

Testimony of Monica J. Lindeen
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Good morning Chairman Pitts, Ranking Member Pallone, and Members of the Subcommittee. My name is Monica Lindeen, and I am the Commissioner of Securities and Insurance for the State of Montana. While I am testifying today in that capacity, I also serve as President-Elect of the National Association of Insurance Commissioners (NAIC), which will also inform parts of my testimony. I appreciate the opportunity to appear before the Committee to discuss two important topics that can have a great influence over the quality of care that qualified health plan (QHP) enrollees receive: the breadth of their provider networks and prescription drug formularies.

Network Adequacy

The use of narrow networks by QHPs sold on both State-Based and Federally Facilitated Exchanges has received a great deal of attention since the beginning of the initial open enrollment period last October. Issues related to network adequacy are nothing new, however. Ever since insurers began using networks, there have been concerns regarding their ability to meet consumer needs, and state regulators have been examining network arrangements to ensure

that they provide sufficient access to care for consumers. While the Affordable Care Act (ACA) has probably accelerated the trend in the individual and small group markets by sharpening competition between insurers selling coverage on Exchanges and by eliminating other avenues for cost reduction, such as medical underwriting and preexisting condition exclusions, insurers and employers have been moving towards narrower networks for a number of years. As price competition on Exchanges becomes more acute, however, regulators are seeing many insurers put pressure on providers to accept lower reimbursements and demonstrate the quality of care they provide. Properly done, this can be a way to push competitive market forces down to the provider level and bend the cost and quality curves. Improperly done, it can deprive consumers of promised services to the detriment of the patient's health and financial security. That is why it is very important for consumers, regulators, health care providers that networks are sufficient to deliver the services promised under a health insurance policy. Ultimately, this is also in the long-term interests of insurers, as a repeat of the managed care backlash of the 1990s could deprive them of the ability to use the provider contracting process to reduce costs and improve quality. That is why regulatory oversight of provider networks has been and will continue to be a priority for me and for other Insurance Commissioners around the country.

In Montana, we have not witnessed the sale of private health insurance plans restricted to certain service areas, and "narrow networks" do not really exist. At this point, very few, if any "HMO" type plans are being sold in Montana, since this state is very rural and HMO products in the past have not been popular. HMO point- of- service products are sometimes offered, but those plans are very similar to the PPO products. I have not yet seen the health plan form filings for 2015. The majority of the health plan products offered in Montana are a variation of a "PPO" product. Two of our three Exchange insurers offered a narrower network option in two cities in Montana,

but both of those companies still offered products in all parts of the state, with access to their complete network, even in rural areas.

Many states have network laws that envision only “PPO” or “HMO” type of products. Over the years, insurers have been experimenting with new types of plan designs, such as “tiered networks” or “exclusive provider organizations.” The older statutes cannot fully accommodate all of the new plan designs. Consequently, the NAIC is working on a new network adequacy model law (discussed later in this testimony) that will provide regulatory flexibility to allow innovative plan designs, but still protect the consumer’s access to necessary healthcare providers.

In assessing the adequacy of an insurer’s network, there are three key considerations that regulators must balance: ensuring adequate access to health care providers, maintaining the affordability of coverage, and ensuring that there is sufficient transparency for consumers to make a fully informed decision when deciding between insurance plans.

The primary objective of network adequacy regulation, of course, is to ensure that if an insurer requires enrollees to receive benefits from in-network providers, or provides financial incentives to do so, the network is capable of providing those benefits to enrollees when needed. This includes looking at the availability of hospitals, primary care and specialty providers, pharmacies, and other types of providers to ensure that networks have enough providers throughout their service area to provide benefits, as well as an insurer’s procedures for remedying any geographic shortages and allowing out-of-network care when warranted.

This analysis should, however, take into account a number of important factors in order to confirm that the standards put in place fully ensure access to care and are achievable by insurers.

These factors include:

General provider availability in a given geographic area. Consideration should be given to the number and types of providers and facilities located in a given area. General availability will vary depending on population, urban density and the provider's willingness to enter into contracts under reasonable terms and conditions. It should also be kept in mind that, as part of the network analysis, network adequacy considerations may have to be modified, depending on a state's specific geographic makeup.

For instance, large parts of Montana are very rural and have no oncologists available for hundreds of miles in any direction. The width of Montana is equal to the distance between Chicago and Washington D.C. Therefore, as the state insurance regulator, I must meet that challenge by proposing rules that provide the most logistical and reasonable method to ensure the population living in those remote areas has in-network access to the type of healthcare they need.

