



**Network Adequacy: Seeking Balance
The University of Pittsburgh Medical Center and
the Blue Cross Blue Shield Association
Alliance for Health Reform
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ED HOWARD: I want to welcome you to today's program on the growing trend for America's health insurers offering consumers provider networks that exclude certain doctors, hospitals, other providers, so-called narrow networks, or value-oriented networks are now offered, at least as an option, almost everywhere. That will broaden consumers' choices at the same time, raising questions about whether patients, especially those with serious or chronic conditions, are going to have adequate access to the care that they need.

Now, back in July we looked at some of the early evidence about these networks and their implications for both the quality and cost of care and patients' access to it. Today we're going to look at the regulatory atmosphere in which these plans operate, what the regulatory framework ought to be, what is being considered to change that framework, and what state and oversight roles ought to be in the first place.

We're pleased to have as partners in today's program two entities whose perspectives on these networks differ substantially, but who agree that policy makers and opinion leaders, that is to say, you folks, really need to be better informed about them. Now, these sponsors are the Blue Cross and Blue Shield Association, whose members provide coverage to scores of millions of Americans, some of them in these narrow networks, and the University of Pittsburgh Medical Center, UPMC, which is ranked among the top dozen hospitals in America according to *U.S. News and World Report*. So, thanks to them for setting aside whatever differences they might have for purposes of educational enlightenment on behalf of our audience.

And I want to now turn to a couple of housekeeping items that, I apologize if you've heard me say before, but it's worth making sure that you remember them. Lots of important information is in your packets, including speaker bios that are more extensive than I'm going to have a chance to give you. There's a one-page materials list that, if you go online to our website at allhealth.org, you can click on any of those items and get further information including the copies you have in your packets. There will be a video of this briefing available, perhaps as early as Monday on our website, allhealth.org, and a transcript a few days after that. There will be a chance for you to ask questions. You can do that by either coming to one of the microphones, or by filling out the green question card in your packets and we'll read them from the dais. And, finally, there is a blue evaluation form that we fervently hope that you will fill out so that we can improve these programs as we go along and respond to the needs that you have for particular topics and particular speakers.

So, we have a terrific lineup of panelists today and we'll hear from all of them and then give you a chance to get into the conversation. And we're going to start off with Governor Michael Leavitt. Mike Leavitt is the founder and chairman of Leavitt Partners where he advises clients in healthcare and food safety sectors. Before that, he served in the cabinet of President George W. Bush as Head of the Environmental Protection

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Agency and then as Secretary of the Department of Health and Human Services. And before that, he was elected three times as Governor of—what was the state again?

GOVERNOR LEAVITT: The state of Utah.

SPEAKER: To which Governor Leavitt is going to repair for as many times as he can as we discussed before we started. My thanks so much for joining us and let's get this discussion off to a flying start with you.

GOVERNOR LEAVITT: I am delighted to be here. I'd like to begin by just making this point: that a network is essentially a natural and intuitive response to economic pressure that always occurs because networks are more efficient than the alternatives. I'd like to cite some examples. It's true of nations and the European Union is essentially a group of mainframe countries that concluded that in a global economy they would be better off working like a group of networked PCs. We see it in the military. Over the course of generations we've had, in our country, the Army, the Navy, the Air Force, the Marines, the Coast Guard—all with separate command structures with separate rank working in silos. Worked fine until we came upon a network enemy called Al Qaeda, and it became clear that if we were to defeat a network we had to become a network because a network is more efficient than a group of siloed organizations working without coordination. It's true in the supply world. If you buy a television at Best Buy it establishes—it sets off a pattern of activity for just in time networks that allow for efficiency to be able to provide high quality products at the lowest possible cost. It's true in transportation. I was in New York, headed for my home in the great state of Utah. I went to Gate 17 where I was to get on a Delta Airlines jet. When I got there it said it was Air France. And when I checked my ticket and looked back up, it was now Alaska Air. And after checking it again, it had become Virgin Air, and finally Delta. Now, I knew exactly what was going on, and so do you. I was part of a code share, or an alliance network that the airlines have created in order to create economic survival and to provide better care – better care for their customers. My point is that we are seeing the formation of networks as an economic response to global economic pressure that requires the United States to become more efficient.

Now, as long as we're on the subject of airlines, I will indicate I travel a lot. I used to think a small airplane was a 737. Now I spend a lot of my time in one of those small regional airlines for which my tush was not well designed. But I continued to ride on them because that's what's available in this network. But I'd like to say, I am a husband and I am a father, but the title after that that I value the most is Diamond Medallion. And do you know why? It's because I have made a deal with Delta Airlines that if I will choose their network and make them more efficient, they will reward me, as a consumer, in ways that will help drive my economic survival and theirs.

So, the point I'd like to begin with today is that this is not the creation of a legislative anomaly. This is an economic, a macroeconomic truism, that as economic pressure is

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brought to bear, networks are more efficient and as efficiency needs to be found, clearly we will move toward network building.

The second point I'd like to make is I believe it can clearly be said this is an important tool in being able to bring greater value to the healthcare system in a way that consumers will accept it. Now, going back to my previous example, if the Congress had suddenly concluded that they would regulate the airlines and their network development in a close way, it's possible they would have required me to fly on Delta. That would have been unsatisfying to me. I would have not—the fact that I have chosen to make this arrangement and that I benefit from it has allowed me to do it. So, I left the government about 5 years ago and I formed a small business and the business point of this story, I had roughly 50 employees and we happened to live in a state where there is an operating shop exchange. And we had a 22% increase from our insurance company, followed by—on top of it—13% the year before that. It just seemed like more than we could sustain. So I concluded to make a new arrangement with my colleagues and I called them together and said, we have been paying 80% of your healthcare and we're going to continue to do that. I'm going to write all of you a check for the 80% that we did last year, and I'm going to add 6% to it, and I'd like you to go to the exchange and choose a plan that is good for you and your family. Now, I was fascinated to watch what happened. Every single person took their check for 80% plus 6, went to the exchange, and found a policy that would pay 100% of the premium. Now, how did they do that? They did it by exercising two tools. The first is, they made a decision in their family on how much risk they could assume, or what their appetite for this was, and they opted to either have a higher or a lower deductible based on their situation. And the second is, they began to opt into networks that could care for them well. The combination of network selection and amount of risk a consumer is able or willing to take are the two tools that allow that decision to be made.

Now, I would just ask again, if society, through some social mechanism, or regulatory mechanism, had made that decision for them, or if I, as an employer, had suggested from this point on you will all have a health savings account with a high deductible, there would have been—and a narrow network—there would have been a revolt. But the reality was, they were all happy because they made a decision based on how wide or narrow their network would be in a way that would fit them.

Last point I will make is that we have some experience with this. While I was the Secretary of Health, we rolled out the Medicare Part B program. Now, you'll remember that it was a new way of deploying public benefits. Rather than have a one size fits all plan the construct is that various providers can organize plans according to some broad outlines and then consumers can choose. And the marketplace was then available and they could choose a network that was wider or narrower, as long as it met some basic standards, and their price would vary based on their selection. Now, there were people who believed that having such a construct would create broad confusion, and it wasn't without a learning curve. But, may I say, we now have an entire generation of consumers,

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of health consumers, who not only like what they choose, but they have learned how to make choices that fit them.

