meet the following requirements for QHPs sold through an exchange, which become effective on January 1, 2014.

ACA Requirements for Network Adequacy

1. Have a network for each plan with sufficient number and types of providers to ensure that all services are accessible without unreasonable delay.
2. Have a network that must include providers which specialize in mental health and substance abuse services.
3. Have a network with sufficient geographic distribution of providers for each plan.
4. Have sufficient number and geographic distribution of essential community providers (ECPs), 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.
5. Make 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.³

The above requirements represent only a broad minimum, and the ACA allows states to develop standards in a way that meets their own unique healthcare market. States and exchange-like entities have undertaken a number of different approaches to promulgating network adequacy requirements that balance the needs of access with attracting enough insurers to maintain a robust health insurance market.

Review of Selected Network Adequacy Policies

The following practices applied to the commercial market, Medicaid, Medicare, and the Federal Employees Health Benefit (FEHB) program were considered by the Working Group in its review and discussion of network adequacy policies. In establishing network adequacy requirements, a key factor that exchanges have considered is what is currently required in the commercial market.

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

¹ Health Benefit Exchange Authority Establishment Act of 2011 (B19-0002).

² Maryland Health Benefit Exchange Carrier Reference Manual.

³ Summarized from US Code of Federal Regulations, 45 CFR 155.1050 and 156.230, Patient Protection and Affordable Care Act: Establishment of Exchanges and Qualified Health Plans.

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: Fewer states (27) have requirements for non-HMO network adequacy, and there is even less standardization in such requirements than in those for HMOs. The District of Columbia does not have network adequacy requirements for the non-HMO market.

Although some states do not establish regulatory standards for network adequacy, many require HMOs, non-HMOs, or both to be accredited. Both the National Committee on Quality Assurance (NCQA) and URAC have established network adequacy requirements that evaluate issuers' policies and procedures; they include measurable standards for the number of each type of provider, including primary, specialty, and behavioral healthcare. 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 NCQA or URAC.

Network adequacy requirements in other markets 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 programs. The District of Columbia has established standards in its contract with managed care organizations. These include standards that are significantly more stringent than those of state exchanges or exchange-like structures. Medicaid regulations provide one example, though with a different enrollment population and therefore different objectives; but all the same they are examples of access standards developed for the unique characteristics of the District's urban market. These regulations include specific provider-type requirements, inclusion of proscribed facilities and provider-enrollee ratios.
- The Medicare Advantage (MA) and FEHB programs 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 an 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 allowing policies to be sold through the program. It 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. It also 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 ensure network adequacy by using retrospective monitoring of plan adherence to network requirements.

The Working Group reviewed states' and exchange-like entities' network adequacy regulations for their similarity to the District healthcare market and because of the advanced stage of their exchange development. California, Vermont, and Delaware are reviewing networks

prospectively starting in the first year of exchange operation, while Maryland is allowing carriers to self-define their networks and is phasing in regulations. Rhode Island is promulgating time, distance, and geography metrics that carriers must adhere to and is requiring that all health plans sold inside and outside the exchange be regulated the same with respect to network adequacy. Massachusetts uses a system in which it gives a “preferred plan” designation to plans that have met its network adequacy standards. The full review of network adequacy regulations for the above six states appears in Appendix 1.

Certification Options

The ACA allows an exchange discretion and flexibility on how to certify that it meets these requirements. In determining how an exchange will verify that these requirements are satisfied, the operational capacity to develop and implement standards within a limited time frame is an important consideration. States in general have been following three approaches:

1. The exchange verifies directly by collecting data that ACA requirements have been met.
2. The exchange accepts verification by a carrier that it has met requirements through attestation.
3. The exchange uses a combination of attestation, reliance on an accreditation entity, and direct collection of data to verify that requirements are met.

The above options relate to how the DC HBX may verify network adequacy requirements, but the Working Group also reviewed the specific metrics and standards for ensuring that a QHP has an adequate network.

Recommendations

The Working Group recommends that the DC HBX adopt a hybrid approach that combines the three basic options that states have used to meet network adequacy requirements. Given that a state-based exchange has the opportunity to establish standards for what constitutes a sufficient number and types of providers to meet its own market dynamics and ensure consumer protection, the Working Group recommends that the DC HBX use the next two years to collect the data needed to adequately assess network adequacy, and then in year three implement District-specific network adequacy standards as outlined in step 3 below.

Recommendation 1: Phase In Network Adequacy Requirements

To meet ACA requirements during the initial start-up period, the Working Group recommends that the DC HBX adopt the following hybrid approach for how carriers will meet network adequacy requirements as outlined below in a three-step process covering the first two years of exchange operation:

Step 1, Year 1 (For coverage effective starting January 1, 2014)

In the first year, the DC HBX will require carriers to attest that they meet the five **ACA Requirements for Network Adequacy** (see page 1) through standards that they have developed or that are in current use.