Medical care referral patterns and hospital admission privileges. Network analysis must include a review of the hospital admission privileges of providers as well as typical referral patterns for a given community or area. This information may be obtained from the state's health department. Hospital admission privileges are typically gathered as part of the carrier's provider credentialing process. Analysis must confirm that providers requiring the use of facilities—including hospitals, ambulatory surgical centers or specialty treatment facilities—are able to admit their patients to network facilities. As an example, obstetricians must have admitting privileges to network hospitals for delivery services.

Availability of hospital-based providers. Hospital-based providers—such as radiologists, pathologists and emergency room physicians—may not be part of the same network as the facility, or may not be in any network. Absence from the network may result in inadequate network for these services. This is particularly the case if the hospital providers hold an exclusive contract with the facility. Historically, ensuring adequate coverage of these providers has been a challenge, as there is often little incentive for them to contract with insurers since most patients do not specifically choose the radiologist reading an imaging test or the pathologist conducting the biopsy on a tissue sample.

State insurance regulators may need to take “provider willingness to contract” into consideration when developing network adequacy rules. Historically, certain categories of physician specialists refuse to contract with insurers, especially in parts of the country where there are shortages.

Geography. Geographical barriers may exist that impede access to care, and the analysis should not rely on a simple mileage factor to determine accessibility. Examples of geographical barriers include mountain ranges and rivers or other bodies of water. I am able to examine the geographic barriers and travel patterns unique to my state, which has geographic barriers in every direction. In a more urban state, such as , New Jersey, that may not be the case.

Essential Community Providers. The location and availability of essential community providers as well as mental health and substance abuse providers is not specifically addressed in most existing state laws. However, the final Exchange rules specifically require networks to include an adequate number of these providers.

Federal regulation requires Exchange insurers to cover at least 30 % of essential community providers (ECPs) available in the state. ECPs serve the low income and medically underserved population. Much of Montana’s population is rural and therefore “medically underserved.” I reviewed the federal ECP list in Montana and found that it did not include many of necessary providers that should have been considered ECPs. I added many more providers to the ECP list. In addition, I have advised all Exchange issuers that they must strive to meet the 80 % standard for ECPs—the same as other healthcare providers. However, I must be flexible, especially when the insurer can show that a particular ECP is refusing to sign a contract. Montana is a huge state that is sparsely populated. The federal “30 %” standard is not in the best interests of Montanans and could result in closest ECP being 400 miles away.

Centers of Excellence. The availability and access to centers of excellence for transplants and other medically intensive services is crucial, as is the availability of critical care services such as advance trauma centers, burn units, etc. If a carrier does not have such providers in their networks, then arrangements must be made by the QHP issuer to ensure access to these specialized services.

Availability for new patients. The availability of provider types as well as their capacity to accept new patients is a critical component of understanding the network. It is also imperative to recognize that different health plans may include the same provider or facility.

Overly rigid network adequacy requirements, however, can lead to premium increases, as insurers lose the ability to meaningfully negotiate with providers over the price of delivered

items and services. By entering into a network agreement with an insurer, providers strike a bargain: accepting lower reimbursement in exchange for the higher volume of patients seeking in-network care. Narrower networks sharpen this bargain even further. Providers must often make greater price concessions to participate, but the insurer's pool of patients is spread over a smaller number of participating providers. According to one analysis of broad- and narrow-network silver level QHPs sold in urban areas across the country, premiums for broad-network plans were 26% higher.¹ For this reason, it is important for regulators to be mindful of the premium impact of requiring insurers to maintain broader networks, especially if a narrower one can still provide sufficient access to all promised services.

It is very important for consumers to understand the network features of a plan during the shopping process and how those features would apply to care provided by specific providers. If an insurer maintains multiple networks, it should be clear to consumers which provider network a given plan makes use of. Similarly, practitioners should have a clear understanding of which networks they are members of in order to prevent confusion and unexpected bills.

In Montana, most of the complaints about network adequacy that we have received since January 1, 2014 involve the consumer's lack of understanding regarding how the plan's network functions and also deficiencies regarding the insurer's provider directory. In Montana, the provider network directories did not function as well as they should have during 2014 open enrollment, and we will continue to work on improving that function. This is why states are focusing on network transparency issues.

Need for continued state control

¹ McKinsey Center for U.S. Health System Reform. *Hospital networks: Configurations on the exchanges and their impact on premiums*. December 14, 2013.

Given the importance of striking the balance that I have mentioned above—particularly with respect to tradeoffs between breadth of network and cost—and the differences in local geography, demographics, patterns of care, and market conditions, it is very important that responsibility for assessing the adequacy of provider networks remain with states that have effective programs in place. It is impossible to come up with a one size fits every state solution.

