ANALYSIS OF HOUSE BILL 2864

Requiring health carrier access plans.

SPONSORS: Representatives Dyer and Backlund.

PURPOSE: To require health carriers to maintain access plans for health care networks.

BACKGROUND: The meaning of managed care varies among private and public purchasers, patients, carriers, and regulators. Although the term is referenced in no less than sixteen sections of state law, a statutory definition is lacking. The Insurance Commissioner defines "managed care plan" in recently adopted rules as a "...plan that coordinates the provision of covered health care services to a covered person through the use of a primary care provider and a network." [WAC 284-43-130 effective 2/22/98] For a recently held legislative training session on the subject, the term was defined as "approaches to health services delivery and benefit design that integrate management and coordination of services with financing to influence utilization, cost, quality, and outcomes."

Although group and staff managed care organizations (MCO's), e.g., health maintenance organizations (HMO's), date back to the late 1920's, the real growth in managed care started in the 1970's; while MCO's had around six million enrollees in 1976, it is estimated that over 100 million Americans are enrolled in some form of managed care today.

In recent years, increasing pressure has been on MCO's from private and public purchasers to control costs, which has met with a corresponding focus among enrollees and providers to assure quality and choice. The confluence of these vectors has resulted in a land-office business of quality assurance activity. The National Committee on Quality Assurance (NCQA), the Utilization Review Accreditation Committee (URAC), the National Association of Insurance Commissioners (NAIC) and other organizations have been actively developing standards to accredit MCO's based on quality measures. Although these activities have had an impact on managed care delivery, they are best described as works in progress in a stage of revision.

Presently, there is no specific state statute setting forth network adequacy or access plan requirements. However, federal law requires certain quality assurance standards for the state Medicaid Healthy Options program, and the Insurance Commissioner has recently adopted rules on this subject, which take effect February 22, 1998 [attached herein]. For statutory authority, the Commissioner has used a series of broad regulatory provisions, e.g., "The commissioner may ... make reasonable rules and regulations for effectuating any provision of this code. ..." [RCW 48.02.060] "Every health care service contractor shall file ... a master list of the participating

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providers with whom or with which such health care services contracts has executed contracts. [RCW 48.44.080]; Health maintenance organizations must demonstrate that its facilities and personnel are reasonably adequate to provide comprehensive health care services to enrolled participants. [RCW 48.46.030(5)]

If adopted, HB 2864 would, for the most part, preempt existing related state statutes and corresponding rules regarding access plans.

SUMMARY:

As of July of this year, each carrier must maintain and annually update an access plan for each of its health care networks, which shall provide certain proprietary information to any interested party upon request.

The access plan must be prepared prior to the offering of a health plan with a substantially different health care network.

The plan must include, at least:

The network of providers and facilities by license, certification or registration type and geographic location;

The process for monitoring and assuring on an ongoing basis the sufficiency of the provider network to meet the covered health care needs of its enrolled population; and

The methods for assessing the health care needs of covered persons and their satisfaction with services.

OIC HEALTH CARE NETWORK AND ACCESS PLAN RULES

(Effective February 22,1998)

WAC 284-43-200 Network adequacy. (1) A health carrier offering a managed care plan shall maintain each plan network in a manner that is sufficient in numbers and types of providers and facilities to assure that all health plan services to covered persons will be accessible without unreasonable delay. In the case of emergency services, covered persons shall have access twenty-four hours per day, seven days per week. The carrier's service area shall not be created in a manner designed to discriminate against persons because of age, sex, family structure, ethnicity, race, health condition, employment status, or socioeconomic status. Each

carrier shall ensure that its networks will meet these requirements by the end of the first year of operation; or, for those plans already in existence, within six months after the effective date of this rule.

(2) Sufficiency may be established by the carrier with reference to any reasonable criteria used by the carrier, including but not limited to: Provider-covered person ratios by specialty, primary care provider-covered person ratios, geographic accessibility, waiting times for appointments with participating providers, hours of operation, and the volume of technological and specialty services available to serve the needs of covered persons requiring technologically advanced or specialty care. Evidence of carrier compliance with network adequacy standards that are substantially similar to those standards established by state agency health care purchasers (e.g., the state health care authority and the Department of Social and Health Services) and by private managed care accreditation organizations may be used to demonstrate sufficiency.

(3) In any case where the health carrier has an insufficient number or type of participating providers to provide a covered health care service, the carrier shall ensure through referral by the primary care provider or otherwise that the covered person obtains the covered service at no greater cost to the covered person than if the service were obtained from network providers and facilities, or shall make other arrangements acceptable to the commissioner.

(4) The health carrier shall establish and maintain adequate arrangements to ensure reasonable proximity of network providers and facilities to the business or personal residence of covered persons. In determining whether a health carrier has complied with this provision, the commissioner will give due consideration to the relative availability of health care providers in the service area under consideration and to the standards established by state agency health care purchasers.

(5) A health carrier shall monitor, on an ongoing basis, the ability and clinical capacity of its network providers and facilities to furnish health plan services to covered persons.