Step 2, Year 1 (2014)

During year 1, the DC HBX works with the Department of Insurance, Securities and Banking (DISB) to collect data to assess the current environment of network adequacy in terms of the following:

- Adequacy of current processes and procedures
- Scope of gaps and challenges with network adequacy as documented through this assessment
- Impact of implementation of the ACA network adequacy standards on key factors such as premiums, carrier participation, provider participation on panels, and enrollment.

Carriers will submit an access plan by July 2014 that reports how they have met network adequacy requirements and their plan to correct any deficiencies. The access plan should consider at least the following dimensions of access:

- Metrics for primary care providers (PCPs), specialty providers, and mental health and substance abuse providers specified in terms of:
 - Time and distance
 - Wait time
 - Provider to patient ratios
- Access to ECPs
- Provider directory accuracy.

In determining other data to include in the access plan, the DC HBX should consider the NAIC *Plan Management Function: Network Adequacy White Paper* and NCQA accreditation standards on access and availability.

Step 3, Year 2 (2015)

Based upon data provided by carriers in the access plans they submit in July 2014, the DC HBX will issue a request to carriers for additional data on DC-specific metrics. It will use these data to develop standards in year 2, with the goal of having DC-specific standards applicable in year 3.

Recommendation 2: Data Collection Process

The DC HBX will work with participating carriers to specify the process for collecting baseline data to assess the dimensions of network adequacy as outlined in the above three-step process. Where possible, given the overlap of markets, the DC HBX will consult with the appropriate Maryland and Virginia agencies to achieve consistency in requests for network adequacy data.

Recommendation 3: DC Specific Standards

The Network Adequacy Working Group recommends that the following areas be addressed in DC-specific standards which would become effective for the January 2016 plan year. It is anticipated that these standards will be verified through prospective regulatory review. The

Working Group further recommends that the DC HBX involve DISB, participating carriers, key stakeholder groups, and quality improvement experts in developing needed standards and the mechanisms for ensuring compliance.

1. Metrics for PCPs, specialty providers, and mental health and substance abuse providers
 - a. Time and distance
 - b. Wait time
 - c. Provider to patient ratios.
2. Access to ECPs. The Working Group recommends that a provision be adopted to encourage the inclusion of ECPs into a carrier's network while recognizing that ECPs must meet applicable carrier requirements.

3. Access to mental health and substance abuse providers.

Note: Following the conclusion of the Working Group meetings, Dr. Stephen Baron, Director of the DC Department of Mental Health, asked that the DC HBX consider including public-sector mental health and substance abuse resources as part of the universe of providers carriers include in their network with the understanding that these public-sector resources must meet applicable carrier requirements.

4. Provider directory accuracy.
5. Ensure that plan beneficiaries have appropriate access to full range of covered benefits.

Note: While the Working Group agreed that the DC HBX will need to ensure that plan beneficiaries have appropriate access to the full range of covered benefits, there was a divergence of opinion about the extent to which this was a measureable problem and, if so, whether a new enforcement mechanism was needed to ensure compliance. Some members of the Working Group supported imposing a remedy such as reduced out-of-network cost sharing when plan members cannot obtain access to in-network providers. Other members opposed the imposition of a policy to reduce out-of-network cost sharing when plan members claim they cannot obtain access. Given this divergence, the Working Group recommends that DC HBX monitor this issue during the two year start-up period and, if needed, develop a policy for the next plan year. In developing this policy, the DC HBX Board should involve representatives from participating carriers and stakeholders.

In summary, the recommended phased approach for assessing and monitoring the network adequacy of the QHPs that will participate in the DC HBX should be designed to meet any documented problems that District residents have in obtaining covered services. This assessment should consider how changes in network adequacy requirements would affect the District healthcare market.

Summary of Working Group Discussions

The following summary of the three Working Group meetings held on February 14, 19, and 21 reviews the process for developing the above recommendations. The full summary reports, agendas, and background materials used by the Working Group can be found online at <http://hbx.dc.gov/>.

First Working Group Meeting

The first Working Group meeting focused on discussing the nature of the problem of access to healthcare in the District and how it related to network adequacy. The background paper reviewed the charge for the Working Group, network adequacy in the context of specific ACA regulations, what other states have done, and available options. Many access problems were highlighted by Working Group members, including provider directory inaccuracies, access to essential community providers for low-income residents, the lack of mental health and substance abuse providers on panels, historical and entrenched health issues within the District, and the access problems of specific geographical areas, such as east of the Anacostia. Other topics included accreditation of carrier networks and whether this was sufficient, provider rate parity throughout the District, the District's unique relationship with surrounding states and the overlap of networks, those with chronic conditions seeking care, the scope of practice for providers, health literacy, and ensuring coverage for residents who move between public and private insurance. The meeting concluded with a discussion of the data needs for better understanding barriers to access in the District.

