Consumer Health First

Access • Quality • Equity

Maryland Insurance Administration
Hearing: Network Adequacy Regulations
2 June 2016

Today I am testifying on behalf of the members of Consumer Health First (formerly the Maryland Women's Coalition for Health Care Reform) as regards the quantitative and, if appropriate, non-quantitative, criteria to evaluate a carrier's network sufficiency. Consumer Health First (CHF) is a nonprofit organization committed to representing the interests and needs of consumers as we promote health equity through access to high-quality, affordable and comprehensive health care for all Marylanders.

First, we would like to state our appreciation for the steps that the Maryland Insurance Administration (MIA) has taken to create a robust stakeholder process. For example, the resource page on the website will be a valuable tool as the process moves forward. We also applaud the deliberative process that has been established to address the regulatory requirements under House Bill 1318/Senate Bill 929 through the schedule for hearings. In this regard, we would note the importance of allowing for adequate opportunities for consumer advocates to reply to any specific issues raised by other stakeholders in their written or oral comments.

As a determination is made regarding the standards to be established through regulation we believe it is important to emphasize the value of these to consumers. As demonstrated in our own report on access to OB/GYNs, as well as that of the Mental Health Association of Maryland for behavioral health providers, consumers today face challenges to gaining access to medically appropriate health care services. At the same time, with greater access to health care coverage as provided by implementation of the Affordable Care Act, individuals are now required to become, as we put it, *health care aware* consumers. We firmly believe that this is not only appropriate, but that in the long run this will mean a more efficient and less costly health care system. However, that goal can only be achieved if consumers have all of the information they need for wise decision-making. For the purpose of developing appropriate regulations,

this means specific quantitative standards to serve as benchmarks by which consumers can measure the full adequacy of provider networks including time and distance standards and provider to enrollee ratios. In this way, consumers will have actionable information upon which they can act.

To support this goal, it is important to emphasize the value of increasing transparency so that consumers can access all of the information they require to make informed decisions when determining the best options for themselves and their families. Therefore, we support the recommendation provided in oral testimony from Ms. Doetzer, Staff Attorney for the Drug Policy and Public Health Strategies Clinic at the University of Maryland, Carey School of Law. That recommendation was for the MIA to adopt a practice similar to the "network breadth" analysis and comparison tool outlined in the 2017 Notice of Benefit and Payment Parameters. With that, CMS will analyze the QHPs available through the Federally Facilitated Exchange. Plans will be classified into three categories based on access to providers using time and distance standards, and provide the information online at HealthCare.gov. By adopting this tool, the MIA can ensure that consumers can weigh all of the factors, including network access, to make informed decisions.

Twenty-eight states have already recognized the value of establishing standards for network adequacy and states like California and Colorado have demonstrated that these are good for consumers and not an undue burden for carriers. In addition, the Center for Medicare and Medicaid Services (CMS) has provided an actionable template through its access standards for the Medicare Advantage plans.

We would direct the MIA's attention to two issue briefs that we believe will be useful as the options for quantitative, and potentially non-quantitative standards are evaluated. These include: *Implementing the Affordable Care Act State Regulation of Marketplace Plan Provider Networks* - Commonwealth Fund, May 5, 2015 and Standards for Provider Networks: Examples from the States - Families USA. While the latter was published in November 2014 much of the information remains relevant to the current discussion on standards.

We also wish to highlight the value of having specific standards that can then be monitored on an annual basis by the Commissioner. This offers greater protections for consumers who have the assurance of effective oversight of the carriers to ensure that networks are truly adequate. At the same time, it protects the carriers from any potential for adverse selection by those with expensive health conditions who would gravitate to plans based upon the robustness of their network. The result would be greater equity with plan selection based upon health management and administrative efficiency rather than disparities in networks. In regard to this annual verification, we believe that Maryland should adopt the annual reporting process now required in Colorado.

The posted hearing schedule calls for each potential criteria, as now set out in statute set out in HB1312/SB929, to be discussed on an individual basis. Therefore, we anticipate further reference to, and recommendations on, specific State and CMS standards as the process moves forward.

Thank you for allowing us to provide our initial thoughts. We look forward to participating in the future and to working with the Commissioner to establish regulations that benefit consumers and address their health care needs.

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