



**Network Adequacy: Balancing Cost, Access and
Quality
WellPoint
Alliance for Health Reform
July 14, 2014**

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ED HOWARD: Okay, my name is Ed Howard, I am with the Alliance for Health Reform and I want to welcome you on behalf of Senator Blunt, Senator Rockefeller, our board of directors, to today's program on the implications of a growing trend in America's health insurance market. That is offering consumer provider networks that exclude certain doctors, hospitals and other medical providers. Some people call that a "narrow network". Some people call it a value oriented network and a lot of people call it controversial. Some of the changes that are brought about by the reform law made it harder to hold down costs using some of the traditional methods, making sure all policies covered things like maternity benefits and that a pre-existing medical condition didn't exclude a person from getting covered. And these new "slimmer" networks are a partial response to that set of changes and therefore the dynamic forces that are work in the insurance marketplace. They are designed to help hold down costs of care and thus insurance premiums, while protecting or improving quality. But some folks worry that these networks hamper provider choice or keep a patient from continuing treatment, using the doctor or health facility that they have depended on. Today, we are going to take a closer look at those concerns and at the efficacy of these new networks themselves. We will also hear about some of the efforts to regulate them. We are pleased to have as a partner in today's program, Wellpoint, which among other parts of its business operates Blue Cross plans in a dozen states and offers coverage for one in nine Americans.

A couple of logistical items before we get started. If you are in the mood to Tweet, the hashtag is #networkadequacy and if you need WiFi to connect before you Tweet, the instructions on how to do that are on the screens and I think on the tables in front of you as well. We have had some adjustments to the program; therefore, some of the documents in your packet may not be quite up to date. If that is the case, you can get the most up to date versions on the Alliance website, which is allhealth.org. In the packets that you do have, there are some important pieces of information including speaker bios, a new improved speaker bio list with a lot more information than you are going to get from the verbal introductions. There is a materials list, single pager, in your kits and to the extent that we had them, the Power Point presentations we received in advance. And if you go to our website at allhealth.org, all of that is online and you can share it with your colleagues. As a matter of fact, I think one of the items that we didn't get updated before we had to come on over, was the selected expert list and you will find that on our website. There will be a video recording in the next couple of days, a transcript also, a couple days after that at allhealth.org. We commend that to you. There is a green question card you can use to ask a question once we get to that part of the program. There is a blue evaluation form, which I plead with you to prepare to fill out and hand in so that we can improve these reapings for your best use. And if you are watching on C-SPAN, you can find all of that background information including speaking bios and the slides that they will be using at the Alliance website, allhealth.org.

These afore mentioned experts are indeed a very good program for your use. They are going to detail the trends in the composition of provider networks and explore the cost

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access in quality tradeoffs that we have been talking about. We had an active weekend at the Alliance as we found out that two of our schedule speakers, Colin Drozdowski of Wellpoint and Jolie Matthews of the National Association of Insurance Commissioners were going to be unable to join us today, but we are pleased to have excellent last minute substitutes. Before I introduce this shiny new lineup of panelists, let me first add a word of thanks to the Alliance staff, particular Marilyn Serifini but also Dexter Williams and our fine summer interns, Joe Cohen and Bejan Mariar for their nimble work over the last 24 hours to allow us to proceed more or less smoothly this morning.

So let me give the merest of introductions to this new lineup, let me do it all at once to keep from destroying the continuity once we get started. We are going to have as our lead off, Daniel Durham; he is the Executive Vice President for Policy and Regulatory Affairs for America's Health Insurance Plans – AHIP, where he is charge of healthcare reform implementation efforts and policy activities. And we have asked Dan to describe what narrow networks are, what factors AHIP's members use when putting them together and operating them and what some of the challenges are in doing that. Actually we are not going to have him first, but he's worth waiting for. And as consolation for having to wait for him, you are going to hear from Paul Ginsburg leading off, who is one of the country's noted health economists. He occupies the Norman Topping Chair at the Shafer Center for Health Policy and Economics at the University of Southern California. We have asked Paul to address the implications of this trend for healthcare costs and quality and consumer involvement. Then following Dan, we are going to turn to Katherine Arbuckle who is Senior Vice President and Chief Financial Officer of Ascension Health, the largest non-profit healthcare system in America. And Katherine is going to discuss Ascension's experiences across the country. It has 70 plus hospitals or so and other facilities that participate in some that works and not in others. So that will be an interesting real life experience. Finally we will hear from Brian Webb, who is the Manager for Health Legislation and Policy at the National Association of Insurance Commissioners – NAIC. Brian is going to talk about how insurance commissioners are examining and acting on this trend and perhaps also describe some of the considerations involved in the model regulations that NAIC is in the middle of crafting. So let's get right to it. We are going to start with Paul and we are very happy to have you with us.

PAUL GINSBURG: Thank you very much Ed. I am really pleased to be here because I always enjoy speaking at Alliance for Health Reform events and so today I'm going to talk about – I have been using the term “limited networks”, it's I think less value charged. And really about why we have these – these plans have really been around for a long time, but with the development of the public exchanges, became far more prominent and just put the issue on the radar screen of a lot more policy makers. I want to start being the economist, saying that limited networks do have the potential to substantially lower costs. Basically they do this – the beginning is identifying which providers are lower cost or higher value and insurers in developing these networks do have the opportunity to use broader measures of costs than just unit prices. And one of the ironic things is that some

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of the measurements of providers to assess who to invite into a limited network, are very parallel to some of the payment reforms that you have heard about. Like episode bundling, patient centered medical homes and the like. So quietly they are moving in the same direction. So where does the savings come from? The savings come from steering volume to lower cost providers and that is a direct thing. In addition, if you are successfully steering patients or have a good prospect of it, you can negotiate lower unit prices with some of the providers in a market. When enough plans do this in a market – enough people are involved, this will strengthen provider incentives to lower costs. Limited networks can also support integration in delivery and this fairly new. If we are going to have provider led plans playing a bigger role, whether they are the providers of the insurer or in partnership with an insurer, limited networks are critical to their being viable because it's really important to steer enrollees to the delivery system's providers. This approach, through our work at the Center for Studying Health System Change, since the mid '90s, we saw provider led plans develop in the mid 1990's and the whole purpose was the expectation that they could offer plans with networks limited to the system's providers. And these were abandoned for the most part when limited networks disappeared back then. I want to briefly mention the highlights of the McKinsey work, about the experience in public exchanges. And they estimated that narrow network plans were available to 92% of consumers using the exchanges and that broad network plans were available to 90%. That narrow network plans accounted for 48% of the offerings and 60% in metropolitan areas. And the key thing was that broad network offerings had premium increases – 13% to 17% greater than the narrow network offerings.

So what is behind the rapid growth in limited networks? Well, I think a big basic reason is that health spending now is increasingly higher in relation to income. So – and we all know about – that is from advancing technology and higher unit prices and it's led to a situation where broad provider choice is a luxury that fewer people can afford. But the key break with the past really was the development of public and private health insurance exchanges. I would say there are two key things. One is that the freedom from one size fits all requirements. If you are an employer and you are offering your employees a plan, there is a strong pressure to make it a plan that almost everybody is going to find attractive. That is not the environment to offer unlimited network plans is. But with exchanges, you are freed from that, because there are a lot of competitors in most exchanges and a plan can be very successful on an exchange if it appeals to just half or even less of the population. This would be a disaster in employer based coverage, unless that employer was offering a wide variety. The other aspect is fact that the subsidies to consumers are fixed. They are based on the second lowest silver plan premium in a marketplace in the Affordable Care Act or in private exchanges. They are also fixed. So it means that consumers are spending their own money for the marginal cost of a more expensive plan.

