# Finding Common Ground: Network Adequacy Principles

One of the significant ways the success of the Affordable Care Act will be determined is by how well currently and newly insured Americans are able to access a range of service providers in a timely manner. Traditional network adequacy standards focus on accessibility – how far people must go to receive treatments – but rarely address other key issues, including affordability, quality of care and transparency.

Given that provider networks will have wide-ranging implications for consumers, we suggest the following principles to unite consumer groups in their advocacy for robust network adequacy standards that ensure affordable access to the highest quality providers.

**Accessibility –** Having an insurance card does not guarantee access to care if consumers are unable to get to health care facilities that meet their needs. Clear and specific access standards should be set to ensure consumers are able to get needed care in a timely manner. These standards could include: number and type of providers in the network, time and distance standards for services, and appointment waiting times.

**Availability –** Health plans should be held accountable for providing access to all covered services. Now that the essential health benefit (EHB) is set as a benchmark package of benefits, health plans have the responsibility to maintain provider networks that are large enough to deliver services in the EHB's 10 benefit categories.[1] Furthermore, it is crucial to have robust requirements on the inclusion of essential community providers (ECPs) that have experience delivering care to millions of Americans from low-income families and underserved communities, many who will enter the health care system for the first time as a result of the ACA coverage expansions.

**Affordability –** Robust network adequacy should not result in unaffordable health insurance costs. While there is no gold standard for defining precisely what is affordable, one helpful metric is to determine what percentage of income a household can devote to health care while still having sufficient income to address other necessities. Insurers build narrow networks in an attempt to reduce premiums.[2] However, narrow networks work only if they deliver cost effective and high quality care.[3] Since many health insurance plans on the market today have high cost sharing, any measure of affordability should account for out-of-pocket costs along with premiums.

**Quality –** Consumers win when the providers included in the network are held to high standards of quality to participate in the plan. A high performance network also has the potential to deliver quality care at lower cost. When making decisions about network inclusion, it is important that health plans consider not just providers' costs, but also the quality of their services. Consumer Assessment of Healthcare Providers and Systems (CAHPS) and/or other consumer feedback data could be used to assess overall quality and accessibility of networks.[4] Health plans could also measure providers by using the Quality

Performance Standards that the Centers for Medicare and Medicaid Services set for Accountable Care Organizations.[5] Another approach could be to offer incentives to providers that deliver high quality care at lower costs.[6]

**Transparency –** Provider networks need to be exceptionally clear to consumers, so people can make informed decisions in choosing health plans. To ensure that consumers have the ability to determine which providers are in the network and which are accepting new patients, health plans should provide consumers with up-to-date and consumer-friendly information on networks. For example, this information could be accessible online and in hard copy, easily to understand and accessible to people with low literacy, limited English proficiency and disabilities. In addition, it is important to properly design a data collection system to monitor health plans' compliance with network adequacy standards and make this data available to the public.

**Authored by,**
**QUYNH CHI NGUYEN, PROGRAM & POLICY ASSOCIATE**

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[3] Ibid.

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