Now, just one little side bar. You're probably aware that in the initial design of that program there was, in the law, a government mandated benefit construction. You might be interested to know how many people actually selected that construction as opposed to having the option to choose one that fit them. It was just under 6%—just over 6% who chose the government-selected version.

So, here are my points. Number 1, the development of network is a fundamental tool, a macroeconomic tool, that allows efficient selection, and when put into the hands of consumers with appropriate constructs, will drive efficient selection and will allow, in fact, efficiency and value to be found. The second point I made is that, in fact, we have experience with this not only in other areas but in healthcare, and that if we were to ever take away the flexibility of broader or narrow networks, we would take away the fundamental tool of economic selection that will make healthcare more efficient and ultimately allow our economic equation to be rebalanced.

ED HOWARD: Alright, thanks very much, Governor. We're going to turn next to Stephanie Mohl. Stephanie is the Senior Government Relations Advisor and the lead lobbyist on healthcare issues at the American Heart Association. She's also a consumer representative for the Heart Association to the National Association of Insurance Commissioners, NAIC. She spent a dozen years on the Hill. Some of you may know her from that incarnation as a Senior LA in the office of Senator Byron Dorgan. People with heart concerns, and I am not all that happy to say that's a group I'm a part of, sometimes need access to a wide array of providers, so they have a strong rooting interest in network adequacy issues. So, we're very pleased to have you here with us, Stephanie, and I should just say for folks understanding if you're wondering how Stephanie is going to cover 36 slides in 8 minutes, she's not. Maybe you could, but we're not going to ask you to. The full side deck, however, describes the report that the American Heart Association has commissioned by Avalere and today is the report's initial emergence, right? And the slides should give you the flavor of the full report which you can read online without killing a forest of trees. So, Stephanie, thanks for coming, and we'll look forward to hearing from you.

STEPHANIE MOHL: Great. Thank you, Ed. Good afternoon. It's a pleasure to be with you today. I think we can all agree that networks are, in fact, here to stay. At the American Heart Association, our challenge is to balance our patients' needs for affordable premiums with their ability to access the care that they need. We've long heard from heart disease and stroke patients about the difficulties they sometimes have accessing the care they need through their health plan's networks, or about the unexpected high bills they sometimes get when they receive out-of-network care. That's why we fought to get network adequacy requirements included in the Affordable Care Act (ACA), and why we're currently playing an active role in the work that the National

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Association of Insurance Commissioners is doing to update its 1996 Managed Care Network Adequacy Model Act.

Consumers need both affordable insurance coverage that reimburses for the range of services they may need, and they also need access to the healthcare providers who can provide those services. And it's important to keep in mind that consumers can't predict, and they certainly don't plan, to have a heart attack or a stroke or to receive that cancer diagnosis, but they still must be assured that the care they will need is available to them, preferably through an in-network provider.

I'm trying to advance the slides. It's probably turned off. There we go. I got it.

So, we've all seen the new stories of the reports about insurers using their networks as a strategy for lowering premiums. Well, this isn't a new strategy. There does seem to be a proliferation of these narrow network plans on the exchanges. The American Heart Association wanted to assess whether the health plans offered through the insurance exchanges were adequately including the range of specialty care that our patients might need when they suffer a heart attack or a stroke. So, we commissioned Avalere Health to conduct a study examining the inclusion of selected physicians and tertiary care hospitals in a sampling of exchange plans.

As I've said, I don't have time to talk about all the results of the study that we're releasing today, but the full findings, including the results for each region or state that we looked at, can be found in your packets.

I'll talk more about the findings in a moment, but as this slide indicates, in general, the study found that coverage of specialty physicians and the hospitals that care for the most complex patients varied widely from region to region. Before going into a bit more depth on the findings, let me briefly discuss the methodology for the study.

We started by selecting 10 metropolitan regions, or states, from around the country. We chose geographically diverse regions that were located in those states running their own marketplaces as well as in states with federally facilitated marketplaces. Given that the study only looks at 10 regions it should be viewed as a snapshot on network access and the findings, therefore, are not generalizable to the entire nation.

We also chose regions in which there were at least two and, in most cases, at least three comprehensive stroke centers. Comprehensive stroke centers are tertiary care hospitals that are jointly certified by the Joint Commission as well as by the American Heart Association as demonstrating that they have the infrastructure, staffing, and protocols in place to care for the most complex stroke patients. Avalere then selected three lower-cost silver plans in each region and reviewed those plans for their in-network coverage of the comprehensive stroke centers and affiliated specialty physicians, those that are most likely to be needed by a patient with a serious stroke or heart attack.

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To evaluate inclusion of specialty physicians, the Association identified three types of specialty physicians: cardiologists, neurologists, and radiologists, most likely to be needed by heart attack or stroke patients. Avalere then selected randomly 30 of these physicians, 10 of each specialty, affiliated with the target comprehensive stroke centers, to review whether or not they are included in the select exchange health plans networks. And, finally, Avalere used the provider directories made available on each health plan issuer's website to determine whether the comprehensive stroke centers and specialty physicians were included in the network.

As this slide shows, coverage of the specialty physicians varied widely from region to region, ranging from inclusion of 8% of the sample of physicians in Los Angeles, to a high of 83% in Philadelphia. It's important to note that because Avalere was examining the issuer's provider directories, these results are only as accurate as the information in the directories. In other words, these findings may either overstate or understate the inclusion of physicians depending on how accurate and up to date the directories are. Avalere did find a number of challenges with finding and searching the directories that make it difficult for even savvy consumers to accurately determine whether specific providers are included in a network.

This next slide shows the inclusion of physicians by specialty. In general, the sample of cardiologists and neurologists were more likely to be included in the plan's networks than were radiologists. There was one region, Los Angeles, where none of the selected cardiologists were covered by the three health plans while, for 5 of the 10 regions examined, fewer than 10% of selected radiologists were included in the plan's networks. This is important because heart attack and stroke patients often don't have a choice as to which physicians they're seeing when admitted to the hospital, and these findings illustrate that patients could have a high likelihood of being cared for by a physician not in their health plan's network, therefore subjecting them to higher out-of-pocket costs.

And finally, inclusion of the comprehensive stroke centers in the plan's networks was also highly variable by region. The American Heart Association isn't taking the position that all of the comprehensive stroke centers in a region need to be included by a plan, but we would hope and expect that at least one facility in the area be covered. Avalere's review found that 7 of the 30 plans reviewed, or 23%, didn't include a single comprehensive stroke center in their network.

So, what does this all mean for the work of policy makers and regulators going forward? The wide variation in inclusion of providers, even on plans in the same region, suggests the need for specific quantitative standards to evaluate whether an adequate number of providers are being included to ensure that consumers can access their covered benefits. It also suggests that consumers need greater transparency in identifying the breadth of a network of the plans they're considering, and they need to understand the tradeoffs they may be making if they choose a plan with a smaller network.

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The Association is not opposed to narrow networks. And, in fact, we recognize that they may be a very desirable option for many consumers, particularly if they're constructed with quality in mind. But we do believe consumers should have a choice of plans and should be able to clearly identify plans with narrow versus broad networks.

And, finally, the findings reaffirm the need for greater accuracy and ease of access of provider directories so consumers can make the best, most informed choices for themselves and their families. Thank you.

ED HOWARD: Great. Thanks very much. We're going to turn now, if I can rescue the clicker from you—thank you—to Jolie Matthews, who's the Senior Health and Life Policy Counsel at the aforementioned NAIC, where she specializes in health and life insurance. She staffs NAIC's health insurance and managed care committee, and that committee's regulatory framework task force. And we're really glad to have her on the panel after losing her to a last minute conflict at our July briefing on network adequacy. Jolie, thank you for coming over.