To do this, some basic tasks need to be done well and they haven't always been done well over the past year. Or this year to date. One is accurate and accessible consumer

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information on the network status of providers and their roles for both plans and exchanges. And I'm often surprised that we don't see more products on exchanges like what the Federal Employees Health Benefits Plan uses. It's a tool from Consumer Checkbook where people click on a plan, they put the names of their providers in and they see which plans those providers are in the network of. There is a need to monitor the network provider capacity. There is the possibility that a lot of plans have the same providers the network and those providers are overwhelmed. This will straighten out over time, I'm sure. And also there needs to be recognition of some of the sub specialties and the attention to physician's hospital admitting privileges in specialties like ophthalmology and orthopedics, they are pretty specialized and someone who has a problem with a retina or a problem with their foot probably doesn't want to just go to any old ophthalmologist or orthopedist. There needs to be a speedy exceptions mechanism to allow a patient with highly specialized need to meet them at network pricing and also something that perhaps the responsibility of exchanges, is ensuring that broad network plans are also available. Now, just a few comments on regulation of network adequacy. There clearly is a need for regulation but there is a very high cost if the regulation goes too far. I think the key needs are basically the transparency needs and the basic tasks I mentioned. Also a need to prevent risk selection strategies based on poor coverage of some specialties and a consumer protection needs, which I would describe as basically – if there are some networks that very few informed consumers would find acceptable, it's probably best that they shouldn't be on the market.

I think some of the dangers is disarming the most powerful market tool that is available, to address the effects of increasing provider leverage in negotiating with insurers. Prices have been going up rapidly, they are most – explain most of the rise in spending. So the success with limited network plans is going to be important for health spending, especially for lower income consumers. Also I am concerned about interfering with some of the steps towards clinical integration.

Let me just talk about the politics. It's inevitable that pressure from providers to be included in narrower networks will happen. We have seen it now particularly from pediatric hospitals being particularly outspoken and we have had any willing provider laws in a number of states that actually have been around since the 1980's, which seem to be a particularly misguided response to this issue. But in contrast to the 1990's, consumers seem much more of a stake of having lower cost products available as a choice. Federal government also has a stake in how high silver plan premiums are and I'm suspecting that we will have a much more nuanced reaction to these issues – thank you.

DANIEL DURHAM: Well, good afternoon everyone, it's a pleasure to be with you today. I plan to briefly cover five topics in my presentation. I will start with some of the latest consumer satisfaction polling and then I will turn to how networks are focused on delivering value to consumers and then a little bit about the importance of increased

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choice and how those choices enhance the value proposition. And then a little bit about how networks are built based on a recent study that we commissioned by Milliman. Then finally I will wrap it up with our commitment to consumers, which really focuses on accessibility.

The Commonwealth Fund recently examined attitudes about satisfaction of coverage in exchanges and found that nearly three out of four are satisfied. This is consistent with the recent morning consult poll that showed that 74% are satisfied with their health plan. And directionally, this matches with what we have seen in private polling, showing that more than nine out of ten registered voters are satisfied with their private health insurance coverage. Consumers' preference for balancing provider access with cost is another very important consideration. A recent poll indicated that 57% of small employers would choose a smaller provider network if it resulted in a 5% reduction in their premium. And this increased to 82% if the result were a 20% reduction in premium. In another morning consult poll of consumers, showed a similar preference with 58% preferring a less expensive plan with a limited network of doctors and hospitals.

Well, health plans are focused on value by finding the right balance for consumers between quality, affordability and choice. Plans are constructed on the premise of ensuring the highest quality at the lowest price to deliver that value to consumers. The Milliman Report I mentioned, finds that high value provider networks allow for more affordable coverage options with 5% to 20% lower premiums compared to broader network plans while placing an emphasis on quality and effectiveness of providers. The McKinsey Report found similar results. Many consumers are looking for this type of balance that delivers value, affordability and choice.

Regarding choice, the recent McKinsey Report that Paul summarized in his presentation, shows that consumers now have expanded choice of network offerings on the exchanges. Broad networks are available to close to 90% of the population. Mirror networks are available to 92%. This increased prevalence of narrow networks gives consumers a wider range of value proposition and prices among health plans. Importantly, McKinsey found that there is no meaningful performance difference between broad and narrow exchange networks based on CMS hospital metrics.

The Milliman Report explains in some detail that high value provider networks are specifically geared toward providing personal and comprehensive care to patients in an environment where providers effectively communicate and coordinate with each other, regarding the best treatment for patients. High value networks are developed through a deliberative evolution process with providers that consider more than just fee levels. Active cooperation and collaboration between health plans and participating providers is really the hallmark of success for high value networks. Performance on quality measures is the key part of the criteria used for provider selection and inclusion in a plan's network. In addition, health plans must meet robust standards for network adequacy and

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access to care. Professional accrediting organizations like NCUA and URAC require plans to meet standards for access and availability for service and measure themselves against these standards on an annual basis. State and federal network adequacy laws ensure that consumers have access to a sufficient number and type of physicians and hospitals and health plan provider networks. Importantly, network development is now occurring in a reform market where health plans have new requirements that restrict their ability to vary plan design and control costs, including essential health benefits, preventive coverage requirements, limits on cost sharing and restrictions on age rating. Variation in network design is one of the few tools for health plans to keep costs low for consumers while ensuring quality.

So here is our commitment to consumers. This is an important slide, so I will spend a little time on this. Our healthcare system is in a period of significant change, which means now more than ever, patients are looking for value and stability in their coverage. Understanding that it is health plan's top priority is to provide consumers with the information they need to navigate the new system and to make the decisions that are right for them. One important step health plans are taking is to improve transparency. I know Paul talked a lot about this. While the use of provider networks has been a key tool in delivering value by preserving benefits, mitigating the impact of rising costs and promoting quality of care, consumers may not be aware of the critical role networks play, how they work or understand which providers are in their networks. Consumers should have the information they need to make the right choices for themselves and their families and that is why health plans support ensuring great transparency of network design by providing accessible, understandable and up to date information about which providers are in a network and timely notice to consumers when providers leave the network. Providing a summary of information about how plans put together their tailored networks to balance cost, quality and access considerations. Providing information on how consumers can appeal plan decisions, submit complaints or obtain referrals to out of network care when necessary. And we also support continuity of care for a minimum of 30 days for individuals undergoing an active course of treatment for conditions that require a more complex care, for serious terminal illnesses and for mental health.

So that wraps up my presentation. Thank you and I look forward to our discussion.

ED HOWARD: Thanks very much Dan and we will turn now to Katherine Arbuckle from Ascension.

KATHERINE ARBUCKLE: Thank you all, everyone in the room, for allowing me, on behalf of Ascension Health to have this opportunity to have this important discussion with you today. Just a little background, Ascension Health is, as Ed mentioned, the U.S.'s largest Catholic health system as well as the largest not for profit health system. We have more than 1900 sites of care in 23 states and the District of Columbia. All the health systems that are sponsored by Ascension Health have considered participating in

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insurance products offered on the exchanges. However, these participation decisions are made at the local community level and as a result we have experience pretty much on all sides of the issue. In some communities, we are the name providers in the narrow networks; named in all of the narrow networks offered. In other markets, we are included in some narrow networks, but excluded from others. In some markets we offer our own offering as a narrow network plan of our own. And then finally, we participate in the non-narrow market, the broad offerings has been described with other providers in those markets. I would generalize that overall in most of our markets, we are in some form of exchange product because generally it fits with our mission to serve the low income and the vulnerable, since that is who is accessing these products on the exchange.

So I do want to comment about these narrow networks and then how they can benefit payers, patients and providers and we do believe there is a benefit in narrow networks. And it can be done through the offering of what we call clinically integrated care. And that is especially helpful for those with chronic diseases. And so some of these benefits that you can outline when you have this tighter integration, is that providers can communicate more opening and easily, sharing information between them about patients and that is especially important and helpful with electronic health platforms when the providers are on the same platform. This can reduce duplicate testing and even conflicting treatment. Payers and providers can share more meaningful healthcare data, work together on healthcare analytics to determine what is the right improvement we can make to quality and cost. The providers within a clinically integrated network can be more familiar with each other's – not just their medical practice protocols, but their administrative practices, allowing handoffs to be much smoother with less error. And then also these tighter relationships allow these providers to comment with the payers back to them, where there are service needs and things that need to be improved.

