December 15, 2022

Alexis Murray
Senior Policy Advisor
America's Health Insurance Plans
amurray@ahip.org

via email

RE: REVIEW OF NETWORK ADEQUACY REQUIREMENTS

Dear Alexis:

As part of the 2023 Notice of Benefit and Payment Parameters final rule, CMS adopted new federal network adequacy standards for qualified health plans (QHPs) in most states with a Federally-facilitated Marketplace ("FFE"). These standards are expected to force issuers in the FFE to change how they contract with providers. The new standards could have unintended consequences. Given the importance network adequacy has on the consumer experience and health insurance more generally, a better understanding of their potential impact is needed.

America's Health Insurance Plans ("AHIP") retained Wakely Consulting Group LLC, an HMA Company ("Wakely"), to explore the potential effects the new regulation may have, both from its immediate requirements and its future requirements on premiums, participation, product offerings, innovation, and consumer experience.

This document has been prepared for the sole use of AHIP. Wakely understands that the report may be made public. This report is intended to provide a summary about potential impact and suggestions for improvement based on interviewees that Wakely conducted with issuer representatives on the regulation and process surrounding network adequacy.

Regulation Summary

The 2023 Notice of Benefit and Payment Parameters[1] set forth new regulations on network adequacy. Starting in 2023, in Exchanges directly operated by HHS (Federally-facilitated Exchanges or FFEs) HHS will conduct reviews of plans to ensure sufficient network adequacy. In particular, HHS adopted quantitative time and distance standards for 2023 and has proposed they will implement wait time standards starting for the 2024 benefit year. The exact requirements differ by provider type. Issuers unable to meet the standards can submit justifications for the discrepancy but even if there are appropriate justifications, issuers must continue to make good faith efforts to meet the standards.

[1] https://www.cms.gov/files/document/cms-9911-f-patient-protection-final-rule.pdf

Methodology

To better understand the impact of the current (i.e., those that went into effect in 2023) requirements as well as future requirements, Wakely conducted interviews with employees of AHIP member plans who offer QHPs in the FFE subject to new federal network adequacy standards. Wakely interviewed approximately a half dozen carriers to better understand current network development strategies and the impact of the application of the new federal network adequacy standards. The plans interviewed varied in their geographical location and other characteristics (e.g., size, types of networks, etc.). Interviewees were provided with specific questions on a variety of topics including network development, impact of regulation, and interactions with CMS (see Appendix). Interviews lasted approximately one hour. The next section discusses key findings from the interviews.

Key Findings

The interviewed issuer employees ("issuers") expressed support for network adequacy requirements to protect consumers and products to be available to consumers at an affordable price. To support this, issuers have established internal processes to monitor their provider networks and identify potential additions to their networks. Issuers stated that the new regulation, while well-intentioned, has shortcomings that will result in negative downstream impacts to consumers. These impacts may include higher premiums, lower quality of care, and a less consumer-friendly experience. In some cases, issuers were concerned that the new requirement would reduce plan options in some service areas or states.

Overall issuers expressed concern about the negative effects include adding providers to the network that are higher cost, higher administrative costs in adding and tracking networks, having to add providers with lower quality, having providers in the network that are less able to integrate into the core system (less continuity of care), and having providers who are not aligned with the core business model. The concerns focused on three main areas. The negative effects of adding more providers to existing networks, difficulties in negotiations with providers to meet the new requirements, and the CMS oversight process.

Concerns with Adding Providers

Issuers have curated their current networks based on a variety of considerations including provider quality, ability to manage care, reimbursement rates and the business goals of the product. Generally, if a hospital or provider is not currently in the network of a product, it is due to the provider not sufficiently meeting one of the preceding considerations. However, the new regulation forces issuers to contract with providers that they have historically elected to not include in their networks. Their forced inclusion could drive downstream impacts to consumers.

The first key downstream implication is the potential for higher premiums and higher out of pocket costs for consumers. Providers outside of the network often have higher charges and

reimbursement rates than the current network. Without the leverage of largescale member steerage to a whole system, issuers are unable to negotiate competitive reimbursement rates. Further, some providers may not be interested in being included in the network for various reasons such as lower reimbursement rates than other lines of business, higher reimbursement rates if the provider remains out-of-network, and general disinterest in contracting in the commercial market.

The second key downstream implication is the potential for lower quality of care. Issuers stated concerns that the quality of care to consumers may decrease if their networks were required to expand. For example, newly added providers may not have access to comprehensive medical history or care management information. Additionally, they may have referral patterns and admit rights inconsistent with the core business model. These factors can contribute to lower quality, poorly managed care, and referrals out-of-network that may result in member abrasion.

The following is an illustrative example around adding additional providers solely due to the network adequacy requirements.

Illustrative Examples

Consider the possible detrimental effect of the regulation on Exclusive Provider Organizations (EPOs). For example, an EPO may establish its network around strategic partners that have high performing hospital and provider systems. The EPO often has integrated medical history, care management, and hospital admission privileges across the network. An issuer can negotiate lower provider reimbursement rates, require higher quality standards, and incorporate a high level of managed care with these partners by agreeing to steer members to the partner systems.