JOLIE MATTHEWS: Thank you very much. As mentioned, I'm with the NAIC and just to take a few seconds of my time just to say, just in case you don't know what the NAIC is, our organization is made up of all the state insurance commissioners, so it's the 50 states plus the U.S. territories. And what the NAIC does is they get together three times a year—used to be four—for what we call national meetings, and they talk about insurance for like five days, so it's a lot. And basically they consider—NAIC considers itself a standards setting organization, and one of the things that we do to set these standards is develop model acts and model regulations, and on issues where we think that there should be some sort of uniformity. And one of those is the network adequacy plan, I'm sorry, the Managed Plan Care Network Adequacy Model Act, which, as Stephanie said, was developed in 1996. And you'll see the major provision in this model, as mentioned on the slide, is Section 5. That basically says that each carrier that offers a managed care plan has to maintain a network that is sufficient in numbers and types of providers to assure services to cover persons and will be accessible without unreasonable delay. There is a lot of wiggle room in that, and I'll discuss that a little bit later.

The other part of Section 5 is that it requires carriers to follow what is known as an Access Plan. What that means is that once they develop a network they have to file with the Commissioner a way for the covered persons' access to get those services through those providers, and that is just a brief summary of what that model is.

At this point, right now, there are only about 10 states that have actually adopted the model word for word. That is not unusual. What states are, if you could imagine, they have different requirements, different things related to the healthcare marketplace, the types of populations, and those sorts of things, so they may not adopt the model in totality, but they'll adopt portions or certain parts of it. If you want to see the model

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there's a link that shows you where it is. We also did what is called a Network Adequacy Guidance White Paper a few years ago, and that's the link to show where that is.

As I already mentioned, I think Stephanie talked about this, we have issues in trying to make sure that there's going to be enough flexibility to recognize the differences among the states, again, as I talked about, in the populations and the healthcare marketplaces. As you can imagine, with 56 members we're not all going to be on the same page, so again, in looking at revising our model, we're going to have to look at flexibility to account for those differences among the states. And, as I already mentioned, one of those issues is really just trying to balance the need of trying to ensure that networks are adequate, and that consumers can properly be informed of the differences in the networks and be able to get the care that they need at the cost that they really expect to pay for that.

As I already mentioned, some of the issues that, when we were looking at revising our model, do relate to the tiered networks and the narrow networks. We're also going to be looking at provider directories and how those directories are updated. As Stephanie mentioned, and I think perhaps at the July conference that you had, there have been some issues the first year with consumers signing up, particularly on the exchanges, for qualified health plans (QHP) plans where they look at what they think is the network based on what was posted as the provider network on the carrier's website, but it turned out that really was not the network. So, we're looking at those issues to try to address them in some manner.

The other issue that I've talked about is consumer information education. As you can probably imagine, there are a lot of consumers that have never had private health insurance before. They don't know how to access it, what these terms mean, and those sorts of things. So, we're going to be looking at that.

Another issue, which I think was sort of touched upon earlier, is so-called "surprise bills". As noted, in some cases you may go to a hospital that may be in your network, but some of the other providers who may be giving you care, such as the anesthesiologist, the laboratory, they may not be in the network at the same hospital, and they're not held to the same standards as participating providers normally would be, so you could get these so-called surprise bills where you may have to pay the difference between what the carrier may pay for this out-of-network service versus what the provider actually charged.

And one issue, too, that has come up in recent discussions on revising our model is, do we have the same standards for those health benefit plans in the outside market, those plans that are not in the exchange versus what's required for qualified health plans in the exchanges? So, we're looking at that.

As I already mentioned, we started revising this model, the Managed Care Plan Network Adequacy Model Act, and basically we had started about a year ago, in 2013, with a group that's no longer active: The ACA Model Review Group. And what this group did

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that I realized, right after the ACA was enacted, that we have a lot of NAIC models that deal with health insurance. Those models are probably going to be impacted in some manner by the ACA, so we took a year to look at just examining all these models, deciding which ones need to be revised, which ones to be basically gotten rid of, what we call archived, and then there's another set where basically we just revise them and just leave them basically alone.

At the top of the list, even before earlier, I guess, late 2013 when, I guess, the Center for Consumer Information and Insurance Oversight (CCIIO) of the Center for Medicare and Medicaid Services (CMS), started to sort of make rumblings that perhaps they could be looking at trying to study federal standards for network adequacy. As you know, states have long been regulators of network adequacy and, as NAIC, we wanted that to continue to happen. So, because of these so-called rumors, things going on with CMS, we decided, it was the NAIC decided, that they wanted to put the Network Adequacy Model at the top of the list to revise because, again, we wanted to have something to show the CMS that we are revising our model to reflect some of the standards of the ACA related to network adequacy, but also that we are ahead of the curve and, again, we want to maintain state regulation of network adequacy. So, the group was appointed in April this year, again, to update to the ACA, update the model to reflect some of the standards in the ACA, and then, also, if you can just imagine the name of the model—it's called the Managed Care Plan—again, that may have been relevant in 1996 but that's totally different now in 2014.

So, those are some of the issues we're going to be looking at. Again, as I think Stephanie sort of alluded to, we started these calls, I think, back in maybe May, was like the first call and they've been continuing pretty regularly ever since then on Thursdays at 1:30 PM Eastern for now what is 90 minutes. And we're talking about these different revisions and we're trying to gauge completion, at least as far as this subgroup, by November or December of this year. I think we're going to try to go to two calls a week now because, again, we want to get this done by the end of the year. And if you're interested in what the subgroup is doing you can look on that link, that page, where we list all the comments, all the dates of the calls, have all conference call summaries—those sorts of things—and if you want to participate on those calls just feel free to contact me. I'm sure there's contact information in the packets that you have.

And again, I won't go over this, but we started requesting comments by July 3rd, and that's what we're looking at on the weekly calls. And then, some of the things, and Stephanie mentioned this, as far as our model; our model right now has what I would call more general standards. When I talked about what Section 5 now says about being able to get access without unreasonable delay, it was very, very subjective. In these calls we've had issues related to maybe we should have more quantitative specific standards, so those are things we're going to have to encounter. Again, we have to build in flexibility for this model for those states that may want quantitative standards versus those that may want more general standards. And I just threw up a few examples. California, at least for now, has more quantitative standards about maximum-minimum distance, waiting times,

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providing early ratios, those sorts of things, whereas in Washington State and Colorado have a more subjective general standard, what we call the reasonableness standard, and that's similar to what the current NAIC model has.

And that's all I have to say right now. Thank you.

ED HOWARD: That's great. Thanks very much, Jolie. We turn now to Gretchen Jacobson. Gretchen is an associate director of the Kaiser Family Foundation's program on Medicare policy, working on projects pertaining to the Medicare program and the population it serves. And we've asked Gretchen to describe the Network Adequacy Standards Medicare Advantage Plans are required to make and Jolie touched on this just now, in case you're wondering why we want her to talk about Medicare Advantage in this context it's because they are in place nationwide. They address the same problem, network adequacy, that we're concerned about today, but of course, for a different population, and, according to some people that Jolie has heard and some people that we have heard and some official announcements by some people at the Department of Health and Human Services (HHS), the Department might be considering issuing further federal guidance for the qualified health plans being offered to the working-age population and we have, in this presentation, some background on actual standards at the federal level that are addressed to this program. So, Gretchen, your presentation is right on point even if it's not immediately apparent that it's on point.

