District of Columbia Health Benefit Exchange Authority: Network Adequacy Working Group Meeting 2 Summary

February 20, 2013

Introduction and Delaware/Vermont Network Adequacy Standards

The second work group meeting began with a call for any additions or changes to the first working group summary. There were no suggested changes.

Ben Dellva reviewed Delaware and Vermont legislation and exchange guidance on network adequacy. There were comments with regards to patient:provider ratios that Delaware and Vermont utilize with one carrier stating that it maintains its own internal patient:provider ratios of 1 to 400 or 500 because they do not capture the entire market. There was also a discussion on the difference between using travel time standards and using transportation standards as the District is an entirely urban market as opposed to Delaware and Vermont. It was noted that one carrier used an internal standard of two primary care physicians within a five mile radius for their urban populations.

DC Medicaid Managed Care Network Adequacy Contracts

Alice Burton reviewed the DC Medicaid Managed Care network adequacy requirements including how states distinguish these requirements for Medicaid and their commercial markets. Medicaid should be viewed as an example or guide but they do provide examples of access standards that have been developed for the unique characteristics of the District's urban market. Specific provider type requirements that Medicaid managed care contractors have to meet was discussed in relation to the commercial and expected exchange markets.

Network Adequacy Regulatory Standards and Process

A carrier noted that NCQA ask plans to submit standards which are determined nationally which often requires that carriers adjust to ensure standards are appropriate and reasonable for the District. These adjusted standards are then use by the carrier to determine deficiencies. It was noted that Maryland requires network adequacy reports every six months to determine if there are deficiencies and if corrective action is necessary. A question was asked about whether the Exchange or the District Department of Insurance, Securities and Banking (DISB) would approve and monitor access plans if this became a requirement.

Maryland is maintaining commercial network adequacy standards with self-reporting for the exchange initially and may reevaluate in future if qualified health plans do not have sufficient networks.

Making data available about provider directories to determine if providers are in network is an important consumer protection. There was also a request to establish regulations requiring that out of network benefits be covered at in network cost sharing if there are problems related to access.

Access to mental health services was noted to be poor within the district leading to residents going out of district to receive care. There was a comment that access may be improved through systematic improvements to the delivery system.

Several commented that "any willing provider" should be limited to qualified providers that meet the health plan's credentialing requirements.

There was a request for information on how specific metrics are calculated such as determining travel times. Additional information would be needed when standards are developed on how such standards would be calculated

Options for Network Adequacy Standards

There were comments and questions as to the ability of the DC Exchange to have the necessary resources to conduct the reviews/data collection. It was noted that different approaches could be used for different standards. Given the considerable work the DC Exchange will need to accomplish in the first few years, the development of new standards may need to be phased in to meet specific the consumer protection goals. This means that the Exchange will need to establish priorities and a timeline for the specific standards and corresponding data that will be needed for their enforcement. There are opportunities to build capacity with federal grants available until 2014 but this would require coordination with the DC Division of Insurance, Securities and Banking (DISB). DISB currently conducts market conduct examinations of which network adequacy can be a component. While there will be federal funding for the development and operation of the DC Exchange through the end of 2015, the Exchange will need to secure funding for 2016 and beyond from some combination of general funds and assessments on premiums. ..

Carrier participants noted that they work hard to build network capacity including having ECPs in their network and that there would need to be extraordinary circumstances to allow out of network coverage at same cost sharing. There needs to be a differentiation between necessary care and inconvenience for out of network coverage.

The following comments and suggestions were made during the discussion of possible standards and approaches to network adequacy regulation:

- It was stated that 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 data that is necessary 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.
- Doesn't make sense to start a standard process until the data is collected and market is known and gathering data should be a first step.
- 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 DC exchange to replicate what carriers already do in determining adequate networks.

After discussing the basic approaches for certifying compliance to standards, the Working Group was asked to express their preference in a straw poll. It was understood this vote was being taken to get a sense for where the group stands on these approaches and should not be interpreted as 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

Proposed process for developing specific standards

The Working Group reviewed the following ACA requirements for network adequacy as reported in the DC HBX Background Paper:

Have a network for each plan with sufficient number and types of providers to ensure that all services are accessible without unreasonable delay.

Have a network that must include providers which specialize in mental health and substance abuse services.

Have a network with sufficient geographic distribution of providers for each plan.

Have 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.

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.

The Working Group expressed support for the following:

- specifying the need for carriers to adhere to the essential ACA standards and collecting baseline data the in first year
- phasing in specific standards in subsequent years

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

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