The new regulations require the plan to contract with additional providers, which often conflicts with the business goals of, and consumer preferences incorporated into, the product. For example, regulatory time and distance standards may require the EPO to contract with entities that provide lower quality care, are unable or unwilling to effectively engage in comprehensive care management, are high cost, and may refer patients to out-of-network providers. As these factors undermine the core tenants of the EPO’s business model, there is concern the product may see reduced feasibility, higher premiums, and decreased attractiveness to consumers.

Issuers also noted they are currently offering many products which cover 95% or more of providers in an area and have not received state regulatory or member feedback that their network coverage is inadequate. However, the network may still be deemed non-compliant under the new regulations. As a result, the issuer is then required to contract with additional providers that have previously been intentionally not included in the network due to reasons such as low quality of care or high reimbursement rates. Issuers also reported difficulties in becoming compliant for certain specialties where provider shortages, unique geographic characteristics, and provider responsiveness exist. Interviewees noted this dynamic was more pronounced in rural areas.

Difficulties in Contract Negotiation

In additional to the above concerns, issuers also noted significant difficulties in the contracting process. Although an issuer may only need to contract with a small handful of providers to become compliant, many of these providers are part of a larger system. These systems often take an "all-or-nothing" stance in contract negotiations, requiring the whole system be included in the network and not just a subset of the system's providers. This dynamic is becoming increasingly prevalent with recent consolidation of providers within the industry. Such negotiations resulted in high administrative burden with few (if any) agreed upon contracts.

Furthermore, accurate, timely, and comprehensive provider data is an industry wide problem. In some cases, the provider information such as location, specialty, or contact information may be incorrect, incomplete, or missing. This makes contact impossible and prevents contracting that would resolve federal network adequacy gaps. Overall, difficulties in data result in higher administrative burden but minimal ability at improvement.

In summary, issuers are facing difficulties in the contract negotiation process despite good faith efforts and, in those cases when providers are added, are faced with higher reimbursement rates and the potential for lower quality and management of care.

CMS Process

It is important to note that issuers reported that CMS was receptive to feedback and has already incorporated the feedback into the process. For example, issuers have noted improvements in the templates. Issuers encourage CMS to continue a collaborative improvement process. Additionally, some of the interviews were conducted before additional changes were made by CMS and consequently may be less applicable.

Issuers did, however, report difficulties in working with CMS on the operationalization of the policy. Issuers noted in the first year of implementation, the overall timeline was not well-defined. Issuers experienced notable administrative overhead and difficulty in responding to the CMS feedback in an expedited manner due to hard-to-use templates. Issuers also noted that while contract negotiations and network adequacy are continuously evolving, the templates did not sufficiently allow for updates or notices when gaps were closed, and had other pertinent issues. Issuers also noted unclear communication and requirements and a tight response window.

Overall Summary

Based on the interviews conducted, there were a few common themes. The first is that there is general support for network adequacy regulations and protections for consumers. However, there are concerns that the new requirements and the implementation of those requirements could harm consumers. The first potential harm is around cost. Provider contracting and higher

administrative burden could increase premiums and out-of-pocket costs. Higher provider costs could also increase out-of-pocket cost sharing for consumers. Secondly, the new regulations may lead to fewer plan offerings, resulting in less choices for consumers. Finally, there were concerns that the requirements could result in lower quality of care with consumers as integrated care may be more difficult to achieve.

Suggestions for Improvement

As part of the interview process, issuers provided suggested improvements focused primarily on the review process. In terms of the review process, suggestions focused on more defined timelines and communication, greater flexibility in template responses, a clearer exception process, and an increased role for state specific factors/state regulators.

- Improved timelines and communication - Issuers suggested providing a clearly defined timeline of the network adequacy process and events. Furthermore, issuers suggested improved communication and advance notice of the timing of CMS feedback and subsequently providing more time for issuers to respond to the feedback.

- Improved Template - In responding to the feedback, issuers noted significant difficulty in conveying the status of network adequacy in the provided templates. Although issuers noted improvements in the templates, issuers encourage further improvements to the templates, such as greater flexibility in providing context. Issuers note network adequacy is a continuously evolving year-round process. They experienced difficulties in communicating progress, closed gaps, and other updates and notes in the templates. Issuers also found the templates to include restrictive fields in some scenarios. For example, a template may constrain a professional provider to be in an office setting while some professional providers may actually be in a hospital setting.

- Clearer Exception Process - Similarly, issuers suggested improvements to the exception process to allow for greater flexibility and clarity in what is allowed. There were concerns that without such a process EPO type networks may face sustainability challenges.

- State Considerations - Issuers suggested incorporating state-based considerations into provider network adequacy requirements. Issuers noted multiple market, provider, and geographic considerations that impact provider contracting and network adequacy. For example, a service area may only have a very limited number of providers or hospital systems. The new regulations create scenarios where the highest cost provider or hospital must be included to meet adequacy standards. This issue is exacerbated when only a select number of hospitals or provider specialties exist in the service area. Greater communication and reliance on state regulators may improve effectiveness of network adequacy enforcement.

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