Network Adequacy Conceptual Framework

Revision of INS 2701 – Informal Working Group July 24, 2014

General Objectives

- Ensure access to services, not specific providers
- Avoid provider monopoly power
- Allow for alternatives to the traditional delivery of care
- Encourage competition among insurance companies and health care providers
- Allow for consumer choice of networks and insurance products

Considerations for Changes to the Rules

- NH statutory requirement for network adequacy
  - "Access without unreasonable delay"
- Requirement is a minimum standard
- Network impact on premium costs
- Local availability of services
  - Number + types of health care providers
  - Differing needs of communities
- Federal requirements for products on NH's Health Insurance Marketplace

Federal Health Insurance Marketplace Requirements

- "At least one Essential Community Provider in each ECP category in each county in the service area, where an ECP in that category is available."

- Apply federal requirement (for the state's federally facilitated Health Insurance Marketplace) to entire small group and non-group markets

Community Focus

- A NH city/town is the focus for access
  - True for health care and other services/goods
- Avoid focusing on member-specific travel times, if possible
- Community-specific requirements, with consideration for providers in neighboring states/counties
- Separately identify services that should be accessible locally and regionally

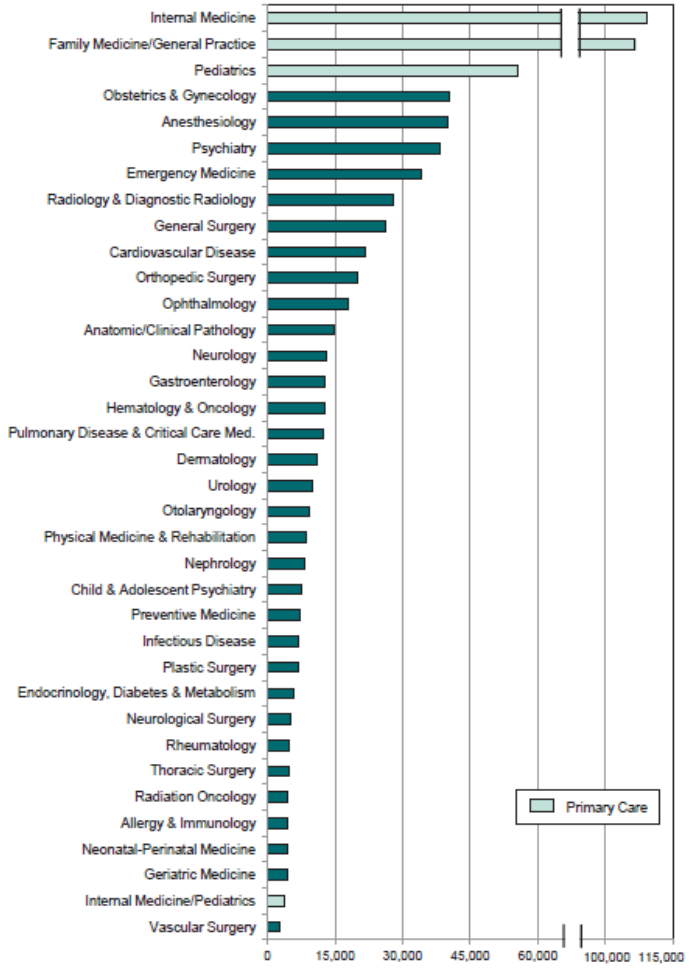
Allow for Telemedicine

- **RSA 415-J:2** "Telemedicine," as it pertains to the delivery of health care services, means the use of audio, video, or other electronic media for the purpose of diagnosis, consultation, or treatment. Telemedicine does not include the use of audio-only telephone or facsimile.
- Access to services provided through the use of telemedicine may satisfy network adequacy requirements
- Must be consistent with current standards of care, as defined by provider community