WAC 284-43-210 Network reporting requirement and access plan. Beginning January 1, 1999, health carriers shall file with the commissioner an access plan meeting the requirements of this subchapter for each of the managed care plans that the carrier offers in this state. The health carrier shall make the access plans available on its business premises and shall provide them to any interested party upon request. The carrier shall prepare an access plan prior to offering a new managed care plan, and shall update an existing access plan whenever it makes any material change to an existing managed care plan. The access plan shall contain at least the following:

(1) A description of the health carrier's network of providers and facilities by license or certification type and by geographic location;

(2) The following provision is a restatement of a statutory requirement found in RCW 48.43.095 (1)(c) included here for ease of reference: "A full description of the procedures to be followed by an enrollee for consulting a provider other than the primary care provider and whether the enrollee's primary care provider, the carrier's medical director, or another entity must authorize the referral";

(3) A description of the health carrier's process for monitoring and assuring on an ongoing basis the sufficiency of the network to provide covered services that meet the health care needs of populations that enroll in managed care plans;

(4) A description of the health carrier's efforts to address the needs of covered persons with limited English proficiency and literacy, with diverse cultural and ethnic backgrounds, and with physical and mental disabilities;

(5) A description of the health carrier's methods for assessing the health care needs of covered persons and their satisfaction with services;

(6) A description of the health carrier's method of informing covered persons of the plan's services and features, including but not limited to, the plan's grievance procedures, its process for covered persons choosing and changing providers, and its procedures for providing and approving emergency and specialty care including the following restated statutory requirements found in RCW 48.43.095 (1)(e), (f), and (i)

included here for ease of reference: "Procedures, if any, that an enrollee must first follow for obtaining prior authorization for health care services. . ., and. . .description of any reimbursement or payment arrangements, including, but not limited to, capitation provisions, fee-for-service provisions, and health care delivery efficiency provisions, between a carrier and a provider. . ., and. . .Descriptions and justifications for provider compensation programs, including any incentives or penalties that are intended to encourage providers to withhold services or minimize or avoid referrals to specialists";

(7) A description of the health carrier's system for ensuring the coordination and continuity of care for covered persons referred to specialty providers, for covered persons using ancillary services, including social services and other community resources, and for ensuring appropriate discharge planning;

(8) A description of the health carrier's proposed plan for providing continuity of care in the event of contract termination between the health carrier and any of its participating providers and facilities, or in the event of the health carrier's insolvency or other inability to continue operations. The description shall explain how covered persons will be notified of the contract termination, or the health carrier's insolvency or other cessation of operations, and transferred to other providers in a timely manner; and

(9) A description of the health carrier's strategy for integrating public health goals with health services offered to covered persons under the managed care plans of the health carrier, including a description of the health carrier's good faith efforts to initiate or maintain communication with public health agencies.

(10) A description of the health carrier's methods for assessing the health status of its covered persons including a description of how the carrier incorporates findings of local public health community assessments.

With respect to the above required elements of an access plan, each carrier shall provide sufficient information to allow the commissioner and consumers to determine the extent of a carrier's efforts. For example, if a carrier makes little or no effort to coordinate health plan services with public health goals, then the carrier shall report that it does not coordinate services with public health goals.

WAC 284-43-220 Network reports--Format. Beginning January 1, 1999, each health carrier shall provide a description of each of its networks to the commissioner. In describing its network, each carrier shall include an explanation of its established access standards, noting the criteria used to measure the standards. For example, a carrier should indicate whether travel distances or driving times are used to determine accessibility. In addition, each carrier shall indicate which providers are classified as primary care providers, obstetric and women's health care providers.

(1) Beginning January 1, 1999, each health carrier shall provide the insurance commissioner with:

(a) An annual electronic or hard copy paper report of all participating providers by managed care plan and monthly updates. This report shall contain all the data items shown in the table. (Form A.) Filing of this data satisfies the reporting requirements of RCW 48.44.080 and the requirements of RCW 48.46.030 relating to filing of notices that describes changes in the provider network.

(b) An annual electronic or hard copy paper report indicating the total number of covered persons who were entitled to health care services during each month of the year, excluding nonresidents, by line of business, by product (with identifying form number filed with this office, if appropriate), by county, and by sex. The report shall conform to the table. (Form B.)

(2) In addition to the provider and covered persons reports, each carrier shall file annual reports meeting the standards below and shall update the reports whenever a material change in a carrier's provider network occurs that significantly affects the ability of covered persons to access covered services. Each carrier shall file for each managed care plan, using a network accessibility analysis system, such as GeoNetworks or any other similar system:

(a) A map showing the location of covered persons and primary care providers with a differentiation between single and multiple provider locations.

(b) An access table illustrating the relationship between primary care providers and covered persons by county, including at a minimum:

(i) County.
(ii) Total number of covered persons.
(iii) Total number of primary care providers.
(iv) Number of covered persons meeting the carrier's self defined access standard.
(v) Percentage of covered persons meeting the carrier's self defined access standard.
(vi) Average distance to at least one primary care provider for its covered persons.
(c) A list indicating alphabetically by county and by city:
(i) County;
(ii) City;
(iii) Total number of covered persons;
(iv) Total number of primary care providers;
(v) Total number of obstetric and women's health care providers;
(vi) Total number of specialists;
(vii) Total number of nonphysician providers by license type;
(viii) Total number of hospitals; and
(ix) Total number of pharmacies.

(3) A carrier may vary the method of reporting required under subsection (2) of this section upon written request and subsequent written approval by the commissioner after a showing by the carrier that the carrier does not use or does not have easy access to electronic or data systems permitting the method of reporting required without incurring substantial costs.