GRETCHEN JACOBSON: Well, thank you, and good afternoon. I will describe, as Ed said, the requirements for Medicare Advantage Plans Provider Networks as an example of federal requirements for provider networks.

As you may know, Medicare Advantage Plans are private plans that provide Medicare covered benefits to people on Medicare including both seniors and persons with disabilities under the age of 65. Medicare Advantage Plans Networks are regulated at the federal level by CMS, and since Medicare Advantage Plans service areas can be no smaller than a county, the requirements for plans' provider networks vary by county.

Plans have the discretion to select providers for their networks but they must meet access and availability standards set by CMS. I will describe how CMS calculates and oversees these network requirements for plans.

So, when we ask seniors and focus groups how they selected their private Medicare plan, seniors said that plans' provider networks are important, however, this quote from a senior in Tampa, Florida illustrates how complex it can be for people to check whether their provider is in a network. The senior said, "I had to check with my cardiologist, I had to check with St. Joe's, I had to check with all these different people and doctors all along the way to see who could refer me to this, that, or the other thing." You can see how it would be particularly complex for people with many chronic conditions and multiple providers.

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The graphic on the right illustrates the many different types of providers that Medicare Advantage Plans are required to include in their network, from primary care physicians to hospitals to skilled nursing facilities to even transplant programs, which are all very different types of providers. The CMS requirements differ across provider types, but the general concept and calculations are similar.

CMS first specifies the minimum number of providers that firms must include in their network in order to offer plans in each county. To help explain the basis of these numbers, so, CMS starts with the number of Medicare beneficiaries in the county, which are represented here. They then take the percentage of beneficiaries who are involved in Medicare Advantage Plans. They then calculate the market share for each plan in the county, array them from low to high, and take the value at the 95th percentile, the upper end of the distribution market shares. And that is the number of Medicare beneficiaries in the county that each plan needs to be prepared to cover as determined by CMS, which is shown here in the red box. That number of beneficiaries is then used by a CMS algorithm to produce a minimum number of providers of each type that each plan needs.

CMS also specifies the maximum time and distance requirements that providers can be from beneficiaries in the county. Specifically, 90% of beneficiaries in a county must have access to at least one provider of each type within the required time and distance. The time and distance requirements vary across provider types and also vary by the county population size and density. So, for example, in Philadelphia, a primary care provider must be within a 10-minute drive, or 5 miles, while in Galena, which is a small rural town, a primary care provider must be within a 40-minute drive, or 30 miles. And the time and distance requirements for hospitals are longer. In Philadelphia, a hospital must be within a 20-minute drive, or 10 miles, while in Galena, a hospital must be within a 75-minute drive, or 60 miles.

Plans can include, in their provider networks, providers that are outside of the county and have them account for its minimum number of providers that they need as long as the provider meets the time and distance requirements for at least one beneficiary in the county.

The oversight and review process for plans' provider networks varies depending upon whether a plan contract is new or being renewed. If a firm is submitting an initial contract application to offer plans in a new area, then CMS reviews the network adequacy of the plan through an automated process. If a firm is renewing an existing contract for the next plan year, the firm must attest to meeting the network requirements. CMS will review the plan's network adequacy if it receives many consumer complaints.

Medicare Advantage Plans can change their provider networks at any time during the plan year. To do so, they must attest that the plan will continue to meet the network adequacy requirements. Beginning in 2015, they must also notify CMS at least 90 days in

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advance of their changes in their provider network. They must notify, also, the providers that will be terminated at least 60 days in advance, and they must notify enrollees at least 30 days in advance.

In general, enrollees cannot change plans outside of the annual open enrollment period, however, beginning in 2015, if a plan makes significant no-cause changes to its provider network and the enrollee was seeking care and receiving care from a provider that was terminated, then the enrollee can request a special election period from CMS to change plans.

Many facets of plan provider networks are not known and they need further research. In particular, how easy is it for enrollees to review their plan's provider networks? This quote from a slide summarizes sentiment that we've heard in the focus groups. The senior said, "It would be lovely if these plans would put down these are the doctors, these are the hospitals, and then you could look at them side by side because I had a heck of a time when I had to switch." We also do not know how frequently plans change their provider networks. How often do enrollees go outside of the network to receive care? To what extent do plans have overlapping networks where they include and exclude the same providers in the same area? Or, even to what extent do plans favor higher quality providers? The answers to these and other questions would help to inform us as to whether the current system of requirements is working well or whether it needs further refinement.

And, from our information, you can see our resources on KFF.org.

ED HOWARD: Thanks very much, Gretchen. And now, I want to introduce the folks who are at either end of the dais. They add some expertise that we will call into play here now in the question and answer period. On my left is Marc Barclay, who is the Vice President of Provider Networks and Contracting at Blue Cross Blue Shield of Tennessee, where he's responsible for the day to day operations associated with provider network contracting; and, at the other end is Steven Shapiro. Dr. Shapiro wears several hats at UPMC, University of Pittsburgh Medical Center, and he's their Executive Vice President. He's President of the Physicians Services Division as well as the Chief Medical and Scientific Officer, and I understand he turns the lights out when he leaves in the evening. And they'll be available to help respond to your questions and comments as well.

As I mentioned, there are microphones on either side of the room. There are green cards in your packets where you can write a question and hold it up and we'll bring it forward and get it, to the extent that we have time for, into the discussion. And when you do go to the microphone we'd ask you to identify yourself and your affiliation if you have one and to be as brief as you possibly can so we can get to as many of your questions as we possibly can.

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And let me just start off by asking all the panelists, what kinds of things, and Jolie Matthews talked a little about this, how active are states putting in place their own standards at this point while they're waiting for, if they are waiting for, the subgroup to come up with recommendations for a model set of standards? And I noticed you talked about California. I've heard things about Oregon.

JOLIE MATTHEWS: I'll take the first. From what I've seen is that states are sort of sitting back and waiting. This is only the second year. Most states already had existing network adequacy standards and so now they're looking to see how those really translate now that we're in the post-ACA. And looking back, getting data, looking at their complaints from consumers, and figuring out what, if anything, they need to do to address those complaints, possible issues. So, again, I see most of our members, at least, looking, waiting until maybe next year to start doing something.

ED HOWARD: Governor, have you heard folks in various states where you've been advising them rumblings of activity or is there a wait possibility?

MIKE LEAVITT: I'll defer to Steven and then I'll comment.

ED HOWARD: Dr. Shapiro.

STEVEN SHAPIRO: I could just give an example where the government has had to get involved. It's our example of western Pennsylvania, which is probably one of the more complicated states because we have two in western Pennsylvania: integrated delivery finance systems payer providers, UPMC provider-led, Highmark Blue Cross Blue Shield, a payer-led, and we had different views of the future. First of all, that's working well. We have one of the lowest – some of the lowest rates in the country because of this competition, but the UPMC vision was one built on us having narrow networks and competing. Highmark's vision was all being in the same network and using curing and steering to differentiate. Governor Corbett and Attorney General Kane, in a bipartisan way, had to come in and very successfully had a patient's first consent decree, where we had a compromise and now we are moving forward.