Contracting & Provider Capacity

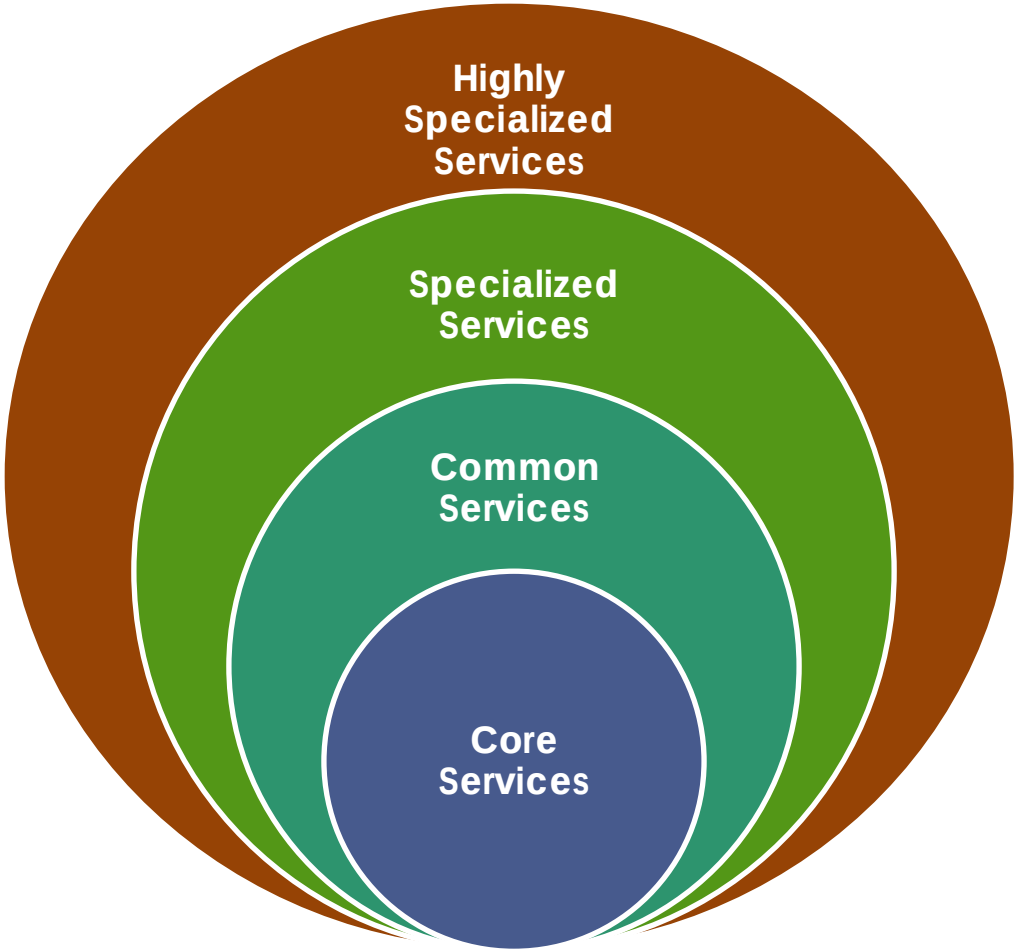
- For core services, carriers must include at least 30% of providers when at least three independent providers exist
- Appointment times:
  - NCQA/URAC standards as stated in rules
  - Length of time until the 3rd next available appointment
- Allow for exceptions:
  - Market competitive rate is offered to the provider
  - Insufficient provider capacity exists

Figure 3. Specialties with the Largest Number of Active Physicians, 2010



Source: AMA Physician Masterfile (December 2010)

Classify Services Based on Urgency/Frequency of Use



Core Services: Access Within the Community

- Primary care (internal medicine, family practice/general practice)
- Pediatrics
- Obstetrics
- Mental health care
- Substance abuse treatment
- Urgent care/emergency services
- Laboratory services (drawing only)

Common Services: Moderate Proximity

- Diagnostic radiology
- Radiation oncology/therapeutic radiology
- Rehabilitation (MD/PT/OT/ST)
- Vision care
- General surgery (Anesthesiology, pathology, related services)
- Allergy and asthma care
- Dermatology
- Endocrinology
- Orthopedics

Within NH or Near State Border

Heart surgery

Neurological services

Oncology/Hematology

Urology

Plastic surgery

Within New England

Transplant services

Specialized complex pediatric care

Specialized surgery (e.g. vascular, thoracic)

Specialized burn centers

When Network Adequacy Requirements Are Not Met

- Action depends on specific requirement that is unmet
  - Exceptions to appointment time requirements
  - Availability of health care providers
- Carrier marketing restrictions?
- Additional disclosure requirements?
- Competitive contract proposed?
- What alternatives exist to ensure access to care?

Summary

- Classify services based on appropriate access levels
  - **Core services –** available within the community (primary care, mental health)
  - **Common services –** moderate travel may be necessary (surgery)
  - **Specialized services –** potential centers of excellence (cardiovascular treatment, neurological services)
  - **Highly specialized services –** available within New England (transplants, burn treatment)
- Community structure (e.g. urban, rural) will affect access standard

Questions

- Is the basic concept clear?
- Will the requirement meet the intentions of the legislature?
  - Protecting consumers
  - Encouraging carrier and provider competition
  - Restraining costs

Next Steps

- **Send us your feedback**. Please email comments to Danielle.Barrick@ins.nh.gov by Aug. 21.

- Depending upon the feedback we receive, we may either host further discussion or present a draft rule at the next Network Adequacy Working Group meeting, to be scheduled.

Thank you.