So I will go on to what we also want to talk about though and that is, there needs to be adequate consumer protection and education. Especially for these families who are accessing these products offered through the exchanges. According to HHS, 85% of individuals that are purchasing products on the exchanges qualify for an insurance subsidy. So I think therefore we can conclude a couple of things. One, they tend to be at the lower end of the income scale and two; a good number of them did not have insurance previously. In fact, one study we have seen, 57% did not have insurance before. So I'm glad we are talking about this question today.

So starting with consumer protection and education, we have invested as Ascension Health, in 200 individuals to become certified application counselors. They have received federal training and they are there to help patients access the networks and understand the website – healthcare.gov. But what we have learned is that counseling takes a lot of time. Not just for those patients who arrive asking for this counseling and this help, but many times when they arrive with the need for medical care. And that is hardly the time to learn, that is when your provider of choice is not in your network. This leads to

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confusion, it leads to frustration and sometimes anger. And I will tell you, in one example, in Wisconsin, a patient arrived at our emergency room in critical condition and needing immediate intensive care. And unfortunately he had just signed up with a health plan that did not include us in his network. We admitted the patient, because that is what the patient and the family wanted, but neither the family, nor us, knew what that patient's liability or financial obligation would be for that bill when it was completed. But we were fairly confident, as Ascension Health, knowing we had admitted, that if this patient is lower income, which likely they are, they will qualify for charity and we'll be left with the uncompensated care, again, because of the confusion of which provider is in the network. So it's obviously important for patients and families to understand their networks when they sign up for the plans. They need to know they may face higher deductibles, high co-pays and co-insurance and possibly the provider is not covered at all. We would advocate to you today that the insurers need to be more accountable on educating their customers on their products. That includes Ascension when we offer a product on the exchange. The education should focus not just on networks and who is in the networks, but education on the related deductibles, co-pays, co-insurance and even education on trade-offs to be made when choosing a low coverage, low premium product versus a higher coverage, higher premium product. And this is especially important with these folks who do not have experience with insurance and have cultural and language barriers as well. We have found that the online directories are often incomplete; they are outdated, sometimes inaccurate information. Hard copies are not existent. It's also not unusual in a community for several practices or providers to have very similar names and that can add to confusion. And finally, the access hours and the capacity for those new patients to access those providers is also important. When an individual is enrolling on healthcare.gov, they have to leave that website and go to the various insurer's websites to determine more about providers and of course we believe that information should be accessible through the healthcare.gov website.

So I want to move on to the quality standards. Ascension Health has been a leader in patient safety over the past decade. We are very proud of our quality record. Our work in the last decade on pressure ulcers has resulted in our pressure ulcer rate being 94% below national norms. Our system wide work in birth trauma has made Ascension hospitals among the safest places to deliver a baby. We believe we should streamline the existing web of quality programs into an outcomes based, uniform national core measurement set used by both public and private sectors. Ascension Health and American's Health Insurance Plan – AHIP, made this recommendation last spring in a document that was published called “partnership for sustainable healthcare”. A defined set of outcome based measurements can provide the consumers with more understandable and meaningful information to be able to compare providers within their communities. Current practice allows an insurance to develop their own quality metrics of their choosing. Sometimes these measures are similar or the same as Medicare, but not always. And a recent Milliman study released by AHIP, which I believe is in your packets, found that the primary measure used in evaluating their own network providers are quality measures

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and the study goes on to describe how those quality measures can be used. There are seven different types described in the document and each has dozens or even hundreds of different measures and metrics. I can tell you, in one of our health systems, they are evaluated by three insurance plans. Same services. One grades them as a three star, another is a four star and another is a fifth star, even though it's all reportedly based on the same metrics. And that causes us back and forth with the insurers to sort out, is it the patient population that was looked at? Is it the time period? What are these differences and what is driving them? And while we have a hard time figuring it out, its much more difficult for physicians to understand how they have been graded as far as quality and frankly, it's a mystery for patients. So considering there should be uniform, helpful, quality information as part of the patient's decision on these networks.

So what is a sufficient number of providers and services to include in a narrow network? I understand the work is in progress and it will continue to evolve and I'm glad HHS and NIAC are working to further define this definition. But I want to point out just a couple of things. First of all, the individual marketplace includes many, many low income families who are also medically vulnerable. So measuring the distance to providers is sometimes not simplistically solved by measuring miles. Ten miles away to a hospital may not seem very far, but if you have no transportation and you rely solely on public transportation, that can be 100 miles to you. Also we have folks that are buying on the exchanges that have complex childcare needs. They need flexible work hours and so their information regarding providers' accessibility within hours, after hours, etcetera is also important. We have seen a few holes in the coverage in some of the narrow networks. For example, in one market where we are the narrow provider, we found one of the narrow networks had no access to PET scans. Another glitch we found was that as their narrow exclusive network provider, they had no contracted with any other outpatient lab services or radiation therapy. And we can provide those services, are happy to provide them, but frankly, getting outpatient lab testing at your hospital may not be as convenient as some of the outpatient labs that available with better parking and better hours.

So finally I would like to emphasize the reality of the marketplace, is still that price dominates. Premiums are what consumers are the most likely to look at when they choose their networks. The Accountable Care Act established affordability standards for health premiums, but its cost sharing subsidies for those with this low income, still leave large out of pocket medical expenses that can be unaffordable in this population. Most households with income below 400% of the federal poverty limit have negative net assets. So as a result, even modest out of pocket costs create affordability problems. I will give you one example; this is from one of our markets that has worked with some folks. A married couple, both age 59 with income of \$48,000 a year, they chose a bronze plan. Their premium is subsidized, they pay \$3600 in annual premium and they have a \$3600 deductible and they are subject to a \$12,000 potential out of pocket maximum. Working through the numbers, if one of this couple needed a joint replacement, let's say a knee or a hip, their share of this procedure including the procedures, the premiums, the

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deductibles, etcetera, would result in an annual expense of roughly \$16,000, which is now 34% of their total income. So these high deductible plans, not only are they unaffordable, but they lead to poor care. Coordinating care for this population is difficult. It's well documented that when people delay seeking their care or have difficulty adhering to their treatment plans when they are faced with large out of pocket costs.

So moving forward, it's tempting to develop policies based on anecdotal information. But the reality is, we need more rigorous information. We need to know what is working what is not working around the nation. What works in one community may not work in another community. The one priority we have for the initial attention in this area is education. Providing clarity and transparency for the consumer so that know which and who providers are in their network, how available those providers will be to them, how much cost sharing they will be accountable for and the quality that can be provided by those providers. At the same time, as this more rigorous information is developed, we believe it's more important also to remain flexible and to respond to any particular egregious situation that may come up, which is what we have done in our healthcare system as we see these specific examples come up, responding with compassion to understand what the patient's need are and meeting that as best we can. Thank you.

ED HOWARD: Thanks Katherine. Let's turn to Brian Webb from NAIC.

BRIAN WEBB: Thank you very much. Good afternoon everybody. My name is Brian Webb; I am with the National Association of Insurance Commissioners. We represent the commissioners from the 50 states; Washington DC just became more important to some people in the room last year. And also the five US territories, which was clarified last week, are not states for title one of the Affordable Care Act. One of our jobs is to develop model laws, rules and regulations that states can choose to use. We do this as an open process. We are bringing stakeholders from various areas and we try to develop one and one of those that we have is the Network Adequacy Model Act, number 74, if you are keeping track at home. Number 74 basically was developed in 1996 and looking around the room, looks about half of you were in kindergarten, so it was a long time ago. And how we are starting to look at it once again to see if it needs to be updated, given the new environment. Looking at the existing model, the basic focus was to make sure that carriers, when they set up their networks for managed care, do set them up in a way that there is a reasonable assurance that somebody can get to an in-network provider in sufficient numbers and types, in a reasonable amount of time. And we leave it up to the carriers for the most part to determine how they are going to set those up, but then states can look at the networks to make sure that definition of reasonable, is reasonable. That when you look at the time it takes people to get to them, any waiting periods, any distance issues, that you make sure that everybody can get to somebody in a sufficient way. And if not, what the model does is, if there is an insufficient network, that the carrier makes sure the person can go to another doctor, another hospital, another provider. And that they would be not charged more for going to them. So there is an alternative