Second Working Group Meeting

The second Working Group meeting covered the role of the exchange in advancing network adequacy regulations, options for the Working Group to consider, and a proposed process for developing District-specific standards. The experience of two additional states and the DC Medicaid program's network adequacy regulations were reviewed. The process for reviewing carrier networks and the capacity of the District to perform this function were discussed because of the timeline and other ACA requirements. The Working Group made the following comments and suggestions for possible standards and approaches:

- It makes sense to start with what we know now and to phase in stronger standards if necessary at a later date.
- Every government has capacity issues, but ACA is moving the bar higher in increasing access standards, which would set a floor and legal expectation for carriers to meet.
- Take the phase-in approach and determine what data will be needed to set standards; use riders to protect at-risk issues.
- Most plans are ready and able to meet standards but don't know what the reporting requirements are going to be.
- It does not make sense to start a standard process until the data are collected and the market is known, and gathering data should be a first step.
- We need to understand that applying rigorous standards may make premiums unaffordable, which could have the effect of limiting access to care.
- Carriers that have or want a significant market share already have the standards to provide an adequate network. Therefore, it is unnecessary for the District exchange to replicate what carriers already do in determining adequate networks.

After discussing the basic approaches for certifying compliance with standards, the Working Group members were asked to express their preference in a straw poll. It was understood that

the purpose of this vote was to get a sense for where the group stands on these approaches, not to adopt a formal recommendation at this stage in the process.

- Option 1: Regulator to verify after phase-in approach: 11.
- Option 2: Regulator accepts attestations: 3.

The second meeting concluded with a proposed process for developing specific standards. The Working Group expressed support for the following process:

- In the first year, specify the need for carriers to adhere to the essential ACA standards and collect baseline data.
- In subsequent years, phase in specific standards.

The Working Group also identified the following as priority areas that should be considered for adoption as additional standards:

- Time and distance
- Wait time
- Access to mental health/substance abuse within network
- Access to providers out of network if enrollees can't get access in network
- Making it easier for providers to enroll and stay on panels
- Adequate access to ECPs and appropriate contracting with ECPs
- Provider directory standards.

Third Working Group Meeting

The final Working Group meeting reviewed a preliminary outline for its recommendations and then debated and revised these. It was suggested to commission a review of the current market and how any changes to network adequacy would affect the market, to better understand access to healthcare in the District. Previously discussed issues such as provider directory inaccuracies, access to ECPs, provider contracting and panel participation, the market overlap with Virginia and Maryland, payment parity for mental and physical healthcare, and the capacity of the DC HBX to perform network adequacy were returned to, before the final deliberation of the recommendations. There was considerable discussion and debate about whether the DC HBX should adopt a policy stating that out-of-network access be provided at in-network rates when reasonable access is unavailable. To address this issue, the Working Group made specific changes to the Preliminary Recommendations presented for the consideration by the Working Group.

A high-level timeline was discussed, with the caveats that the exchange has to balance realistic expectations with data collection and measurement capacity, and that this timeline would need to be reevaluated as more information becomes available. For 2014, carriers will attest with documentation how they will meet the ACA network adequacy requirements. Carriers will submit an annual Access Plan that will assess the extent to which they are meeting the ACA requirements and present a plan for how they will address any deficiencies. In 2015, using data from carrier annual access plans, the DC HBX will develop District-specific standards and metrics for how carriers will meet all required standards. In 2016, prospective certification for

QHPs will be instituted, and in their annual access plan carriers will report their compliance on meeting the ACA requirements and DC-specific standards.

Following the third meeting, Kaiser Permanente requested that the DC HBX recognize that the ACA regulation permits health plans that meet the alternative standard ECP requirement to satisfy the ECP requirement through their existing network.

Preliminary and Final Votes

After the final Working Group meeting, a preliminary vote was conducted; 14 members accepted the final draft recommendations as written, and 8 accepted with exception language submitted. The exceptions were considered by the Chair and Vice Chair, and the above final recommendations were submitted to the Working Group for a final vote. The final vote to approve the recommendations was 19 members accepting and 0 members dissenting.