States have a much more detailed understanding of these competing factors. In particular, they will have a better sense of the general availability of providers to contract within the various parts of their states, which depends greatly upon population, urban density, and willingness to enter into contracts. Based upon its analysis of these factors, a state may need to modify its network adequacy standards, and should have that flexibility.

Because effective network analysis must account for hospital admission privileges and referral patterns in a given community, as well as geographical barriers that will be more well-known to state regulators than to federal regulators in Washington and may impede access to care and can make the application of a simple mileage factor difficult in determining accessibility. Mountain ranges, for example, can be difficult to travel through in certain times of year and can make a seemingly close provider facility difficult to reach.

States are best positioned to balance these competing factors and have the detailed knowledge and understanding of their markets that is needed to make these determinations. On April 30, I and my fellow insurance commissioners sent a letter to President Obama, urging him to keep network adequacy review at the state level, where it can be most thoughtfully performed within the context of the market in which it occurs and to allow the NAIC, in consultation with all

affected stakeholders, to examine and potentially revise its current model act. CMS should not engage in further rulemaking until the states have time to act.

ACA Requirements

The final Exchange regulations promulgated under the ACA require each QHP “maintains a network that is sufficient in number and types of providers, including those that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay.”² This establishes a minimum network adequacy standard for QHP issuers while also providing sufficient discretion to Exchanges and states to structure network adequacy standards that are consistent with standards applied to plans outside an Exchange and are relevant to local conditions.

In federally facilitated and partnership Exchange states in 2014, the Centers for Medicare and Medicaid Services (CMS) deferred to state reviews, as long as the state had an effective network adequacy program in place under which the state has statutory authority to review insurers’ networks, and whether the state’s authority allows the state to determine whether those networks are sufficient in number and type of providers to ensure that all services will be accessible without unreasonable delay. If a state did not have an effective program in place, CMS accepted an accreditation that included it accepted an insurer’s attestation of adequacy, so long as that insurer was accredited for an existing line of business by an HHS-recognized accrediting entity.

² 45 CFR 156.230(a)(2)

In all other cases, CMS collected an access plan for the QHP and monitored accessibility complaints.³

Next year, CMS will be collecting full provider lists from all QHPs in FFMs and SPMs as part of the plan management process and will use that data to review the adequacy of their networks. It has also indicated that it intends to use the provider lists and its experience in states where it is making network adequacy determinations to inform possible future rulemaking in this area. While state regulators are encouraged that they have pledged to work in consultation with state regulators conducting network adequacy analyses, they are also wary of federal overreach in this area where state oversight is so important.

In 2013, the legislature amended the Montana preferred provider organization (PPO) network adequacy law, making it overall more protective of consumers. The new law specifies that an insurer who has 80 % of all of the healthcare providers in the state and 90 % of all the health care facilities in the state in their network is “deemed” adequate, although I have the discretion to determine that a lower percentage is also adequate. The trade-off for obtaining these high percentages is that the law now allows the cost-sharing differential between in and out of network services to be much higher. I also review the adequacy percentages for certain provider types, such as mental health professionals and other specialties. My office is currently working on draft administrative rules that will clarify the network adequacy requirements for PPO products. This rule will focus on network transparency for consumers and also issues relating to geographic barriers, the availability of providers in a particular area, as well as their willingness to contract.

³ Center for Consumer Information and Insurance Oversight, *Affordable Insurance Exchanges Guidance, Guidance on State Partnership Exchange*

The Montana statutory amendment was not in response to any ACA requirements. The current ACA requirement for network adequacy is a very broad reasonableness standard, as stated above. In general, I would judge the Montana network adequacy standards to be more protective than the ACA standard. My staff reviews the network adequacy of every health plan approved for sale inside the federal Exchange in Montana, as well as those sold outside the Exchange marketplace. Because I conduct the same network adequacy review inside and outside the Exchange, I am able to ensure a level playing field in the Montana health insurance market. I believe that the major medical health insurers approved to sell in Montana, on and off the Exchange, have healthy and adequate provider networks. The draft administrative rules for network adequacy also protect Montanans who need to seek care from specialists by requiring insurers to cover claims as if they are in network, if a specialist is not available within a reasonable distance—or if it is necessary to seek care out of state.

However, the issue of access to healthcare providers is always complex and requires some compromises in order to achieve affordability. Therefore, there will always be consumer complaints on this topic, which regulators like myself must weigh carefully. When there are issues that need to be resolved, I try to work with insurers to solve them when possible, but will take regulatory action when necessary.