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mechanism set up. And to regulators, what they do, they require the carriers to file an access plan with the commissioner prior to offering the new managed care plan. And what goes into that is of course, a description of the network. They need to also say how they are going to monitor that network on an ongoing basis. What the grievance procedures are going to be if somebody has a problem or a question about the network. Notification. How are they going to notify the consumer if there is a change in that network? Either the provider decides to cancel or they are terminated by the company and also – and this is very critical – the continuity of care. So if somebody is dropped, how are you going to make sure that person continues to get the care they need, either from that provider at no additional cost or through a separate provider. It also goes into the contracts. You want to make sure that the contracts that are being set up are not done in a discriminatory way. You are not only with certain kinds of providers so that certain consumers can't get their care. You want to make sure they are not basically giving inducements to providers to make sure they are not providing certain medically necessary care or there is some kind of gag rules, they can't discuss certain kinds of care. So all those are all rolled together into our model act. About ten states have taken and adopted our model verbatim. Taken it just as it is. Another ten have some kind of similar – and I just want to point out, even on those 20, states through guidance and through other regulatory have adopted these concepts. They work with the carriers, the carriers do use a lot of these standards in developing their networks. If you want a copy of it, you can go to the NAIC model – go to store and go to “free”. There is a whole section of free materials you can get including all of our models. We also have a white paper that we did on this, going back a couple of years. You can get that as well, which kind of looks at the issues that we are now going to be looking at, as we look to revise our model. We have set up a subgroup, which is currently doing regular phone calls. They are open phone calls, anybody in this room can sit in on them if you have nothing else better to do with your life. I always picture a 40 year old man in his mother's basement, but I don't know why. Just sitting down there, calling in. And you can do that. You can provide comments. Anybody and everybody can provide comments, suggested changes, however you want to do it. And we have gone through a series of calls now where we have had all the stakeholders, the carriers, providers, the – who else? Consumers of course. Others that have come in and brought us their ideas. And we are going to soon start the process of updating it. And there are a couple of areas we are clear we need to update. One of the concepts of an essential community provider. That is not something that we were really looking at before. Are those now included in your networks? There is also just issues in the new environment of, are we applying it to all manner of managed care? Some states only did what you would call your old managed care closed network type of plans. Now, do you go out to PPO's? Do you go out to others as well to make sure everybody is doing what they need to do? We are having weekly calls, in fact our next one is Thursday, July 24th at 1:30 pm, mark it on your calendars, be there, as we start looking at amendments. We have received comments from about 30 different groups so far and we are going to start going through those and seeing where we need to update our model. If you want information, the website is there; you can go and get the exact call in information. What

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are the issues? One is just the flexibility to reflect state needs. This is always going to be our number one point. We don't want a one size fits all federal government comes in and says, this is exactly the time and distance for each type of provider. We don't think that will work. I don't know about you, but Wyoming is just a tad different than Los Angeles. So what are the standards? How do people get there? There were some good examples brought up as well – what about certain populations and certain – maybe very populous areas, but maybe some transportation issues. And states have been looking at these issues and are best to address these issues given on their needs. But then we do – as is been brought up, we need to balance. There is no sense in going here and saying, we need to get rid of all of these. No narrow networks. Because we need to balance quality, we need to balance affordability and then we need to balance access and how do you do that and how do you do that in a model and make sure everybody is protected – is our number one concern. Some of the key issues we are going to be looking at – tiered networks and narrow networks. Tiered networks are basically if you go to this group, you have to pay this much. If you go to this group, this much, this group, that much. And you kind of – they are tiered up. Especially in formularies, which we are looking at more and more now than we have in the past for prescription drugs. How are those set up? Narrow networks, one issue in particular we are going to be looking at is, in a couple of states, carriers said, if you purchase in the state, we will cover you either as in-network or out of network, but if you go to any provider outside the state, we will pay nothing. It's not even like a higher cost sharing. It's just; we will pay nothing not covered. We are going to have to look at that. We are also going to have to look at provider directories and updates and I think that was already addressed here and this was probably the most critical issue. You can't have a free market when people cannot get access to information. We had that this year. I'm not placing blame on anybody; it was a rough year, just trying to get plans on, getting things up and running and get it out there. But we have got to do better in 2015 open enrollment period. Consumers need to know that if they purchase that plan, is their provider in the network or not? They have to have clear access to the website to make sure they can know which ones are in and which ones are out. And to tell the truth, providers do too. I had so many provider groups calling us and saying, I had no idea. I got the call from the consumer. They were doing their due diligence. I said, I'm in; I have a contract with that company. Then I find out I don't have a contract for that particular plan. So we need to make sure everybody has the information they need and if there are updates that those notifications are going out so that the consumer is well aware of what their options are. And we do want options. There are many plans and we are going to have more plans on the exchanges next year, across the country. Are some of them narrow? Some of them not narrow. Do people know the difference and do they have the options available to them? So the directories, are the accurate? The updates, accurate? Consumer information, education, do they have the right choices before them? And then another issue we are going to be looking at is the surprise bills. How many like surprises? I like surprises, but not when it's a bill. And this where you go into – for a procedure. Your doctor is in the network, your hospital is in the network and your anesthesiologist is not. That is called, surprise. You are going to be charged higher for that. Making sure

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everybody is educated. States have been doing things on this. Federal government has even looked at this. It's something we are going to be looking at to make sure everybody is educated. Its okay if he or she is not, what is not okay, is nobody knows and really no choice was given.

I will leave you with this last slide. If you have any questions, please call Jolie. She was supposed to be here and I ain't taking the questions. So if you have any questions, she is the staffer in charge, she is the one writing and updating the model. If you do have any questions, please call her. She will be able to help you out. And if you are interested in this, please join the calls. We hope to be done by November of this year with a brand new model that states can use to update their procedures and if you want to be a part of that or just want to know what is going on, jump on the calls, we would love to have you. Thanks.

ED HOWARD: Terrific, thank you so much, Brian. Brian has agreed, in the course of the Q&A session to channel his inner Jolie, so you have a chance to join the conversation. I'm going to exercise a little bit of prerogative just to clarify some things. At the appropriate time, you can fill out a question card that is in your packet. You can also go to one of the microphones that are in the room and you can tweet a question using the #networkadequacy. So you have all sorts of channels.

The first thing I want to do is sort of a factual clarification. We have heard a lot of talk about in-network and out of network. How many people don't know the difference between in-network and out-network for purposes of this discussion? We have a very sophisticated audience here. So the question is, is there a typical pricing pattern? In other words, what is the penalty – maybe not out of state being zero, but in a typical plan, if you are in a narrow network and have to go out for some reason or think you do, is there a substantial differential or is it fairly nominal? So how important is this? Is what I'm asking. Dan, do you have any sense of that?

DANIEL DURHAM: Sure. Again, I think it's critical from the point of view of providing value to consumers, that we allow these high value networks to be a choice. As many of you heard from a number of speakers today, many consumers are buying based on premiums and to get that premium point down to an affordable level, plans are offering their own networks. Its not the only option. You have broad networks, as you can see in the McKinsey poll, available to over 90% of the population. So it's a choice there, but if you are in a plan that does have a specific network, then there are certain requirements to go outside that network. Plans don't say you can't do that, but they will work with the individual on their specific needs. So if there is a particular type of specialist that simply is not in the network, then the plan has an obligation to work with that customer to find someone out of network that can provide that medically necessary service.

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PAUL GINSBURG: If I can add something. You know, part of it depends on the type of plan you have. If you are in an HMO that does not have out of network coverage, then it's far more restrictive, then you won't get anything out of the network, then if you are in an HMO with point of service coverage or a preferred provider organization. But I would say the differences are substantial. I think they have to be for the narrow network approach to work. Because it's not just that you will pay a higher say, co-insurance rates with the out of network, but that you won't be benefiting from the insurer's negotiating ability to have negotiated a network price. So that you will be liable for the amount beyond what the insurer allows for out of network care in addition to the extra co-insurance.