Appendix 1: Selected State Approaches to Network Adequacy

| State Exchange | 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. |
| Delaware | Managed care organizations (MCOs) must maintain an adequate network at all times. If a plan has a deficiency, the MCO must cover non-network providers, and must prohibit balance billing. The MCO must allow referral to a non-network provider, upon the request of a network provider, when medically necessary covered health services are not available through network providers, or the network providers are not available within a reasonable time. The MCO must submit evidence of network adequacy to the department upon request. If the department receives a complaint regarding an MCO's network adequacy, the burden is on the MCO to prove network adequacy to the satisfaction of the department. | QHPs must have PCPs available within 20 miles or no more than 30 minutes' driving time, meet timely access to care standards, establish mechanisms to ensure compliance by providers, monitor providers regularly to determine compliance, and take corrective action if there is a failure to comply with network standards. QHP networks must consist of hospitals, physicians, behavioral health providers, and other specialists in sufficient number to make available all covered services in a timely manner. Each primary care network must have at least one full-time equivalent PCP for every 2,000 patients. The QHP issuer must receive approval from the Insurance Commissioner for capacity changes that exceed 2,500 patients. |
| Maryland | <p>For HMOs: Provisions for assuring that all covered services, including any services for which the HMO has contracted, are accessible to the enrollee with reasonable safeguards with respect to geographic locations.</p> <p>Non-HMOs: Insurers must implement an availability plan describing standards for the number and geographic distribution of providers, the method used to annually assess the carrier's performance, the method used to ensure timely access to healthcare services, and the process for monitoring and assuring on an ongoing basis the sufficiency of the provider panel to meet the healthcare 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. |

| State Exchange | General Network Adequacy Requirements | Exchange Network Adequacy Requirements |
|----------------------|--|--|
| Massachusetts | <p>For HMOs: An HMO must annually notify the commissioner of any material change to the information submitted. These materials include but are not limited to a 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 healthcare, and medical care services.</p> <p>Massachusetts does not have regulations for non-HMO policies.</p> | <p>The Massachusetts health insurance exchange selects “preferred plans” in which network adequacy is evaluated, including for time and distance standards.</p> |
| Rhode Island | <p>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 the exchange.</p> | <p>Exchange regulations specify geography, time, and distance standards for 2014 and will be reevaluated on an annual basis.</p> |
| Vermont | <p>MCOs must ensure that their policies and procedures facilitate the provision of healthcare services to their members; ensure timely access to effective, medically necessary care; manage the benefits available for treatment of mental health and substance abuse conditions in a manner that allows for the effective provision of medically necessary care in urgent, medically complex, and unique situations, including but not limited to situations involving children and adolescents; authorize covered benefits necessary for a medically safe and appropriate discharge or transition plan developed after consultation with the treating healthcare provider or the provider’s designee before the managed care organization renders a decision that will result in discharge or transfer from a facility; and collaborate with healthcare providers to monitor and improve coordination between mental health and other healthcare.</p> | <p>QHPs must confirm that they have met the ACA network adequacy standards in addition to specific Vermont provisions that include travel time, wait time, access to general and emergency care standards, and other consumer protections.</p> |

Appendix 2: Members and Organizations

| Name | Affiliation |
|------------------------------|---|
| Chairs | |
| Diane Lewis | DC HBX Board Member |
| Stephen Jefferson | DC HBX Advisory Board |
| Working Group Members | |
| Wes Rivers | DC Fiscal Policy Institute |
| Paul Brayshaw | Hemophilia Association of Capital Area |
| Alan Gambrell | Public Ink |
| Will Robinson | NCQA |
| Luis Padilla | Unity Healthcare |
| Julian Craig | Internist |
| Gwen Melnick | Greater Washington Society of Clinical Social Workers |
| Rhodo Nguyen | DC Association of Naturopathic Physicians |
| Christian Cornejo | Mary's Center |
| James McSpadden | AARP DC |
| Claire Mcandrew | Families USA |
| Ron Simmons | Us helping us, People into living |
| Lindsey Steinberg | DC Behavioral Health Association |
| Chris Brehm | Carefirst |
| Kishan Putta | Advisory Neighborhood Commission 2B04 |
| Andrew Patterson | Legal Aid Society of DC |
| Judith Levy | DC Coalition on Long Term Care |
| Julie Lloyd | Aetna |
| Farzaneh Sabi | Kaiser Permanente |
| Arti Mehta | DC Association of Naturopathic Physicians |
| Attendees | |
| Jay Brain | Kaiser Permanente |
| Tonya Kinlow | Carefirst |
| Tonya Robinson | Kaiser Permanente |
| Katherine Stocks | DC Chamber of Commerce |
| Eric Vicks | DC Primary Care Association |
| Lisa Bass | DC Cancer Consortium |
| Louis Banson | |
| Adrian Anthony | Pratt Consulting |
| DC HBX Staff | |
| Brendan Rose | |
| Bonnie Norton | |
| LMI Staff | |
| David Helms | |
| Ben Dellva | |
| Alice Burton | |

Appendix 3: Considered References

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