National Experience

Over the past several months, my colleagues in other states have run across a number of issues associated with narrow networks in QHPs. A common issue is the inclusion of children's hospitals and academic medical centers in provider networks. Care at these facilities is often more expensive than in other nearby hospitals for similar procedures. Consequently, some

insurers, particularly on Exchanges where price competition is more acute, have sought to reduce their spending by excluding them from their networks. In many cases, insurers have agreed to allow enrollees to use these facilities to access specialized care that is not available from network providers within a reasonable distance without imposing out-of-network cost-sharing. While I and my colleagues agree that containing costs and bending the curve is critically important to the future of health care affordability in this country, we must also be vigilant about cost-cutting measures that negatively impact the quality of care that patients receive.

Another issue is when policies exclude coverage, even on an out-of-network basis, for any care provided out-of-state. Health care delivery markets often cross state lines, and many consumers are used to relying on nearby providers in other states for needed care. While this plan provision may not necessarily be prohibited, regulators have worked very hard to ensure that insurance agents, navigators and others assisting consumers in plan selection make consumers fully aware of these limitations before they purchase the plan so that they will not be surprised with large bills after receiving care. Currently, Montana does not have any health plans that exclude care for out of state services.

In response to these and other issues, a number of states have revised their network adequacy requirements. Washington State has recently revised its regulations to, among other things, require insurers with an insufficient number of in-network providers in an area to allow enrollees to receive needed care from nearby out-of-network providers with out-of-pocket costs that are the same as those for in-network care. This is similar to the proposal in the Montana draft network adequacy rules. This provision is also in the current version of the NAIC model law on network adequacy.

On a national level, state regulators recognize that current state standards may be in need of revision to effectively address the increased use of narrow networks by QHPs and to reflect the ACA's requirements to include providers who specialize in mental health and substance abuse services and Essential Community Providers. The NAIC identified its *Managed Care Plan Network Adequacy Model Act*, which was first adopted in 1996, for revision late last year. The model sets out requirements for health carriers in designing and establishing their networks to assure adequacy, accessibility and quality of health care services for carriers that offer a managed care plan. In 2014, the HHS identified the NAIC model as a floor for states to adopt to meet the ACA's network adequacy requirements.

The NAIC appointed the Network Adequacy Model Review Subgroup in March to review the model and make necessary revisions. The Subgroup began holding weekly open, public conference calls in May and intends to finish its work by the end of this year. Before drafting language to revise the model, the Subgroup is hearing from various stakeholders, including consumers, providers, business groups, accreditors and insurers, on the issues and concerns they are currently seeing related to network adequacy inside and outside the health insurance marketplaces. It has also asked these stakeholders to propose solutions to address the problems they have identified.

Among the issues the Subgroup is likely to address is the definition of what constitutes a "managed care plan" subject to network adequacy standards today, as opposed to what fell under that definition when the model was first adopted in 1996. With the advent of tiered networks and other plan designs used by carriers, the Subgroup anticipates making revisions to clarify that term and its application under the model. Another issue relates to the provision of provider directories to applicants and current enrollees. The current model does address how, and in what

manner, provider directories must be made available to consumers. It is anticipated that the Subgroup will consider revisions to the model that will dictate: 1) when provider directories must be provided to applicants prior to enrollment and current enrollees prior to renewal and other times, such as when the directory is materially updated; 2) the periodic update of each plan's directory – annually, quarterly or more frequently; and 3) in what manner the directory must be made available, such as electronically on the plan's or carrier's website or on paper, at the request of an applicant or current enrollee. Consumer transparency regarding the adequacy and function of a health plan's network was identified by consumer advocates as one of their top concerns.

Formulary Design

A second quality issue that has arisen over the past several months concerns the design of QHP prescription drug formularies. In 2014, because of federal law, all individual and small employer group health plans sold in Montana must offer prescription drug coverage that meets the requirements contained in the Montana essential health benefit benchmark. Under the essential health benefits (EHB) regulations, all non-grandfathered, non-transitional plans in these markets are required to provide coverage for at least as many drugs (but at least one) in each therapeutic category and class as the benchmark plan in the state. In addition, if a particular drug is not covered, there must be a waiver (or appeal) process that requires the insurer to consider the medical necessity of covering particular drugs that are not currently part of their formulary. Prior to January 1, 2014, most small employer group health plans were covering prescription drugs, but not all individual health insurance coverage included prescription drug benefits. Prior to the ACA, Montana law did not require coverage for prescription drugs. Our experience is that health plans sold in 2014 in Montana adequately cover medically necessary drugs.