ED HOWARD: Paul, it is typical that if that happens, whatever the out of pocket expense incurred is, doesn't count toward the out of pocket limits or the deductible in the plan or not?

PAUL GINSBURG: Yes, the co-insurance counts, but not what we call the balance billing.

ED HOWARD: Okay. Yes sir, do you want to identify yourself?

AUDIENCE MEMBER: My name is Daniel Davis, I am with the Administration for Community Living in HHS and one of the considerations that we are looking at quite a bit right now is the access to providers for people with disabilities in narrow networks, specifically there are considerations where there have been a number of studies on sub specialties where there is 20% or 40% of providers, according to some secret shopper tests that in certain sub specialties that don't serve patients with mobility disabilities and to what extent are NAIC and private insurance industry taking that into consideration and making sure that there isn't inadvertent health status discrimination?

BRIAN WEBB: With the NAIC, yes, that is something that has been raised as an issue and something that we need to look at. Something that state regulators need to look at when they are reviewing the various plans. Not just that, but especially with mental imparity and things coming on and new requirements on behavioral health, etcetera. There is a lot of issues there that we need to make sure that everybody is taking into consideration. So we would agree.

DANIEL DURHAM: I will just add that health plans work very hard to comply with all the federal laws, state laws, rules and regulations and they submit their plans for review and they are approved in the state and if they are a qualified health plan also by the federal government and they are certified, so they have to meet the standard set and statute and in regulation to be able to compete in the marketplace and we take that very seriously and if you don't meet those requirements, then you are not certified to be on the market.

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ED HOWARD: Having the gentleman from the Administration asking that question reminds me of a question that was submitted in advance that is related. It makes reference to the fact that the Administration had communicated with plans not so long ago. That they were going to focus on areas that have – and the questioner actually quotes “historically raised network adequacy concerns, including among others, mental health providers”. I wondered if we have any other elaboration of how the current discussions or the current controversies for that matter, deal with behavioral health issues. Katherine, do you have anything to add on that?

KATHERINE ARBUCKLE: I will just add that clearly that is a consideration. We focus so much on first the – what are the physicians and the hospitals in those networks and that becomes the bulk and then as Brian pointed out, then you have the anesthesiologists. My point was, there is also out patient access that needs to be considered. Mental health, home health, all over the care continuum for clinically integrated network to be successful it has to be considered and that entire network has to be considered. I don’t have any specific examples for you, but I absolutely agree with your point.

ED HOWARD: Caroline?

AUDIENCE MEMBER: I’m Dr. Caroline Poplin; I’m a primary care physician. I have two questions for the gentleman from AHIP – one, in the satisfaction surveys that I think you presented, did they break out people with chronic illnesses or people who have had a serious illness in the last year versus healthy people? Because most people are healthy most of the time and if they don’t use their network, they will be satisfied with it. My second question has to do with choice. Each – it sounds like each insurance company, in an exchange, will present a variety of plans. I guess maybe they are required to present, you know, bronze, silver, gold, platinum and the experience with part D has shown that people get very confused when they have too many choices. When they have five insurance companies offering 50 plans, that is hard to deal with, especially if you have to do it every year. And in part D, I think there was a study that showed that in fact, most people didn’t change their primary plan, they just kept the same plan year after year, even though it wasn’t the best plan for them.

DANIEL DURHAM: Well, thank you for those. First, on the poll, the Commonwealth Fund survey that I mentioned in my slides was very comprehensive. I don’t have the actual sample data in front of me to answer your specific question, but if you go to their website, they provide a very thorough explanation of where their sample was drawn from, so you could find whether or not it covered the specific populations that you mentioned.

AUDIENCE MEMBER: Oh whether it’s separated to specific populations. Because you are going to get a different answer for people who have to use the plan versus people who

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just think it's going to be great because they don't really know. They have never had to use it.

DANIEL DURHAM: Right and that survey also included those that actually have used their plan too and there is data on that as well. So again, I encourage you to go to their website and pull up their survey. It is very comprehensive and very informative. With regard to your second question, if you could repeat that for me.

AUDIENCE MEMBER: Do you worry about the fact that people are going to get confused by having too many choices? Each one has a lot of information. The Part D experience hasn't been all that reassuring on the question of whether people can make a good choice.

DANIEL DURHAM: That is a very good question. It really depends on the individual. Some are very savvy and sophisticated about looking through the websites and finding what is best for them. Others need a lot of help and that is why the ACA provides for navigators, assistors, we have brokers as well, and others that can help individual review plans and make the choice that is best for them and their families. And health plans are doing a lot too in terms of basic education and putting as much information as they can on their websites to help individuals make the best choice, including things like cost calculators, so you know you are going to have a specific procedure, what your out of pocket cost would be for that and the like.

PAUL GINSBURG: If I could add something to the proliferation of choices, I think the structure of the offerings by being grouped into tiers, defined by actuarial value, probably helps consumers a lot with going through this. Because I suspect that most consumers first decide what tier – what metal they want to get and – so the numbers of plans aren't as great.

ED HOWARD: I wanted to follow up just a little bit, because one of the questions that has been raised, at least in the materials that our staff has assembled, is the question of how a consumer, in trying to make the choice, can distinguish between a narrow network and a broader one and presumably those aren't two different things. There is a blend; there is a range of narrowness if you will. Are there some standard formulations that are being used either on the marketplace websites or among the plans that can help people who don't deal with this kind of terminology every day to understand which of the choices they are making along that spectrum?

PAUL GINSBURG: And reading the McKinsey study, I'm presuming that there is nothing out there like, as you were saying, Ed. But they came up with their own definitions of whether it was ultra narrow or just narrow and it was merely based on what proportion of the hospitals were in the network and it probably would be a good idea going forward in the same way that we have four metal tiers of plans, to also – they will

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be arbitrary, but say it's a plan that has below a certain threshold to providers, is called a narrow network plan and in a sense, consumers can put some aside and then they won't be standardization like actuarial values, but at least it would help the consumer simplify their search.

ED HOWARD: Brian, any talk of something like that in the revisions that NAIC group is considering?

BRIAN WEBB: No, not at this time as far as in our model. It is something that as far as choices and information, I think states would like to look at. I mean, we don't – in the past have seen carriers really try to hide things like that. They want the information; they want to distinguish between one plan and the other, so how that is done and how clear it is, we will work toward that. It is probably not something that can be in our model specifically. Trying to standardize it in any way.

DANIEL DURHAM: And I will just add that plans do provide a summary of benefit in coverage on healthcare.gov and so that provides important information to shop around. There is other information on healthcare.gov. New information will be coming in the future, specifically with regard to quality and consumer satisfaction. They are currently building that in and working to produce that. So I think just with Part D, it will take a while for the website, healthcare.gov to get where it needs to be, to provide all the information that consumers want. But you have to walk before you can run, so we are still in the first year and I think we find from the experience in state based exchanges, those states have tried to do too much on their websites, ran into some real challenges and lesson learned there, but health plans are committed to providing the necessary information so consumers can make the best choice for their families.

ED HOWARD: Yes ma'am?

AUDIENCE MEMBER: Hi, Lauren Kennedy with the National Partnership for Women and Families and the question follows nicely – your last comments, which is – I was wondering if any of the panelists can speak to what have been successful strategies for ensuring consumer access to this type of information specifically with regard to quality and performance data. I think it was in everybody's presentation that this is a key criteria, not just for provider selection – performance on quality and value metrics, but also the consumer's ability to access that information understand it, and use it to make informed choices and specifically with regards to exchanges, how do we support consumer access not just to plan performance on quality and metric – so being able to rate plans by quality data, but also consumer access to how providers themselves are performing on quality metrics? I think we would make the case that if we are looking at narrow choice through narrowed networks or high value networks; however they are referred to, that consumers have a distinct interest in understanding how individual providers in the network or

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facilities are performing on quality metrics in a way that is consumer friendly and understandable to them.

ED HOWARD: No one disagrees, apparently.

