

COMMISSIONER OF SECURITIES & INSURANCE

MONICA J. LINDEEN
COMMISSIONER



OFFICE OF THE MONTANA
STATE AUDITOR

July 16, 2014

Representative Joseph R. Pitts
Congress of the United States
House of Representatives
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515-6115

Dear Representative Pitts,

Thank you again for inviting me to testify at the subcommittees hearing on June 12, 2014. I appreciated the opportunity.

Please find my written responses to committee member's written questions below:

From the Honorable Michael C. Burgess:

1. *In plan year 2014, Montana had three carriers in your exchange. As you look at plans that will be offered in 2015, how are you ensuring that plans have an adequate number of physicians in each specialty, or subspecialty? And what do you consider "reasonable access" for non-urgent care?*

Ensuring that Montanan's have reasonable access to specialists and non-urgent care:

In 2013, the Montana legislature amended existing statutes regarding network adequacy for PPO plans. The new law sets the following standard: insurers who have contracted with 80% of healthcare providers in the state and 90% of hospitals and other facilities are "deemed" to have an adequate network. Below that threshold, the insurance commissioner may determine a network to be adequate. All of the major health insurers in this state are at, near or well above the 80% threshold for physicians and the same for the 90% threshold for facilities. In 2015, we expect to have 4 insurers operating in the FFM. We have numerous other insurers in the employer group market, all of whom are also held to this standard.

Montana also has rigorous standards for HMO network adequacy; however, there are few, if any, HMO plans offered in Montana at this time.

Access to specialists

My staff is currently working on administrative rules that provide additional protections for consumers and also further defines and refines the review my office performs regarding network adequacy. For instance, one of the proposed rules specifies that if a particular network does not have a specialist available within a reasonable distance, the insurer must pay the claim as if it were in-network.

Reasonable access

Montana is a very rural state, with large distances and a sparse population. Therefore, when reviewing networks for adequacy, I must consider geographic barriers, typical travel patterns and availability of healthcare providers in certain areas. Therefore, determining "reasonable access" for non-urgent care is not a simple process. However, my staff and I take the issue of provider access very seriously and work hard to ensure the best possible access to care for Montana consumers, including access to care out-of-state when necessary.

Another important component of access and network adequacy is consumer education. In all of our consumer outreach efforts and in the extensive training that my staff has done with agents and other assisters, we stress the importance of evaluating the insurer's network and the consumer's medical needs **BEFORE** they choose a plan. Our network adequacy review now includes a review of the insurer's provider directory in order to ensure that it is complete, transparent, and easy to understand and access.

2. *Are you seeing plans narrow their networks further for plan year 2015?*

No. All of the plans sold on the FFM in Montana are offered in all parts of the State. Two insurers offer a more restricted network option in two cities only--the only two cities that have two hospital systems. These narrower network plans offer lower premiums and richer benefit packages. However, there are plenty of other options available in those two cities that have no network restrictions.

3. *One issue that has been raised to me is that it does not appear insurance plans differentiate subspecialties when evaluating a specialty area. For example, in Dermatology CMS recognized six sub-specialties, one of which is Mohs surgery, which is used to treat skin cancer. How do you ensure enough subspecialties providers are in a network and how do certify they are adequately trained to provide the subspecialty service?*

It is true that "subspecialties" are not really part of the adequacy analysis in Montana at this point in time and most insurance plans only identify "specialists." However, I am not sure how many "subspecialists" are even practicing medicine in the state of Montana. Some of this type of care would be sought "out of state," which is why we educate consumers on the need to evaluate how a particular health plan will reimburse for services received out- of-state. Also, the rule discussed above concerning reasonable access to specialist care would include subspecialists. If access to a subspecialist is medically necessary and one is not reasonably accessible "in network," the plan would have to reimburse the same as if the care was provided "in network."