And, I think, to highlight some of the issues that Jolie mentioned, this is already confusing for the patient, even just the natural progression, and when you start to try to perfect it and protect the patients, even when successful; it makes it even more complicated. So, we now are spending a lot of time trying to educate the patients so that they know that, for example, the UPMC doctors within the greater Pittsburgh region are out of the network except if it's Children's Hospital Psychiatric, Oncology, or Emergency Services. The same physician who is out of network in Pittsburgh could be in-network outside of Pittsburgh, so you get the point. It's very confusing. And I'm very hopeful that our patients really will have high quality affordable care, but it just highlights the need to really educate the patient so that they don't get stuck being surprised that their doctors are out of network where they get a large out-of-network bill.

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MIKE LEAVITT: I would like to just advocate openly that the right thing to do is to go slowly with a regulatory response here. We're one year into this. And there's going to be a lot of change that occurs in the marketplace as well as with the plans. Most of them we're making guesses on their rates during the first year. The second year they'll have a bit of information that will be more scientific. The third we'll begin to get real credible data. But it's not just the providers and the insurers, it's the consumers. I'll just relate my own experience.

I bought, I went to an exchange, actually, and I acquired what looked to me to be a proper network at a very low price. And about three weeks later I got a call from my wife explaining to me that her doctor was not part of the network. I made a consumer decision to keep my wife happy and changed networks. I paid a little more. My point in telling that story is that consumers are going to see where the holes are here, too. They're going – and they're going to begin to reward and punish, in the marketplace, those who have inadequate networks. And I have to confess that as a regulator and as a former head of HHS, I learned to be a bit suspicious of anything that was brought to me where they said, I used a logarithmic approach based on some surveys in order to establish a 42-page regulation on exactly what ought to be in this or not. Simplicity.

There are two roles the government can play here. Clearly, government's going to be involved here, but government can take the role of organizing or it can take the role of operating. And when we get too detailed and move too quickly we start to operate the system from government as opposed to organizing and allowing the system to become efficient.

ED HOWARD: Okay. By the way, I have been remiss in not reminding everyone that if they want to Tweet about this event you can see the hash tag on the screen behind you and there are instructions if you need WiFi to get at the Tweet, on how to connect with that.

And we have folks at the microphones, so let's start with Joyce.

JOYCE: Hi. Joyce Frieden, MedPage Today. Question for Ms. Matthews. Can you talk about the timeline for the NAIC model reg and when we might see something?

JOLIE MATTHEWS: We're working very, very hard to actually meet our November-December deadline. I'm hoping that we can actually meet it. Again, we're going to start possibly having calls two times a week in order to ensure that we meet that. Once our subgroup decides on its revisions they adopt those. Then, unfortunately, for good-for bad, we have a hierarchy we have to go up. So, the groups that come after that are the task force, but luckily the chair is the same for the subgroup and the task force, so that should be easy. But I think ultimately the timeline will be that our health insurance committee, which is the parent committee, has to adopt it before it goes to the full NAIC membership. That will be probably in the spring of next year. However, for the most part,

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I would say 95% of the time, once the lower level groups are done, meaning, in this case, the subgroup and a task force, there will absolutely be no substantive changes from then on. It's just a matter of going through the procedures. So, the bottom line, I believe, we'll be ready to have something that will be official sometime, I would say, in March of 2015 at the latest.

JOYCE: Thank you.

ED HOWARD: There's actually a parallel question on one of the cards having to do with federal regulations. What is the current status of federal activities to issue or revise federal regulations on network adequacy for exchanges; what is CCIIO considering, and when will any decisions be made, and are any agencies other than CCIIO playing a role. And if our panelists want to demur and there's someone in the audience who wants to speak up, we'd be happy to hear from them. I also ought to mention, at this point, that there is, and I'll ask our experts to correct me if I'm wrong, a change already in place from last year to this having to do with the Central Community providers and an increase in the percentage of those providers who have to be included in a particular plan, and I wonder how that relates to these potential changes in the standards that we're talking about.

Anyone want to take a stab at that, whether it's rumor or not?

SPEAKER: If someone does, I'd just like to take some notes, so speak slowly.

JOLIE MATTHEWS: I have to admit, I haven't been actually following a lot of it. I've been sort of busy. But it has been, I think in the—and Stephanie can correct me, but in this year's open enrollment for plans they have to, now there's going to be data, I guess, gathered, and the thought was, at least what we had heard at the NAIC with this information gathering was the precursor to perhaps federal regulations on network adequacy that would apply in the private insurance market. But, other than that, I have not heard any timelines specifically from CMS. I know CMS is looking at the work that we're doing and, again, we're hoping that any thoughts of such federal regulation are stymied now that we are working and ultimately will have something early next year.

ED HOWARD: Okay. Yes, ma'am.

SPEAKER: Hi. Clair Cruz from the Deloitte Center for Health Solutions and it's kind of building on what we've already been talking about, but I was reading a Robert Wood Johnson report this week that came out and they surveyed 6 states looking at their network adequacy standards in the states, and most of the insurers that they were looking at had built their standards based off of pricing as the primary factor for their networks. I'm wondering if any of the panel believes that quality will be built into these standards a little bit more at some point without plans being required to, or if there are any thoughts around that.

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ED HOWARD: And I would add to that a question that we got on a card, I actually got it in advance, and that asks: how are plans able to measure provider quality reliably to ensure the highest quality providers are included in these networks?

MIKE LEAVITT: I could comment on that.

ED HOWARD: Yes.

MIKE LEAVITT: I believe we will very clearly begin to see a movement toward quality being listed or evaluated alongside price. Now, we're not very good at evaluating quality yet. We talk about it a lot, but the truth is we're not very good at it yet. The 5-star system is one way which we've begun to proceed forward. It's helpful. But I think this whole movement isn't just about networks, it's about value. It's about driving value. And until we have both the price and the quality measures we will not have achieved that. And so, I think we'll see more states insisting on it. I think we'll begin to see consumers insist upon it. And I think we'll see insurers who will, those who are the plan builders, whether they're insurers or hospitals, will find it in their interest to do that.

STEVEN SHAPIRO: Can I follow up on that? That's great. As a physician being rated on quality, I think it's essential, it's important and as you just heard from Mike, that it is something that's an imperfect science that we need to perfect. For example, a lot of what we're measuring now are simple process measures. Did you measure this test or that? Occasionally is it in normal range? But not did we make the right diagnosis to begin with. We have a lot of people reporting on statistics and we don't know really what data they used to get them or the statistics that they used. And two variables that are extremely important and not accounted for well are 1) complexity of illness; and 2) socioeconomic status. And this becomes critical, particularly for academic medical centers (AMC). AMC's are juicy targets for narrow networks because they're expensive, in part because of their research and education mission, and, in part, because they take care of an inordinate number of the sickest and poorest.

So, we really need to get these measures down. This isn't an excuse. The academic medical centers are the ones that need to come up with these tools and need to become more efficient as well to improve their value.

MIKE LEAVITT: Can I make one other comment?

ED HOWARD: Sure.

MIKE LEAVITT: While I've indicated I see the imperfection, and most others would too, of our capacity, I think that it is likely that over the course of the next three to five years that most of our quality measures will really be patient satisfaction as opposed to hard capacity to look at specific measures as outcomes. Now, that's imperfect. But it is a

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measure, and I think that the market will begin to reward people who are listing them alongside price.