AUDIENCE MEMBER: It's not an argument, I was wondering if you are able to share some strategies that you have seen successful or that you might be sort of contemplating or policy changes that might be necessary in order to sort of compel this type of consumer access to provider and facility level performance data/

ED HOWARD: And can you do it directly or do you have to do it by requiring the plans to collect the information in some way?

PAUL GINSBURG: I think this is a direction we want to go and I think the first thing is to get more meaningful quality data on providers and I did notice that two of our panelist's organizations together were promoting the idea of standardizing quality measurements and I think that as we get better at measuring quality and as we get some consistency, then it's going to be far more possible for plans to really advertise or inform about the quality of the providers in their network. Because ultimately, as you said, I think what matters most to many people is the quality of the providers.

ED HOWARD: Paul, is it a fair assessment of the state of the art that the people who measure quality aren't very happy with the state of quality measurement at this point?

PAUL GINSBURG: Yes. I think there is a consensus on the direction of getting rid of a lot of the process measures of quality and replacing them, because now we have the ability to do more in the way of outcome measures.

KATHERINE ARBUCKLE: I do believe we would advocate for collaboration and to make it more universal as I stated earlier. That having each – so many different ways of measuring quality and that is where we are today in our healthcare delivery. But with so many different ways, you get completely contradictory conclusions. You read magazine covers of who is the best hospitals and they are in, they are out, and you don't get any real conclusion as to who is providing the best quality. So I think this area has to be improved. It needs to be universal and we advocate working with insurers, employers and patients to come up with the right quality metrics.

AUDIENCE MEMBER: Can I ask just one follow up? Do you feel that that's best in the private sector, in the public sector or in sort of collaboration with both if we are sort of aiming towards better alignment and standardization?

KATHERINE ARBUCKLE: Well, with as far as we have to go, it is certainly going to start in multiple areas, public and private. I think our point is that the ultimate goal would

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be single. It should be something universal that we are all accustomed to and understand. I think in the interim though, we will work with insurers, we will work with HHS. We are interested in pursuing this to help – not narrow the number of quality indicators, but make them more understandable and comprehensive.

ED HOWARD: Let me just digress for 30 seconds and tell you that Jim Talon who is on the Alliance board and who runs the United Hospital Fund in New York City, once observed that because of all these various rating systems, a New York city contained 40 of the top 25 hospitals in the United States. Yes, go ahead.

AUDIENCE MEMBER: Stuart Gordon with the National Association of State Mental Health Program Directors. In the mental health field, a lot of services are provided through peer support in mental health and in substance use. And an aligned area, I know a lot of services, despite scope of practice laws in the state, can be provided by nurse practitioners and physician assistants. Is that something – I guess its two facets of the same issue, is that something that NAIC is looking at in its revised model?

BRIAN WEBB: It's not currently on the table, as an issue that we are going to be looking at. We have tended in the past not to get much involved in who provides the care and those kind of certifications. But if it is something you would like us to look at, you know the number. But it is not something in the past we have dealt much with.

ED HOWARD: And I should say that we have received several questions on cards asking about the role of nurse practitioners and other non-physician providers in these circumstances and I wonder, are there states that have taken steps to define adequacy to include some of these non physician providers? Anybody know? There is a crowd source question for you, if anybody knows the answer to that question and will send it to us at allhealth.org, we will put it on the website. Yes, go right ahead.

AUDIENCE MEMBER: My name is Chandler Wyland and I am a consumer and caregiver. Katherine, you have come across caring for the consumer and yet, lamenting that your narrow network lacked an outpatient laboratory that the narrow network included a hospital laboratory, but it didn't seem easy for the consumer related to parking issues, which I totally understand. But it would seem that they have all of their information, that that little parking ticket can be validated at the lab. So it would not necessitate hiring or contracting with an outside lab. Just a simple thought bubble I had.

KATHERINE ARBUCKLE: Appreciate the thought. And I would, if you will allow me to just add, we would be happy to serve all out patients for their lab testing and make the access into that garage or parking lot as easy as possible, whether it's getting a ticket validated – but even just getting them from the garage in, if we can give – some people have trouble walking from that parking lot up to the entry. And I'm saying, folks may not

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want to come to that big hospital campus, they may want to go to the accessible Quest lab that is a half a mile from their home.

AUDIENCE MEMBER: Most of the parking lots that I have been in for hospitals; they have a button as you enter the parking, if you need assistance.

KATHERINE ARBUCKLE: Sure. Again, we would be happy to provide that.

ED HOWARD: Yes?

AUDIENCE MEMBER: Hi, I'm Mary Tierney; I'm a pediatrician and my background is also that I ran EPSDT in the office of child health, working for a man by the name of Leonard Shaffer. So obviously my question is going to be on pediatrics. What are we really doing for kids that absolutely must have tertiary care, children's hospitals and so on? I just talked to a man the other day who had – talked to him again, who had a child born with [Tetrology flow], a very complex heart disease, that wanted to send his child to a surgeon who hadn't done any heart surgery on kids in about 10 years. We luckily got him into a children's hospital. So how are addressing these things, especially with kids with very complex needs.

DANIEL DURHAM: Well, I think that is where choice comes in and in this current marketplace, there is a lot of choice. Whether you want to choose a very broad network or a very narrow network or something in between, so its important that consumers have the right information, so they can make the best choice for their families to get the care they need.

PAUL GINSBURG: I have an answer to the question. You know, this sounded like a case of the need for a very speedy appeals process to provide access for very specialized care to those providers who really are experienced in it. You know, in the various work I have done over the years in healthcare markets, one of the observations is that often the pediatric hospitals are by far the highest priced hospitals in the area, so the inclination to create a network without some of them, I can fully understand that. But if you are going to do that, comes the obligation of providing access for those that cannot be served in the general academic medical centers that are in the network.

AUDIENCE MEMBER: I just add consumer education and involvement.

BRIAN WEBB: If I could just add to that because often the Departments of Insurance, the commissioners do get involved in these kind of cases. They work very closely with the insurance companies as well as with the consumers to try to make sure, if it's determined to be insufficient, to just resolve the issue instead of just saying, you have to cover everybody, let's deal with it situation by situation. That is why the grievance

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procedure is there. That is why there is regulation. Just to make sure everybody can resolve the issue and it most often does.

ED HOWARD: I would like to follow up with something with a question on a card and I should say that we have enough cards to carry us through Tuesday of next week, so you might want to use the microphones if you absolutely, positively have to get your question answered or at least addressed. This one is also directed to you, Brian. What is the NAIC position on mid year network removals, as we are seeing with the Medicare Advantage plans. I want to come back to the Medicare Advantage part, but what happens when you sign up for a plan that has the physician you want and then she or he drops out halfway through?

BRIAN WEBB: Our current model deals with that by making sure everybody is notified of those changes and then also make sure if there is an issue of continuity of care, that is taken care of. It is something we are looking at. Especially since, again, there has been a drastic change in the marketplace, especially the individual market where we do have a policy here – we really didn't have that before. So we are going year over year and so we are looking at how that can be resolved. It is something that needs to be done there. We have no position yet whether it should or shouldn't, but it is something we are looking at, given the new environment.

ED HOWARD: Dan, you do want to comment on that? Is there a general industry practice for that kind of situation?

DANIEL DURHAM: Well, you mentioned Medicare Advantage and their plans are under extraordinary pressure, as you know, the ACA reduced payments by over 200 billion dollars over 10 years for MA plans. And the administration has added some additional cost reduction on top of that through the regulatory process. So plans have to find a way to provide value to consumers and some of that is by taking a closer look at their networks and to see if there are ways that they can tailor their networks to provide more value to consumers. There has been a lot of discussion with the administration in terms of adequate notification to consumers and the like and we feel that is important and we are working towards that goal.

PAUL GINSBURG: I'm not sure how we get there, but I think to the degree that I believe that limited narrow networks are going to be an important part of the landscape for a long time, we should start thinking about how to move the system so that all network agreements between plans and providers conform to the date to the plan, so they are on a calendar year. So then this issue of provider dropping out of the network would be very limited to a provider that got out of practice or something like that.

