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Issue Brief on Network Adequacy

And Solicitation of Comments

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This issue brief identifies several of the challenges associated with determining the adequacy of provider networks offered by health benefit plans under the federal Patient Protection and Affordable Care Act. It also briefly discusses some solutions considered by the Division of Insurance. Finally, it solicits comments on the challenges identified and the solutions discussed.

Background

The Patient Protection and Affordable Care Act[1] and the Health-related portions of the Health Care and Education Reconciliation Act of 2010[2], collectively known as the Affordable Care Act ("ACA"), dramatically altered the landscape of the health insurance and health care industries in the United States for consumers, providers and insurers. As part of the health insurance market reforms the ACA requires the establishment of an American Health Benefit Exchange ("exchange") in each state[3] with the general purpose of "facilitate[ing] the purchase of qualified health plans." In supporting these exchanges the Secretary of the Department of Health and Human Services ("Secretary") is required to establish criteria for health benefit plans seeking certification as qualified health plans ("QHPs") including criteria that "ensure a sufficient choice of providers" to prospective enrollees.[4] These specific criteria are commonly known as "network adequacy."

On March 27, 2012 the Secretary codified regulations requiring that the QHP certification function be performed by each exchange.[5] Barring a legislative change or other arrangement this regulation would have resulted in a potentially problematic scenario in which network adequacy was regulated under state law by the State Board of Health (for health maintenance organizations)[6] and under federal law by the exchange (for all qualified health plans). After discussions among the various state agencies (Nevada Division of Insurance, Nevada Department of Health and Human Services, Silver State Health Insurance Exchange) it was agreed that in order to best protect consumers and maintain a consistent regulatory environment the network adequacy determination function should be vested in one agency. The Division of Insurance ("Division") offered to conduct the network adequacy function, having experience in regulating fully-insured plans, managed care organizations, and health maintenance organizations ("HMOs").

During the 77th (2013) Legislative Session the Division sponsored Assembly Bill 425 ("AB 425"). With the support of the Nevada Department of Health and Human Services ("DHHS"), AB 425 transferred the network adequacy function for HMOs from the State Board of Health to the Division effective January 1, 2014.[7] Additionally, the Division, DHHS, and the Silver State Health Insurance Exchange ("SSHIX") entered into a Memorandum of Understanding to cede the network adequacy function as established under federal law from SSHIX to the Division.[8] To complete the legal authority of the Division to conduct the network adequacy function AB 425 explicitly granted the Division authority to determine the adequacy of the networks for all network plans[9] issued in Nevada.[10]

[1] Public Law 111-148
[2] Public Law 111-152
[3] ACA § 1311(b)(1); 42 U.S.C. § 18031(b)(1)
[4] ACA § 1311(c)(1); 42 U.S.C. § 18031(c)(1)
[5] 45 C.F.R. § 156.200
[6] Nev. Rev. Stat. § 695C.080
[7] Assem. B. 425, 77th Leg. (codified as Nev. Rev. Stat. § 695C.080-.090 , 695C.140 (2013))
[8] 45 C.F.R. § 155.110
[9] As defined in Nev. Rev. Stat. § 689B.570
[10] Assem. B. 425, 77th Leg. (codified as Nev. Rev. Stat. § 687B.490 (2013))

Issue

The concept of network adequacy is not new to Nevada; health maintenance organizations ("HMOs") licensed pursuant to NRS 695C have been subject to some form of network adequacy standard since 1973. What is new is the requirement that any health benefit plan seeking certification as a QHP, and thus enabling it to be sold via an exchange, is subject to network adequacy standards, including health benefit plans issued under NRS 689A, 689B and 689C. Traditionally these non-HMO network plans have not needed a determination of network adequacy; by providing out-of-network benefits and not using a "gatekeeper" model of care management through a primary care physician[11], policy holders were free to seek the care they thought appropriate from the provider of their choice.

The application of network adequacy standards through the ACA presents several challenges to the Division, most notably the inherent differences between HMO and non-HMO network plans, the challenges in building an adequate network in the state's rural communities, and the emergence of "narrow" networks to combat escalating premium rates.

HMO and non-HMO Network Plans

HMO plans originated in Nevada as closed-network plans[12] reimbursing contracted physicians through a capitation or modified capitation[13] model. Primary care physicians ("PCPs") were incentivized to carefully manage the treatment cost of each covered individual under their care and individuals were required to obtain a referral from their PCP before they could seek treatment from a specialist. Referrals were only made to other providers contracted with the HMO. In the decades since then HMOs have largely abandoned the capitation model in favor of fee-for-service arrangements with providers[14] but have retained the gatekeeper model of utilizing PCPs and requiring in-network referrals for specialized care.