STEPHANIE MOHL: If I could just chime in as well. At the American Heart Association we very much also see the value of incorporating quality into network development to a greater degree, and I think what we've already seen is plans starting to market networks as being high value networks, etcetera. And what isn't always clear is what are the criteria that are being used to make that evaluation and if; in fact, they really are using quality as opposed to price. And so we certainly hope that, as part of the NAIC's work, that quality will be a component of it. There's already been a fair amount of discussion in the subgroup about exactly how we go about doing that. But, fundamentally, we are advocating for just greater transparency in terms of the criteria that plans are using, and also, hopefully, better uniformity so that's another thing that we've been seeing in the marketplace is, you know, one plan is using this set of criteria and another plan's using another set of criteria and coming up with very different value networks which is obviously very confusing to consumers and probably also to providers. So, just greater transparency in terms of what is being measured and how is it being measured.

ED HOWARD: Marc Barclay, you must have to worry about that as you put together the provider networks in Tennessee.

MARC BARCLAY: That's a great question and I'm glad somebody asked that question because I was going to feel bad if I didn't say anything.

No, so the irony is, you know, Blue Cross of Tennessee is the largest insurance company in Tennessee. We actually insure over 3.3 million members. When the marketplace rolled out we were very successful in picking up about 90% of the marketplace membership. And having said that, I probably spend 95% of my time talking about narrow networks with our members, the Tennessee Medical Association, the Tennessee Hospital Association. So to kind of tack on what Governor Leavitt said, you know, we're not waiting for the state regulators to come in and impose more rules. I mean, we're kind of held to a higher standard by our members and by the associations that we work with and we are, in Tennessee, you know, adding doctors and hospitals on a regular basis to our networks. Now, we do offer a broad network that includes everybody in the state of Tennessee for these members and we have a smaller network and then an even smaller network and there's a tier premium. So, you know, the one size fits all, you know, obviously, is probably not going to work in the future so we offer our members choices.

SPEAKER: I was just wondering if the panel had any thoughts on how maybe the MA model would work or not work in the context of plans in the exchange. Thanks.

STEPHANIE MOHL: I'll tackle that. This has been a discussion of a lively debate in the NAIC subgroup calls, I think Jolie would verify. And I think, you know, we have

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recognized that there, you know, needs to be flexibility. Certainly what works in Montana is not going to be what works in California. And so the position that the American Heart Association and the other consumer representatives took, is that there should be quantitative standards such as provider enrollee ratios or waiting time distance types of standards. But each state can, and should, set its own standards so it wouldn't be a nationwide standard. I do think that there are elements of what CMS has done for Medicare Advantage plans that could be informative to states, so, for instance, the way Medicare Advantage basically divides the counties up by different tiers, and Gretchen can talk about this better than I, but, you know, you essentially have 5 different tiers of population density, so you have the really large metropolitan areas and then you have the rural and even, you know, frontier counties and different standards apply to those different counties. So, I think that, you know, there are some lessons that state regulators could learn from Medicare Advantage, but we've also heard loud and clear that having one single national standard is probably not going to go over very well with the NAIC.

ED HOWARD: How about with the American Heart Association?

STEPHANIE MOHL: Well, like I said, we've advocated for each state to set its own standards, but we do believe there need to be quantitative standards.

GRETCHEN JACOBSON: Just some things to think about in this area. So, there's a lot of similarities and differences, obviously, between Medicare program and between qualified health plans in the exchanges. I mean, so you might want to think about, one, they do serve different populations, so that might play into the time and distance requirements—should the time and distance requirements be longer, shorter, for seniors and people with disabilities. It might play into the number of providers that you need. It also might play into, of course, Medicare Advantage as a county-based system, and the exchanges really aren't. But, on the other side, there are some similarities to think about. It's often the same companies that are both offering Medicare Advantage plans and plans in the exchanges, so in some sense uniformity and rules could be something that'll make things a little bit easier. And, there will be people who will be in both qualified health plans and then going on to Medicare Advantage plans in that they may be going on in the same companies, and so it's something to think about in terms of different consumer experiences for the same consumer across different programs.

So, I think there are a lot of different facets to think about and it's probably not a straightforward like everyone has indicated.

MIKE LEAVITT: I think there are several ways in which a standard can be expressed. There is the rhetorical, or rather the written standard that goes page after page trying to describe how everything will work, and then there's the actuarial equivalent standard where people have the ability to take a quantitative approach to this, and within that find innovation. And I would argue that we ultimately will have standards here, but to the degree that we can express them in a fashion that will stimulate innovation in care models

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and other things and not restrict them. Simply because of the way something is written it will be substantially more innovative and substantially less expensive and allow more care to be delivered as opposed to a regulatory burden.

ED HOWARD: Okay. Yes, sir.

JOHN GRAHAM: Thank you. John Graham from the National Center for Policy Analysis. And I think my question also has a Medicare Advantage compare and contrast to it. I was very interested in the Avalere study that Ms. Mohl presented to us today. The radiation-oncology was very poorly covered, and it follows on from Avalere's study a few weeks ago that showed that coverage of oncology drugs and HIV/AIDS drugs was really bad. You know, really expensive for the patients. And it looks like the plans can hit their actuarial value boogies for the standard population, quote/unquote, while still, you know, selecting risk pretty aggressively. So, I wonder if the narrow networks that people are complaining about in the exchanges are actually a symptom of bad risk adjustment and would any of the panel recommend changes to the risk adjustment, and certainly after the 3 years peters out of the federal subsidies.

MIKE LEAVITT: I'm commenting on many of these, so I'll be brief. I think the reality is that some experience is necessary. Risk adjustment is a function of a lot of large numbers. We have to have more than 1 year to make logical conclusions here. And so, there's no question there's going to be some anomalies in the first year that we'll look at and say how could that be? We've got to do a regulation to change that. And then the law of unintended consequence takes over and begins to complicate in a whole series of ways we haven't seen. So I, again, would argue that we need to be slow in our response. Let me restate that. We need to be methodical in our response and careful in the way we go about this that we do not set off a whole series of unintended consequences that will be more difficult and create more inequity than it will actually solve.

ED HOWARD: Okay. Please.

KATIE ALLEN: My name is Katie Allen. I work for Congressman Burgess. I think we talk a lot about who's in the network but maybe even more important is the ability for the consumer to determine who's in a network. Ms. Mohl talked about that a bit. Even savvy consumers have a very difficult time figuring out who's in, who's out. Related to that is some articles in the *New York Times* recently about people being treated in a hospital that is in network by providers that are in network but then there are other providers that aren't in network and they leave the hospital with astronomical bills. Where do you see this going in the future with transparency and true choice? And is there a role for the federal government here?

STEPHANIE MOHL: I thank you for that question. There are a lot of questions but we definitely see a role for regulators. You know, I think at this point, we're working, I think, our view is that the state regulators are in the best position to regulate and oversee

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network adequacy and having an adequate network of providers is sort of fundamental to trying to prevent the surprise billing issue.

Now, in our study, one of the reasons we specifically wanted to include radiologists is because, as a hospital-based specialty, we had a hypothesis that they would be less likely to be included in the networks. Quite honestly, they don't have the same financial incentive to negotiate with plans that other providers might have, so they have sort of a captive patient base. And so, I think the Avalere study reaffirmed that and, you know, those were exactly the kinds of stories we were hearing from our patients when they would have a heart attack or a stroke and, you know, need their CT Scan read, and then they would get the surprise bill even though they were at an in-network hospital.

