AHIP Testimony
Nevada Interim Health Committee
July 17, 2019 Las Vegas, NV

Good Afternoon, Madame Chair and Members of the Committee:

My name is Sunshine Moore. I am Regional Director of State Affairs for America's Health Insurance Plans. Thank you for allowing us to present today on the value of health plan networks in the commercial market and how health plans work to provide Nevadans with access to high-quality care at lower cost through our networks.

AHIP is the national association whose members provide coverage for health care and related services. Through these offerings, we improve and protect the health and financial security of consumers, families, businesses, communities and the nation. We are committed to market-based solutions and public-private partnerships that improve affordability, value, access, and well-being for consumers.

I'll try not to repeat the same information you've heard from some of my colleagues already. I would like to provide some insight into how plans build and maintain adequate networks, the importance of networks and provider credentialing in ensuring patients have access to high-quality providers at lower costs, as well as some of the innovative ways health plans are developing networks that incorporate telehealth, value-based care, and quality metrics.

Networks have been a mainstay of private health insurance coverage for more than 35 years – providing consumers with access to a broad range of hospitals, physicians and other providers along with financial incentives for members to obtain medical care within the plan's network. Health plans include providers in their networks that meet standards set by established accrediting organizations to ensure consumers receive high-quality, effective care. Networks also enable plans to make care more affordable by negotiating lower prices within the network.

Health plans evaluate doctors and hospitals for quality and safety by ensuring facilities and providers meet patient safety goals and credentialing standards. Performance on quality measures is a key part of criteria used for provider selection and inclusion in a plan's network – including high-value networks, which we're going to talk about in a moment.

Provider performance is measured and evaluated based on consensus quality, patient satisfaction, and health outcomes measures developed by organizations such as the National Committee on Quality Assurance (NCQA) and the Agency for Healthcare Research and Quality (AHRQ). The strong emphasis on provider quality and effectiveness improves value for consumers.

Credentialing and periodic recredentialing allow consumers to have confidence that the providers in their network have been carefully vetted for inclusion in the health plan contract. Our processes generally look at:

- Academic background;
- Relevant professional training;
- Clinical privileges;
- Licensure;

- Board certification and/or registration in a specific healthcare field, which is a voluntary designation that goes beyond licensing and requires providers to keep up with the latest medical advances in their field;
- DEA or Controlled Dangerous Substances certifications, this can be helpful in knowing which of the physicians in our network are DEA-waivered to prescribe Medication Assisted Treatment for substance abuse, for example
- Any actions taken against the provider's license, or other sanctions, disciplinary actions, felonies, or consumer complaints;
- Liability and malpractice insurance;
- Malpractice history; and,
- Professional competence.

Health plans may also include a site visit to ensure proper medical record keeping, accessibility, or compliance with medical privacy practices. This process may be repeated at least every three years to update appropriate information and ensure providers still meet high quality standards.

Health plans may also be required to meet specific credentialing requirements. Medicare Advantage plans, for example, have a certain set of criteria for provider credentialing. All QHPs on the exchanges must be accredited, and those accreditation standards include both network adequacy and provider credentialing. In the Medicaid space, the "mega-reg" reinforces the importance of credentialing and recredentialing by extending the requirement regarding the selection and retention of network providers to include behavioral health and long-term services and supports.

URAC and NCQA are two such nationally recognized accreditation bodies that have robust standards for network management, including:

- Consumer complaint and appeals processes,
- Quality assurance and improvement programs,
- Ongoing monitoring to ensure networks are meeting enrollees' clinical needs,
- Timely access to care, such as regular appointments, urgent care appointments, and after-hours care, and, 24/7 member services lines.

Over the years, health plans have worked together with providers to streamline this process and many vendors on the market offer solutions that reduce the administrative burden and timeline associated with credentialing and recredentialing. These companies aim to minimize the data gathering and verification process to improve efficiency and speed up total completion times, but many players are involved in the process and so we all try to work together to ensure back and forth communication and timely responses.

In addition to quality standards and provider credentialing, there are three key factors health plans keep in mind when developing their networks – flexibility, choice, and affordability.

The DOI and DHCFP have already provided you with an overview of the minimum standards health plans have to meet to ensure networks are adequate. But beyond the minimum number,

type, and location of providers, a health plan's network also depends on the product design the employer or the consumer chooses to purchase.

So an HMO, for example, includes designation of a primary care physician and a general requirement that enrollees seek care from in-network providers. Out-of-network care is generally only covered in emergency situations or through an exceptions request for complex cases where an appropriate in-network provider isn't available.

In a PPO, enrollees do not have to select a primary care physician (although many choose to have a main doctor they prefer to see), and they may seek care in-network or out-of-network but their out of pocket costs are lower when they choose in-network providers. Because the network tends to provide more flexibility and choice for the consumer and because there is so much price variation among providers and facilities even within the same geographic location, PPOs can often be more expensive than HMOs, where the network is more limited and consumers – for the most part – are staying in-network. This can make costs lower or more predictable, but the trade-off is that the network may not be as broad or the consumer may not have as much flexibility.

Health plans have developed ways to incent and reward high-quality, lower cost providers by developing tiered networks or high-value networks. In these products, consumers may have multiple providers or facilities in their network for a given service, but there is a lower co-pay associated with the lower cost providers. They can still choose to go the other provider, who is still in the network, but the co-pay may be slightly more. Premiums also tend to be lower, which saves costs for the employer or family choosing that product. With rising health care costs, purchasers are extremely price sensitive. Numerous surveys have found that health care shoppers appreciate the option to select a plan that has a lower premium with a smaller network that still meets all of the standards required for network adequacy or to select a plan that has a broader network or perhaps a specific doctor or hospital that they prefer even if it may mean a higher monthly premium. So tiered networks are another way health plans balance flexibility, choice, and affordability. And it's also a way for health plans to compete, which is also good for consumers and helps contain costs.

There are many other ways that health plans are working together with providers to meet specific health care challenges – we don't have time to go through all of them, but rural access to care, for example. Plans are incorporating telehealth products and services, using teams of clinicians to better coordinate care for patients across the spectrum of health care needs, and building out networks with non-traditional sites of care, such as urgent care centers and retail clinics.

In closing, I hope we have helped shed some light on the robust state and federal requirements with which health plans comply to meet network adequacy as well as the innovative ways that health plans work to provide consumers with affordable, high-quality networks of providers, both tailored, high-value networks at lower cost as well as more traditional, broader networks for those who value choice and flexibility even if it means slightly higher costs.

Again, thank you so much for having me here today and I'm happy to take your questions.