DANIEL DURHAM: And I will just add too, which I think is an important part of this debate – there have been numerous studies out there that show tremendous price variation

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with little or no correlation to quality. And so that is something that we have to take a close look at and plan to try to deal with that by saying, let's focus on those providers that provide value. Given the tremendous price value variation in this country, you can provide good quality service to consumers by finding those providers that provide valuable services, high quality services at a lower price. And that is the premise behind doing networks in a way that is focused on value. And if we just open it up to everyone, including – then we are stuck back in this fee for volume type system which we all agree we have to move away from and this is one of the ways that plans are helping to move us towards a value based system.

ED HOWARD: Yes sir?

AUDIENCE MEMBER: That was actually my tweet and you answered all my follow up questions now, so I will just sit down.

ED HOWARD: Let the record show, we respond to tweeted questions. Yes, go right ahead.

AUDIENCE MEMBER: My name is Marshall Landis with Truven Health Analytics. This question is for Brian, but for anybody on the panel that feels like chiming in. Brian, going back a couple questions when you mentioned stepping in, in that pediatric example, when a network was determined to be inadequate. What other tools do you have at your disposal when networks are determined to be inadequate? Are there fines on plans that don't offer enough coverage? Are there bans on them offering – continuing to sell insurance in a state? Or do they just have to sort of promise to get better and to improve the problem?

BRIAN WEBB: Well, it depends on the state and whether it's actually in the law, in the regulation as to what the standards are. They are going to file their plan at the beginning of the year when they are saying we want this plan; they will file their access plan. The state will look at that. If they don't approve it, then they will ask the company to re-file it. So you have to get that approved first. But then if during the year, there are a lot of grievances and a lot of issues, then of course the state, as the regulator, can step in, can talk to the company, can ask them to make some changes to fix issues and then you can always do a market conduct review. Eventually you can fine them, you could withdraw their license. I mean, you have all of those at your disposal. I mean, we are not going to get there on this kind of issue, but yeah, you talk to the company and usually you can resolve the issue that way. But you have all of that as your background. You are the regulator; you have said that that company can sell that product in that state. If they are not actually fulfilling their access plan, which they filed with you, then you can take action against them. To fix it.

AUDIENCE MEMBER: Thank you.

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AUDIENCE MEMBER: Bob Griss with the Institute of Social Medicine and Community Health. There are two issues that I haven't heard addressed so far and yet they are trends in a sense, in the healthcare marketplace. One of them is concierge medicine. How will this focus on network adequacy deal with doctors who want to collect a special fee just for the privilege of going to them. Secondly, the subject of conscience clauses, since we have a representative of the Catholic hospital systems, when providers choose not to provide certain FDA approved medical services, what obligations does the health plan or provider have to ensure that that patient is able to get the medically necessary treatment that they want?

ED HOWARD: I'm not sure that the provider has the sole responsibility here, there is a matter of disclosure up front about what providers are providing what services and people do sign agreements and waivers and – I may be wrong on this and I would be interested in Dan's comment about this, but if you are a plan, presumably you have the responsibility for making sure that the services are available through one or another of the providers.

DANIEL DURHAM: It really depends on the state; there is a lot of variation in state law on this particular issue.

KATHERINE ARBUCKLE: Well, I will comment generally that of course being our mission base, we would not provide, ethically – we follow ethical religious directives, but as patients and families access these plans and are wanting other services, it's expected through the plan to get them the access that they need. So its determined at the plan level.

AUDIENCE MEMBER: So how do you do that if – let's say you a hospital – in fact, let's say you are the only hospital in a geographical area and you decide that something is not consistent with your religious – with the providers or the owners' religious beliefs, how does the patient get the medically necessary treatment?

KATHERINE ARBUCKLE: I can't comment on all, I can tell you in our markets we are not the sole provider in our markets.

ED HOWARD: And I don't want to belabor it, but we are getting a little bit off the question of adequate networks at the plan level and I want to make sure that we don't miss out on the opportunity to get to these questions. That means, calling on you at the moment.

AUDIENCE MEMBER: Thank you. My name is Camille Banta and I am with Summit Healthcare Consulting and I represent a number of provider organizations. Thank you, this has been a really terrific panel discussion. I'm glad the topic of network adequacy has been brought up with respect to Medicare Advantage plans because I think some of

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the same issues regarding transparency to patients about who is in their network at any given time due to mid year contract terminations at no cause are very concerning. And then whether subsequently there is adequate network providers. I will add that Senator Sharon Brown and Congresswoman Deloro have introduced legislation pertaining to those mid year terminations. But on the topic of network adequacy, I know the question was raised of what do you do if you determine that a network is inadequate, but I think also importantly, what are the tools being used to ascertain whether or not a network is adequate. And Mr. Ginsburg, you raised a really important point at the very beginning of this conversation. So I would welcome a response from either Mr. Durham or Mr. Webb – but if a plan looks at it's network and says, well we have 30 ophthalmologists in our network and they are looking at the specialty designation, but they are not looking at sub specialists for which there may not be a Medicare subspecialty designation, should they be doing a little bit more of a deeper dive if for example someone needs to see a retina specialist, but that ophthalmologist doesn't provide a lot of retina services. Should they be taking it down to the CPT level to find out, do we have an adequate number of retina specialists in our network to be caring for patients with very specific needs? So I think that is a really important point and I have heard of health plans using the GO access reports to help determine network adequacy. That does not go down to the subspecialty level; it may just look at the specialty designation. So I would welcome any thoughts that Mr. Webb or Mr. Durham have on – or Mr. Ginsburg, on ascertaining whether truly there is network adequacy.

PAUL GINSBURG: Let me just say something quickly about the subspecialties and then move on to the other questions. I would say we are in a learning process about how to regulate and have transparency for limited network plans because they have just arisen. I am familiar with some anecdotes where – say in ophthalmology, which I know fairly well, where the issue about retina specialists was raised through the Academy of Ophthalmology, it went to the insurer, who I think just responded. Oh, we didn't know that so we will make sure to put some retina specialists in the plan. So I think it's just discover that this is an issue and I would say yes, the detail that is going to be needed in some specialties probably will have to go by subspecialty and it's going to make it more complex, but this is going to be a big part of our market environment, so we might as well just do that.

BRIAN WEBB: It does vary by state, but some do a deep dive. And they go down to specialist, sub specialist – not in Medicare Advance though, we don't get to regulate that, so we are excluded.

ED HOWARD: Yes, go right ahead.

AUDIENCE MEMBER: My name is Jesse Bushman and I work with the American College of Nurse Midwives and I want to give a little bit of information and then ask a question. We have been doing a survey of the plans that offer coverage through the

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exchanges – calling them and asking them about inclusion of nurse midwives and their services in the plans, provider network. What we have discovered is that of those who responded to our survey, which is about a third of the plans, 15% of them flat out do not include a nurse midwife in their network at all. About 40% of them do not cover birth centers either and about 35% of them do not pay the nurse midwives at the same rate that they pay the physician for the same services being provided. And my question is, in the regulation, CMS very carefully stayed away from dictating what types of providers would need to be included in a plan. So the insurers could have the flexibility to do exactly what we are talking about and maintain lower levels of premiums. That is understandable. But my question is, in our case, the CNM's are attending 8% of the births that occur in the country, which is fairly significant. And maternity and newborn care is a required part of the essential health benefits package and so I would look at that and I would – I think I could argue reasonably that that's a provider type that should be included in a plans network. I'm wondering how you make decisions about what types of providers are and are not going to be in your network and what is the criteria? I think if I was to argue that a plan could include a few family practice docs doing deliveries and therefore did not need to include any Ob's, I think people would say that was unreasonable. So my question is, where is the line and how do you decide when is a certain provider type necessary for inclusion in your network?

ED HOWARD: Is that an NAIC question, Brian?

BRIAN WEBB: No. We check to see if all the ones required by law are in there. So that is what we do.

ED HOWARD: Dan, you are the default second place answerer.