You know, I will say that CMS has indicated that, while they're collecting data for 2015, they have indicated that they're interested in doing something more in the future. It's not 100% clear to me whether they just would do something more for all qualified health plans or whether it would just apply to the QHP's in the federally facilitated marketplaces, but I think the feds are watching closely what the NAIC does and if, you know, they don't think that that goes far enough then they will step in, and, in fact, we might advocate for them to step in.

ED HOWARD: Yes.

STEVEN SHAPIRO: Might I just add that the onus really is on the providers to develop tools that will give the patients up front what to expect so that they aren't surprised at the end, and, of course, the insurer has to agree to it. And, as we move more toward value type of compensation models with bundles, for example, that example in the *New York Times* with surgery, if you have a bundled price there are going to be no surprises because that's your bundle. So, I think these types of new models will simplify that as well.

ED HOWARD: Yes. Go ahead.

MARC BARCLAY: I just want to add one thing, and this is for Tennessee, but for our narrowest network, we have partnered with some anchor systems and all their providers are contract including the hospital base network, such as radiology. I think one issue with the study I just saw is that the majority of the insurance companies actually did not put hospital base providers, radiologists, anesthesiologists, emergency doctors, or pathologists in their directories. So if you're truly going off a directory screen capture it's probably not going to show those positions even though they are contracted.

ED HOWARD: Can we just talk about those directories for a moment. It seemed to me, when I was reviewing the materials that a lot of the more dramatic complaints had to do with the inaccuracies or the lack of timeliness in the directories. As Stephanie said, people don't know they're going to get cancer three months after they sign up for a plan

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and they're not worried about the oncologist. And I also noticed that a bunch of states have different rules for how often states or companies need to update, anywhere from 6 months to, I think in New York, they said it was every 15 days, was being talked about. And Gretchen mentioned that there are some standards for timely updates and advance notice in the Medicare Advantage standard. So, how does this play out in the NAIC negotiations, in the states where people are grappling with what the questioner was asking about?

JOLIE MATTHEWS: The group hasn't gotten to it yet, but I know for sure we'll be putting something in about provider directories. I think it will address, at least try to address, issues of timeliness, how it's given to the consumer, how the consumer knows where it is electronically. You can get it in paper if you want it. One issue that did come up, and this was when we had stakeholder calls, is that, again, almost with the hospital physicians or hospital-based physicians not being in a network, some of this onus is on the providers as well. Insurers are saying that you have to help us as the providers. So, if we wanted to say we want timely information from you, you have to give it to us. And so, there have been concerns about that. I think the working group is going to try to work through that to make sure that both the provider and the insurer can work together to make sure that the directory is accurate and that it's updated in a timely manner.

ED HOWARD: Yes, Mike.

MIKE MILLER: Thanks, Ed. Mike Miller. I'm a health policy physician consultant.

ED HOWARD: You want to get closer to the microphone.

MIKE MILLER: Sorry. Can you hear me? Mike Miller. I'm a health policy physician consultant. I wanted to pick up with something Steve had brought up a little bit in terms of how the hospitals are paid. And just to clarify, if the panel could, the network adequacy rules that NAIC is working on and what Medicare Advantage has, doesn't get to how the individual hospitals are paid. So if there's like three hospitals in a network, the payer can pay one on bundled, one on shared savings, and one just on a straight fee schedule, right? And, are there issues for the network adequacy and how a payer might tier incentives for the members towards those different hospitals because of those different payment structures for providers within the network? Is that an issue or is that too far down the road?

JOLIE MATTHEWS: I think Stephanie talked about this a little bit. We have discussed that in the subgroup about how to deal with tiered networks. And I think, at this point, the subgroup is sort of wary because, as you can imagine, all these things are changing all the time, so they're not sure they're going to put something on directly on the model, but they do want to address the issue and basically it's going—right now we're looking at more of a consumer disclosure transparency issue that if you're in a tiered network, or at least the state regulators, you need to know what is covered in that tier and how it really

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works. So, I think at this point, again, we're sort of wary. At least, right now, the subgroup is wary to put any specific language, but if they did it would be more toward disclosure and transparency.

ED HOWARD: I think it was Steve who was talking about steering and tiering, and there may be one or two other people besides me who don't fully understand what that really means, and since the question had to do with tiering it might be useful if someone who really understands it could tell us all about it, or very briefly explain what it is. What's a tiered network in this context?

MARC BARCLAY: I can try to address it. So, a tiered network would be a broad network, narrow network, where the member co-pay or co-insurance differs by the provider. So, you might have three hospitals in a city on the same network but they might be a tier 1, tier 2, or tier 3 type provider based on quality, cost. So the member's incentive to go to the tier 1 hospital, and there might be a reduction in co-pay or co-insurance. I mean, so in Tennessee, for the exchange business, the co-insurance and deductibles, some have none, so obviously, the tiering is not going on in Tennessee.

GRETCHEN JACOBSON: I'll just confirm that. For Medicare Advantage plans it is completely up to the plans to negotiate what the hospitals that they need to have in their network, as well as additional ones they want to have in their network. There is one part of Medicare law that does influence those negotiations, and it's that for out-of-network hospitals, if someone goes to receive emergency services at an out-of-network hospital, then that hospital is limited in what they can charge for the cost for that service. They can't charge more than traditional Medicare spending—to what traditional Medicare would have reimbursed for that visit.

ED HOWARD: Very helpful. Thank you. Yes.

CLAIRE McANDREW: Hi. Good afternoon. I'm Claire McAndrew with Families USA and the discussion you brought up a little bit ago about timely updates to provider directories actually spurred a thought in my mind. I've been looking at this issue a lot and, you know, one thing I've noticed is that a lot of health plans actually voluntarily indicate that they update their directories, you know, every 6 days, every 5 days. I know a lot of states do have these requirements, you know, you must update your directory every 15 days. I don't think plans aren't updating their directory, you know, as quickly as they are getting information from providers and I don't think that's really going to solve the problem. So, I guess my question, I noticed New Jersey passed a regulation last year that the plans actually have to look back, and if a provider hasn't filed a claim within the last year they have to go look into whether that provider still is actually in their network. And I'm thinking that we have to sort of get past these just timely update standards and get into more sort of internal auditing of the directories, or do something that goes beyond just timely updates. Because I guess I think timely updates are happening and not addressing the problem.

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So, I'm wondering if anyone sort of, you know, whether it's in your health systems or in the health plans you're working on, or within the NAIC, if any of the discussion has sort of gotten into going just beyond timely updates, what can be done. Because I think the problem is just that the communication between the providers and the plans—you know, as much as we want the providers to be fulfilling the obligations of the contract to always tell the plan if they're leaving, if Dr. Jones is retiring to Costa Rica, we just can't count on him to tell us that, and I think we're going to have to do something else besides a timely update standard. So, I'd love your thoughts on that.

MARC BARCLAY: That's a great question, and truly nobody benefits from having an out of date network. You know, on an annual basis, go through our provider data and it's amazing the number of physicians that are listed that died 10 years ago on a network. So, you know, it's a two-way street; that we want to update our directories but our physician partners have to tell us, and obviously, if they died, that's a problem.

The other issue is that I'm not sure I've actually seen a printed directory in the past 10 years because any printed directory, as soon as it's printed it's outdated. In fact, by the time you get the data to the printer and it takes 2 weeks to print it and, I mean, it's already outdated. So, you know, we actually, you know, have it online. It's actually updated every 24 hours. You know, we encourage our members to check it online. If they don't have Internet access, you know, call our member services. And the best place is to ask their providers if they're participating in the network.