Non-HMO network plans, such as preferred provider organizations ("PPOs") emerged as a cost-control alternative to traditional indemnity insurance plans. Indemnity plans permit covered individuals to seek care from any provider they wish without referral; the indemnity plan will either reimburse the covered individual or the provider a set amount of the cost of the care provided. Because pure indemnity plans offered insurers little or no ability to control costs and provided little incentive for covered individuals to ration their care, costs quickly skyrocketed. Network plans like PPOs provided a way for insurers to better control cost without crippling a covered individual's ability to select their own providers: the covered individual could still see any provider they wished without referral but were encouraged to visit providers in the plan's network through preferred pricing and cost-sharing.

It is this flexibility in networks for non-HMO network plans such as PPOs that makes adoption of a network adequacy standard difficult. Should HMOs be held to a different standard because of the inherent lack of freedom in provider choice? How does a non-HMO network plan's out-of-network

[11] *See* Nev. Admin. Code § 695C.070

[12] A closed-network plan is one that does not offer benefits when the covered individual seeks treatment from a physician that is not contracted with the plan.

[13] Capitation (and its derivatives) refers to a method of payment in which physicians receive a fee for each covered individual ("per capita") regardless of services rendered by the physician.

[14] A fee-for-service arrangement reimburses the provider for the specific care dispensed to a covered individual.

benefit affect the determination of network adequacy? In other words, to what extent should non-network providers be considered to meet the adequacy standard if they should be considered at all?

Complicating matters further is the emergence of HMO/non-HMO hybrid plans such as point of service ("POS") plans, so called because the benefit the covered individual receives is determined when they arrive at the point of service. POS plans and other hybrids can often be found using a system of tiered benefits, such as providing a preferred tier of benefits that operates similar to an HMO, a middle tier of benefits that operates similar to receiving care from a provider in a PPO network, and a bottom tier of benefits that operates similar to receiving care from a provider outside of a PPO network. These hybrid plans bring their own difficulties in determining adequacy of provider networks. Are they held to an HMO standard or a non-HMO network plan standard (assuming a difference)? Should the top-tier benefits be held to an HMO standard while the lower tier benefits are held to a non-HMO network plan standard?

Solicitation

The Division solicits comments on the structural composition of HMO and non-HMO network plan adequacy of provider networks, particularly:

- Should HMO and non-HMO network adequacy standards be different?
- How do network adequacy standards reflect access to non-network providers in non-HMO plans?
- To what standards should HMO/non-HMO hybrid plans be held?

NOTE: The Division is not currently soliciting comments on specific standards to be used in determining adequacy of provider networks, such as physician count, travel time, or wait time.

Rural Community Networks

In 2009 Nevada had 19.8 active physicians per 10,000 civilian population; this ratio ranked 49th among the 50 states and the District of Columbia, trailing only Mississippi (18.2) and Idaho (18.4).[15] At the same time the national average was 27.4 active physicians per 10,000 residents.[16] This is, quite possibly, indicative of a shortage of all practitioners within the state of Nevada. Nevada also ranks tied with California for 46th in percentage of population uninsured (18.9) ahead of only Arizona (19.1), Florida (20.9), New Mexico (22.6) and Texas (25.5).[17]

Of Nevada's seventeen counties ten have been designated as "Counties with Extreme Access Considerations" ("CEACs") by the Centers for Medicare and Medicaid Services ("CMS").[1819] These

[15] U.S. Department of Health and Human Services- Centers for Disease Control and Prevention National Center for Health Statistics, Health, United States, 2011 with Special Feature on Socioeconomic Status and Health, pp. 349, http://www.cdc.gov/nchs/data/hus/hus11.pdf (1/28/14)

[16] *Id.*

[17] *Id.* pp. 422

[18] For the purposes of Medicare Advantage plans.

[19] U.S. Department of Health and Human Services- Centers for Medicare and Medicaid Services, Calendar Year 2015 Medicare Advantage HSD Reference File, http://cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/Downloads/CY2015_MA_HSD_Reference-File.zip (1/28/14)

counties have a total population density of less than 10 persons per square mile.[20] CMS effectively enforces minimal network adequacy standards in CEACs, with good reason: providers do not exist in significant quantities in such counties, especially providers in specialized medicine.

Assuming that traditional ideas about network adequacy such as number of providers per population or travel and wait times will not be applicable to Nevada's CEACs as well as Micro and Rural counties (only Clark, Washoe, and Carson City meet CMS's definition of a Metro county), what measures can Nevada take to ensure access to care? What flexibility should residents of non-Metro counties have to purchase insurance that offers care in another community within the state? Should networks account for access to care in neighboring states? What effect might telemedicine have upon access to care in non-Metro counties, accepting that physicians in Metro counties may themselves have strained capacity due to increased demand for their services within their home county? At what point do services become structurally deficient within Nevada such that network adequacy in a particular field or service becomes impossible?