The issue of adequate training for subspecialty services would be addressed during the credentialing process, which is part of the provider contract. State insurance regulators do not generally have control over the contracts between health care providers and insurers.

4. *There is a trend for insurance companies to acquire hospitals and clinics to provide medical services for their enrollees. How would such an arrangement affect MLR calculations?*

Staff-model HMOs and other insurers that own or control entities that directly provide health care services to plan enrollees typically will maintain the part of the company that provides health care as a separate legal entity which it reimburses for medical care provided, often on a capitated basis. This reimbursement, whether capitated or fee-for service, would cover the health care provider's direct costs of patient care and any administrative and overhead expenses associated with the provision of that care, just as it would if it were coming from an unrelated payer. All of these reimbursements, which include the provider's administrative expenses, would be included in the numerator of the MLR calculations as claims costs. To the extent, however, that the provider is billing the insurer for administrative functions performed on its behalf of the insurer that are unrelated to direct patient care, those expenses do not qualify as medical care and would be excluded from the numerator. This would be the case regardless of whether the provider is owned by the insurer or is an unaffiliated provider providing services under a contractual arrangement, however.

Question from the Hon. Jim Matheson:

1. *You come from a large rural state, much like mine. I am concerned about accounts I have read about the narrowing of provider networks that is occurring*

and how that might impact patients access to care. While this would likely be more acute in states like ours, I know that it is not just limited to rural states.

When you think specifically about the unique needs of rare disease patients and the challenges associated with accessing care, particularly specialists, you can understand that this could be a big problem for these patients. What are you doing in your capacity as Insurance Commissioner to ensure that these patients are not left out in the cold when so few treatment options are available to them from the start?

Montana has not yet seen a proliferation of "narrow" networks and the rules I am proposing would limit that as an option for health plan issuers. In addition, the proposed rule addresses the issues of reasonable access to specialists, as discussed in the answers above.

The unique needs of rare disease patients living in Montana often must be addressed by seeking care from out-of-state specialists and facilities. All of our health insurers have out of state networks; however, some of those out-of-state networks meet the needs of certain patients better than others. Individuals with special medical needs must be savvy health insurance shoppers. As mentioned above, my staff and I address that issue through consumer education and training of enrollment assisters and producers. We stress the need for consumers to research insurers' provider networks, in-state and out-of-state, before deciding which health plan to purchase. We also emphasize research on the insurer's drug formulary. We often partner with consumer advocacy groups, such as the cancer association to deliver that education and training. My consumer education efforts include a website dedicated to health insurance issues.

In addition, when there is a dispute about coverage for a particular medical procedure, we assist consumers with appeals and other types of claim resolution issues every day, and usually very successfully.

1. *(From the Hon. Michael Burgess): What happens when an insurer buys a doctors group? Do administrative costs get transfer to the clinical side?*

Please refer to the answer to Question 4 above.

1. *(From the Hon. Lois Capps): Have you done anything that has been working to broaden the networks that you could share?*

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Please refer to the discussion above about Montana's amended PPO network adequacy laws, the current network adequacy reviews conducted by my office and the discussion on the administrative rules on network adequacy that I am proposing.

1. *(From the Hon. Gene Green): Would you provide the committee with some specific changes or reforms you would recommend making to the ACA to improve the law?*

a) Change or eliminate the "affordability" test for employer coverage.

b) Modify the employer responsibility requirement; for instance, allow employers to offer coverage to dependents, but don't require the offer to bar access to tax credits on the exchange if dependents choose individual coverage instead of the employer's health plan.

c) Allow individual policyholders who don't qualify for tax credits to receive tax deductions, similar to what they would receive under a cafeteria plan in an employer group health plan.

Please feel free to contact me, if you have further questions on these topics.

Sincerely,

A handwritten signature in blue ink, appearing to read "Monica J. Lindeen". The signature is fluid and cursive, written over a light blue horizontal line.

Monica J. Lindeen
Commissioner of Securities and Insurance