ED HOWARD: And presume they know. I've certainly had experiences with some people, not the physician specifically, but the people in their offices who have no idea whether my plan is covered or not.

STEPHANIE MOHL: We've heard that from consumers as well.

ED HOWARD: Yes, go right ahead.

HEATHER FOSTER: Hi there. My name is Heather Foster. I'm with the National Association of Community Health Centers and I think that was a really interesting point on the timely updates. But, I wonder also, to what extent you are sort of looking at the other piece that plays into the provider networks around reimbursement in that, you know, maybe there are providers that aren't in the networks because they can't actually get a good contract, or plans aren't really having a good back and forth discussion. How do we look at that and how do we work that into fixing this problem as well?

MARC BARCLAY: I mean, so, one of the advantages of billing a network, and we've been around in Tennessee for 65 years, is that we know who the quality providers are. And so, that's definitely one of our strategies is we partner with the quality providers. And having said that, I think there was a question earlier about how do we track quality.

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Well, I mean, that's an ever changing process. I mean, there's the stars ratings and the HEDIS and things such as that. But a lot of the quality is actually tracked by the systems themselves, and, in fact, a lot of it is self reporting. So, just because a provider's not in the network today because of quality, I mean, they might be in the future as their quality improves.

HEATHER FOSTER: I guess my question isn't so much about quality as payment, and making sure that, you know, how do we make sure that plans are paying providers adequately enough that they are able, and want to be in these networks, as well. Or, having real discussions about payment so that they can be in the networks, rather than just, you know, sort of, here's what we pay, you know, here's our standard offer, take it or leave it. How do we make sure that there's more of a discussion and back and forth so that we can make sure that there are an adequate breadth and type of providers that are involved?

MARK BARCLAY: I mean, I wish we could say that in Tennessee—here it is. Take it or leave it. But we can't because, again, we've had to partner with several large health systems and they've encouraged us, you know, to pay them a certain rate to take care of these members. So, I think the perception that the insurance companies kind of set the rates is not really accurate. I mean, the hospitals and the health systems, you can look at UPMC, I mean, these systems are as sophisticated as they've ever been, and I think there's more of a balance now between a payer and health system as there's ever been.

STEVE SHAPIRO: For the small private practice provider it is very difficult and that's sort of why a lot of private physicians are joining large systems like UPMC and others so that they can have more of a voice at the table. But what you're talking about is a real problem and the way that we're dealing with it is leading to consolidation and merging and acquisitions which have good and bad consequences.

ED HOWARD: Go ahead. There are a couple of questions here that grow out of some of the conversations and actually echo a little of this last questioner's concern. In your packets, there is a piece of testimony from a hearing by the Association of Children's Hospitals, raising the concern that children's hospitals disproportionately were not being included in some of the more popular networks to the detriment of some of the sickest children. And, in fact, this question asks: how does this narrow network phenomenon impact the sickest children's access to pediatric subspecialties, the largest pediatric access problem; and similarly, another questioner asks about the kinds of providers who are particularly useful for people living with HIV/AIDS, and their ability to get those kinds of specialized providers.

And I don't know, Stephanie, are these kinds of questions that you have to grapple with?

STEPHANIE MOHL: They are, indeed. So, you know, I think fundamentally, we've taken the position that if it's a covered benefit then there should be providers in your

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network to provide that service. There are some cases, particularly when it comes to special populations like children or very complex conditions like, you know, in the cardiovascular disease world, we see children who are born with, you know, very, very complex congenital heart conditions, where there really are maybe a handful of cardiologists in the country who have expertise in those conditions.

So, you know, we've taken the position that, you know, in those kinds of circumstances, it's not reasonable, you know, to expect the health plan to contract with those providers, but that there does need to be some kind of process in place for patients to gain access to those providers when they need them. So, you know, that should be the exception, not the rule. So, you know, I think we would say that, you know, having zero children's hospitals in a network is probably not acceptable, but, you know, and again, that's going to depend on where you are in the country. But, that there should be some basic standards for assuring access including for those specialty kinds of services, but then there should be remedies for patients when insurers can't contract with very specialized providers.

ED HOWARD: Any other comments? Yes, Mike.

MIKE LEAVITT: There is, playing out in this marketplace, competition in two values. The first value is the value of compassion. We all want people to be cared for when they're sick and when they're injured, and we want to be in a society where that's the case. The second value is not so much a value as a force, and I'll call it global economic dispassion. It's not so much lack of compassion as it is a force that is driving this conversation. I mentioned earlier that networks were a macroeconomic response to economic pressure. The question is a classic example of that. We all want every child to be cared for and yet we're involved in this collision between these economic forces that are outside of our control and our compassion and we're seeing those collide. And through the course of it we're working this out. We're finding what, I think Stephanie mentioned earlier, as the balance between them. And there are two ways to try and reach that balance. There's a constant regulatory response where we're writing things down and trying to make it exact in our solution, or there's the market response. And, again, it will be balance. It won't be one or the other.

So, I think we ought to acknowledge that this is going on and that we're in a process here, or that we'll go over a period of time, and in the course of that, those two great forces of compassion and then this economic, these economic pressures that are driving this, will ultimately find their way to the golden mean. Or, at least that should be our aspiration.

ED HOWARD: We are just about out of time. I want to try and squeeze in a couple of questions and I apologize who took the time to write them on a green card and we haven't been able to get to them. But, several different questions have mentioned the idea of enforcement of sanctions. In all of these regulatory schemes, whether it's the Medicare Advantage scheme that's already in place, or the ones that are being developed, or the ones that states have already put in place, what happens if you don't get your directory

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updated, or if you don't have a pediatric subspecialty that you're required to have? And what should those sanctions be if there aren't any?

JOLIE MATTHEWS: Well, for state insurance regulators, typically there are enforcement mechanisms and sanctions and fines and various ways if insurers do not comply with their regulations and laws. However, they do try, as much possible, not to impose those so they work with the insurer. In this case, with network adequacy, if they find that the network is not adequate then they will go back to the insurer and say, you need to do X, Y, Z to make it adequate and continue from there. But, again, insurance regulators do have enforcement, and ultimately the biggest one is to pull their license. But, they never get there. Again, they try to work with the insurer.

ED HOWARD: And, Gretchen is that what happens in Medicare as well?

GRETCHEN JACOBSON: Well, I'm actually trying to recall instances, even recently, when there have been sanctions, but there actually haven't been. There have been a lot of changes in Medicare Advantage provider networks which have been well publicized. But there actually haven't been any sanctions because, upon review, those provider networks still met the requirements for CMS. Although, it is worth adding that, in a lot of areas, the requirements for a lot of the provider networks, they require one provider of a specific type and one provider of another specific type, and the plans to have to attest that they still meet those minimum requirements. So, but to the best of my knowledge it hasn't.

ED HOWARD: Okay. Well, we haven't quite solved all of these problems this afternoon, but we've sure taken a bite out of a bunch of them, and we're going to take another bite, Marilyn, when is it? Sometime in October we're going to do a webinar to pick up some of the pieces that we haven't finished yet. The 15th of October. The Ides of October. So, watch you inboxes for a notice about that.

Thanks to both UPMC and the Blue Cross folks for their support and sponsorship of this series of events. Thanks to you for asking some terrific questions for which I am very grateful, and ask you to help me thank our panel by letting them know how much we appreciated it.

[Applause.]

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