Drug costs often account for a very large percentage of claim costs in a health plan. Health plans need to have some way to protect consumers from price gouging by large pharmaceutical companies. Most plan designs sold in Montana have a tiered drug plan; (i.e. different cost sharing for generic, brand name and specialty drugs—each tier has a different cost sharing amount).

Some plans also use a cost management approach involving “step therapy,” meaning that lower cost or generic drugs must be tried first--before more expensive drugs can be covered. Both of these types of plan designs provide important methods to keep drug costs under control. The use of tiered formularies by both group and individual health plans to encourage greater use of appropriate generic drugs can be extremely effective and has been a major factor in the recent trend towards lower prescription drug spending.

Generally speaking, obtaining prescriptions from an “in-network” pharmacy is not a significant problem for consumers in Montana. There are local pharmacies, as well in mail order pharmacies readily available. All of the prescription drug coverage in Montana, and all states, falls under the “maximum out of pocket” protection provided under the ACA (\$6350/individual in 2014)—no waivers from that provision have been allowed in Montana for fully insured health plans. Therefore, even if there is higher cost sharing for specialty or brand name drug tiers in a particular health plan, the maximum out-of-pocket costs for the consumer is capped at \$6350, or less depending on the plan design. Many plan designs available for sale in Montana have lower caps on out-of-pocket costs.

We must also be vigilant that plan designs aren’t structured to discriminate against those individuals who need coverage most. ACA nondiscrimination requirements prohibit QHPs from

engaging in “marketing practices or benefit designs that have the effect of discouraging the enrollment in such plan by individuals with significant health needs.”⁴ This requirement serves two purposes. First it seeks to ensure that individuals with serious medical conditions receive equal treatment from insurers and have coverage available that meets their health care needs. Second, it prevents some insurers from attempting to shift the costs incurred by these individuals to their competitors, creating an adverse selection situation.

Recently, the AIDS Institute and the National Health Law Program filed an administrative complaint with the HHS Office of Civil Rights, which administers the nondiscrimination provisions of the ACA and other federal health statutes, including Section 1557 of the Rehabilitation Act, which prohibits discrimination against individuals with disabilities, including those living with HIV/AIDS, in federal programs.⁵ In the complaint, they allege that several insurers selling QHPs in Florida have placed all covered drugs used for the treatment of HIV/AIDS, including both brand name and generic drugs, in their highest tier, reserved for non-preferred specialty drugs. Drugs in this tier are subject to the highest level of cost-sharing, with coinsurance ranging from 40-50% after a separate prescription drug deductible are satisfied. These drugs are also subject to prior authorization by the insurer and may only be dispensed in limited quantities. The complainants allege that this constitutes a discriminatory plan design that serves to discourage individuals living with HIV/AIDS from enrolling in these insurers’ plans. Unfortunately, these types of issues are going to be difficult to spot in the initial plan approval process given the resources state and federal regulators have at their disposal and the fact that nearly half of the issuers selling QHPs on that state’s Exchange used this sort of plan design. This is a good example, however, of how issues can come to regulators’ attention through back-

⁴ ACA 1311(c)(1)(A)

⁵ 42 USC 156.125(a)

end complaints. A number of states have already taken action to prevent similar problems. The state of Maryland has enacted legislation that would limit cost-sharing for specialty drugs to \$150 for a 30-day supply,⁶ and the Illinois Insurance Commissioner issued a bulletin on May 23 reminding insurers in the state of the prohibition on discrimination against individuals with health conditions, including HIV/AIDS.⁷ In that bulletin, he also signaled his intent to closely examine plans' compliance with this provision, including by looking at plans' medical management techniques and preauthorization requirements.

In Montana, my staff has received complaints from consumer groups alleging that certain companies have imposed excessive coinsurance in the "specialty" drug tier. We are currently investigating those allegations. I may be able to disapprove those prescription drug plan designs on the grounds of discrimination because only people in certain disease groups (such as M.S. and rheumatoid arthritis) would need to purchase drugs in that tier. State insurance Commissioners are reacting to these complaints and taking steps to protect consumers during the health plan approval process.

Once again, I would like to thank the Subcommittee for holding this hearing to look at this important topic. The use of networks and prescription drug formularies to reduce costs is one way that insurers can compete with one another inside and outside of Exchanges and bring down premiums, but we must be vigilant that it does not come at the expense of patient access to care. Thank you again for the opportunity to testify today. I look forward to your questions.

⁶ Maryland Senate Bill 874

⁷ Illinois Department of Insurance. *Company Bulletin CB2014-08: Discrimination and Qualified Health Plan(QHP) Certification or Recertification for 2015 Plan Year*, May 23, 2014. Located at <http://insurance.illinois.gov/cb/2014/CB2014-08.pdf>