DANIEL DURHAM: Again, we talked about this previously. To be a qualified health plan, the plans have to be certified and part of that certification process is review of how they meet the network adequacy standards. And if you don't meet those standards, you are not a qualified health plan to participate on the exchange. And OCMS is looking at this this year, they required health plans to submit a lot more information in terms of who is in their provider networks. The names of the doctors, the hospitals and the like and so they have all this data now, the plans have supplied it, so they can do a test using the software that they have to make a determination whether or not they believe the network is adequate based on their standards. If it's not, then they can work with the plan to get it to a place where it needs to be to get it certified. So it really depends largely upon the rules and the regulations that are applied to meet the certification, but I would also add that there is a measure of choice here. Some plans go beyond what other plans are doing and they may have a higher price level because of that. Broader networks, lower out of pocket maximums, lower deductibles, but it comes usually with a higher premium in a platinum plan or a gold plan. So there are tradeoffs here that consumers need to look at before buying a plan.

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AUDIENCE MEMBER: I would offer just one follow-up to that, and that is that from an insurer's standpoint, I'm not so much complaining about them as wanting to say that there is a huge opportunity for savings for the insurer to take advantage of because the practice pattern of the nurse/midwife is something that reduces the levels of interventions and therefore reduces cost. Because I don't see it so much as a complaint against the insurance companies as something that we can do to educate them to say, here is an opportunity for savings. And I think it would result in savings for your members as well.

PAUL GINSBURG: Well, I agree with you. A lot too depends on state laws. I mean, we would like to see states go to a place where nurse practitioners can practice to the top of their license. For other providers as well, so we could take advantage of those types of cost savings while preserving quality.

AUDIENCE MEMBER: Thank you.

ED HOWARD: If I can ask you to suspend for just a moment. I wanted to take just a couple of the questions that have come in on cards, which actually dovetails very nicely with a couple of questions that we have received in advance. It has to do with the question of essential community providers. First of all, I want to make sure that everybody knows what an essential community provider is and so I would like one of our expert panelists to take a crack at that. But the ACA requires plans to include substantial numbers of them, whatever they are. And they are particularly important to the lower and moderate income folks and isolated populations that Katherine was talking about. How effective is the regulatory device which I think is a threshold of saying that you need to have 20% of all of the essential community providers with a change pending to raise that to 30%. Is that the appropriate way to assure that folks can find the providers they need?

BRIAN WEBB: I mean, as far as the ending I see in our work on the model, we are just going to have to put in what that requirement is. As far as the regulation, we are looking at it, especially when it comes to some of the Native American and Alaska natives and what they have to do there. Have to at least try to get a contract with them, whether they can get one or not is the question. And there is a lot of things involved in that. That is going to have to be something that kind of evolves over time. We have the thresholds in place and now we have to look at how we can enforce that, what is necessary, and that is something we are looking at with our model. Get the thresholds in there, but then from there, how do we move forward and how do we regulate and make sure that they are contracting with them and reaching out to them and what those things mean. So it will take time, but we are working on it.

ED HOWARD: Katherine?

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KATHERINE ARBUCKLE: Yeah, I couldn't comment on this 20% the right number or 30% - obviously it depends on market success, access and etcetera, but I will say that we are supportive of essential provider requirements. Given our history and our footprint, we do a lot of work and partner with federally qualified health clinics as well as we are the safety net provider in many of our communities, certainly right here in Washington DC, we do a lot of work with Unity, the FQHC here. So we are just proponents for making sure that is coverage there to serve the poor and the vulnerable.

PAUL GINSBURG: I will just add, the threshold has increased for 2015, so in 2014 plans participating in the exchange had to include 20% of essential community providers in their area and now it's 30% for 2015 and so plans are meeting that regulation, but again it comes at a tradeoff in terms of price to the extent you continue to expand the network access requirements and health plans. That in turn will lead to higher premiums, so we have to be cognizant of that tradeoff as we look to further regulate and restrict plans ability to provide that kind of high value to consumers.

ED HOWARD: We have just a few minutes left if we are going to get this question and maybe a couple from cards before we finish, but I would ask you to fill out the blue evaluation forms while we are finishing up the conversation so we can get some feedback from you about this program and others that we might do. Yes sir, thank you.

AUDIENCE MEMBER: Hi, my name is Doug Jacobs, I am a medical student and also an intern with HHS. I understand that health insurance companies, they are using value as a way to select physicians. My concern is that they would also exclude physicians who treat sicker patients because those physicians would be more costly to include in the network. So I was wondering, is this happening? Also if anything is being done to prevent it from happening?

DANIEL DURHAM: I have seen no evidence of that.

PAUL GINSBURG: Yeah, I would say that when insurers are trying to look at value, which to me has two dimensions besides price. They are looking at broader measures of costs to see - for an episode of care or for a period of time, which provider is less expensive. Then there is the quality dimension. I would think that insurers would want to adjust for different patient populations, but what they can effectively do is an open question. So it's probably not ideal now. Hopefully it will get better.

BRIAN WEBB: I would just note that in our model and something to look for, is that non-discrimination, that you are not contracting with providers because they happen to care for certain types of diseases or groups of people. So that is something that we look for and will continue to look at that as we move forward.

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ED HOWARD: We have a question here that would go initially to Dan. Providers listed on plan networks may not be accepting new patients – how do plans inform current enrollees and potential enrollees about which providers are truly available?

DANIEL DURHAM: That is an important question and that is one thing that plans are committed to, to provide up to date provider networks on their website, but it's a two way street. If a provider is no longer taking new patients and they fail to communicate that to the plan and the plan tries to make it very easy for them to do so through special call in lines and the like, but part of this rests on the provider to let the plan know when they are no longer taking new patients. So we have to work on this collaboratively to make sure that consumers have the latest information.

KATHERINE ARBUCKLE: That is a fair comment. The providers need to be in contact with the plans for sure. I can tell you, in our health system, if someone is calling for an appointment and that physician has reached capacity, cannot take the patient, we will ensure that they get referred to someone who can, within the area. But that is our practice. I don't know that that is any regulation or requirement.

ED HOWARD: Brian, anything? If I can go back to the related question of the – not completely accurate at directories or mid year cancellations as opposed to physicians who aren't taking new patients. Who bears the burden of the lag in information? Is it the patient, is it the provider, is it the plan? What happens when that surprise bill shows up? Whose surprise is it?

DANIEL DURHAM: It depends on the circumstance. We think it's important that, for example, hospitals that are in the network of the plan, but employ anesthesiologists or pathologists or other specialists in their hospital, that are not in the plan, they have a responsibility of notifying the patient before they go under surgery to say, well this particular anesthesiologist is not participating in the plan that the hospital is and so it could result in higher out of pocket costs. So we think there is some responsibility there on the hospital side and that type of situation.

PAUL GINSBURG: One thing I can add is that outside of this issue of networks that a number of states have put restrictions as to how much these out of network physicians can charge. These anesthesiologists and other hospital based physicians where consumers are just not in the position to make those judgments.

KATHERINE ARBUCKLE: I would like to add just one comment to this point and I do believe that yes, the providers are standing in the relationship with the patient and as we have done, we are educated we are working with them to know which providers are in their networks and not, but I do come back to – as the patient or family is signing up for a network, they are entitled to know who is in, who is not, and we do see that education requirement needs to be provided by the plans and probably something in much more

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robust than just directories. Probably something more like examples, scenarios, things to ask, so that that patient can be more informed.

ED HOWARD: Okay, I think that probably is a very good note on which to bring our discussion to a close. We didn't get – I really apologize to those of you who spent the time to write some very good questions on the green cards, but it's a subject that we are not letting go. Obviously there is a high level of interest in it. There are a lot of complex pieces of it. And so we plan on revisiting this issue in the fall, probably with a briefing, perhaps with a webinar. Keep tuned and we will try to explore this question of network adequacy as it develops. Thanks to our friends at Wellpoint for helping us put this program together. Thanks to our emergency panelists who filled in so greatly, I think, and thanks to you for asking all the questions that we have tried to address. So if you would join me in thanking our panel, I would very much appreciate it.

[applause]

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