Solicitation

The Division solicits comments on the structural composition of network plan adequacy of rural provider networks, particularly:

- Alternative means of determining adequacy in a limited-service environment;
- Parameters surrounding intra- and inter-state border crossing; and
- Telemedicine.

NOTE: The Division is not currently soliciting comments on specific standards to be used in determining adequacy of provider networks, such as physician count, travel time, or wait time.

"Narrow" Networks

The term "narrow" network has come to mean either a network of medical providers that offers a limited selection of physicians and facilities or one in which the geographic diversity of physicians and facilities is limited. The two uses are not mutually exclusive and a network may be narrow both in geographic area and provider selection. Plans with narrow networks generally offer lower premiums than other plans and can be of benefit to all parties involved. There is concern that a plan with an improperly or insufficiently disclosed narrow network could disadvantage consumers.

Should Nevada permit plans to be issued with networks that are narrow in provider selection and/or geographic area? Premiums have risen approximately 170% from 1999 to 2012[21] while at the same time the Consumer Price Index, a common measure of inflation, has risen approximately 40%.[22] If narrow networks are permitted, what steps can be taken to ensure that plans continue to offer networks with robust geographic and diverse physician choices? In other words, can a standard be created that

[20] U.S. Department of Health and Human Services- Centers for Medicare and Medicaid Services, MA HSD Provider and Facility Specialties and Network Adequacy Criteria Guidance, pp. 9, http://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/Downloads/CY2014-HSD-Provider-and-Facility-Specialties-Criteria-Guidancev2.pdf (1/28/14)

[21] Kaiser Family Foundation, 2013 Employer Health Benefits Survey, Exhibit 1.13, http://kff.org/report-section/ehbs-2013-section-1/ (1/29/14)

[22] U.S. Department of Labor- Bureau of Labor Statistics, Consumer Price Index- All Urban Consumers, ftp://ftp.bls.gov/pub/special.requests/cpi/cpiai.txt (1/29/14)

permits narrow networks to be offered without permitting the offering of such networks to dominate the market?

The ACA requires qualified health plans to have networks adequate within a defined geographic service area, a requirement that is extended to all health benefit plans in Nevada Revised Statute 687B.490. Given that a geographically-narrow network is inherently limited to providing services to a subset of the defined service area, how can adequacy be defined within the rules?

Solicitation
The Division solicits comments on the structural composition of network plan adequacy of "narrow" networks, particularly:
The appropriateness of narrow networks, generally; and
The appropriateness of limiting narrow networks to ensure an appropriate amount of accessibility in the various defined geographic service areas.

NOTE: The Division is not currently soliciting comments on specific standards to be used in determining adequacy of provider networks, such as physician count, travel time, or wait time.

Discussion

The Division recognizes that creation and enforcement of a single objective quantitative standard may be impossible. Such a standard would be unable to account for the disparities in providers among urban areas and between urban and rural areas. Even multiple objective quantitative standards tailored to different regions appear implausible; it is quite possible that certain rural areas may not be able to meet any objective quantitative standard at all.

Inadequate objective quantitative standards can be supplemented or replaced with subjective quantitative and qualitative standards, which offer more flexibility. A provider network that would otherwise be deemed deficient may be acceptable given subjective review. A lack of providers offering services, or offering services at acceptable rates, may be a consideration in approving a network plan under subjective review. Flexibility comes with a price: disagreement. While there is usually little disagreement in meeting an objective quantitative standard (the number is either sufficient or it is not) the same cannot be said for subjective standards. The three primary stakeholders, consumers, insurers and providers, can and often will disagree as to the proper application of subjective standards. While current law allows for "any person aggrieved by any act, threatened act, or failure by the Commissioner to act" to request a hearing[23], the hearing process can be time-consuming, cumbersome and expensive, especially for individual consumers allegedly aggrieved by a network adequacy determination.

Solicitation

The Division is currently soliciting comments on the following topics:

- The structural composition of HMO and non-HMO network plan adequacy of provider networks;
- The structural composition of network plan adequacy of rural provider networks with special consideration upon alternative means of determining adequacy in a limited-service environment;

[23] Nev. Rev. Stat. § 679B.310

- The structural composition of network plan adequacy of “narrow” networks; and
- The structural composition of a process to apply objective and/or subjective quantitative and/or qualitative standards to the determination of network adequacy with special consideration upon dispute resolution of aggrieved parties under an objective standard (if applicable).

NOTE: The Division is not currently soliciting comments on specific standards to be used in determining adequacy of provider networks, such as physician count, travel time, or wait time.

Comments on these issues may be used to formulate a proposed regulation for network adequacy standards pursuant to NRS 687B.490 and should be directed to Adam Plain in writing at aplain@doi.nv.gov or to the mailing address on the cover of this brief. Time is of the essence; the deadline for submitting comments is 5:00 PST on Friday, February 28, 2014.