



Network Adequacy: What Advocates Need to Know

Introduction

Network adequacy refers to the ability of a health plan to provide enrollees with timely access to a sufficient number of in-network providers, including primary care and specialty physicians, as well as other health care services included in the benefit contract.¹ In addition to expanding health insurance coverage for millions of people, the Affordable Care Act (ACA) also requires that health plans participating in Marketplaces must meet network adequacy standards. These criteria ensure that consumers have access to needed care without “unreasonable delay.”² Because the essential health benefit (EHB) package requires a minimum level of benefits for all health plans, enforcing and strengthening the adequacy of provider networks will be the next critical step in determining how easily consumers can access a covered benefit.

This brief provides an overview of network adequacy requirements outlined in the ACA for qualified health plans (QHPs) and other standards applied in private insurance markets, Medicaid, and Medicare. We also recommend key issues for advocates to consider when advocating for strong network adequacy standards for QHPs in Marketplaces.

ACA network adequacy requirements for QHPs

The ACA directed the U.S. Department of Health and Human Services (HHS) to develop criteria to certify health plans sold in Marketplaces. These criteria³ aim to ensure:

- a sufficient choice of providers;
- an inclusion of essential community providers (ECPs) to serve predominately low-income and medically underserved individuals; and
- the availability of providers to new patients

HHS issued final rules in March 2012 elaborating on the ACA requirements, and giving states considerable flexibility to establish their own standards. In order to ensure that all services can be accessed without “unreasonable delay,” the final rules required QHPs to have provider networks that are “sufficient” in number and types of providers, including those that specialize in mental health and substance use disorder services.⁴ However, there is no further clarification on what the terms “sufficient” or “unreasonable delay” mean, thereby leaving the implementation of specific standards either to insurers or to the states.

In terms of ECP inclusion requirements, regulators from states running their own Marketplaces are responsible for establishing minimum contracting standards based on states’ unique geographical and demographical factors.⁵ For Federally-facilitated (FFM) and Partnership Marketplaces, HHS set the minimum expectation that all participating health plans include at least 10 percent of all ECPs available in their service areas in their provider networks.⁶ However, it is important to note that in a letter to insurers dated in March 2013, HHS promised to consider

“factors and circumstances” that prevent them from meeting the minimum standard when evaluating their compliance.⁷ There is no further explanation of what these factors and circumstances should be. This suggests health plans were allowed to go below the ten percent minimum expectation, at least for the 2014 plan year.

QHPs also have to make provider directories available to enrollees both online and in hard copy upon request. These directories must clearly indicate if any providers are not available to new patients. However, HHS also leaves it to the states to assess insurers’ network adequacy and monitor plans for compliance once they are operating in Marketplaces.

Other Network Adequacy Standards Applied in Private Insurance Market and Public Programs

Most health plans in the private insurance market and public programs (such as Medicaid Managed Care and Medicare Advantage) are required to meet certain network adequacy standards. Although these standards vary between regulatory, accrediting, and contracting bodies at the state or federal level, they are generally based on how far people must travel to receive treatment.⁸

Health Plans in the Private Insurance Market

Most states have broad standards requiring health plans in the private insurance market to have a “robust” or “sufficient” network. To help states set network adequacy standards, the National Association of Insurance Commissioners (NAIC) developed the Managed Care Plan Network Adequacy Model Act #74 recommending the following criteria:⁹

- maximum number of enrollees per primary care and specialty providers
- geographic accessibility
- waiting times for appointments with participating providers
- hours of operation
- volume of technological and specialty services available to serve the needs of covered persons requiring advanced technology or specialty care

Although the Model Act, which has not been updated since 1996, applies to all managed care plans such as health maintenance organizations (HMOs), states could adopt it as a requirement for health plans to meet these standards.¹⁰ Currently, 20 states have network adequacy requirements for HMOs. However, only 8 states adopted NAIC’s Model Act.¹¹

In most states, the Department of Insurance (DOI) oversees network adequacy. In some states, the Department of Health (DOH) reviews plans’ network adequacy when an HMO applies for licensure or as part of an HMO quality assurance assessment.¹² However, during the review process before private insurance plans are sold, most states do little to assess their network adequacy. To the extent state regulators provide oversight, it is most commonly in response to consumer complaints.

Medicaid Managed Care Plans¹³

Medicaid managed care plans such as managed care organizations (MCOs) must meet a combination of federal and state requirements. According to federal Medicaid law¹⁴, each

Medicaid managed care plan has to provide timely access to all covered services, including in-network and out-of-network providers. These services must be available at all times, and include a range of preventive, primary, and specialty care services. In addition, managed care plans must maintain a provider network sufficient in number, type and geographic distribution.

Building on federal Medicaid rules, states develop contracts for MCOs with more detailed standards for access and availability to reflect the geographic and demographic diversity of the states. Though they vary across states, these standards often include:

- enrollees-to provider ratios
- travel time and distance to providers
- appointment availability standards
- in-office wait times for appointments

Because Medicaid MCOs are health care programs that receive federal funding, they must comply with any applicable federal nondiscrimination provisions.¹⁵ These provisions, such as the Americans with Disabilities Acts, Section 504 of the Rehabilitation Act, and Title VI of the Civil Rights Act of 1964 require that all health care programs receiving federal funding must account for the physical accessibility of participating facilities for enrollees with disabilities and cannot discriminate based on gender identity and sex stereotypes. They must also provide other services such as interpretation and translation for enrollees with limited English proficiency.

Medicare Advantage Health Plans¹⁶

The Center for Medicare and Medicaid Services (CMS) requires Medicare Advantage health organizations (MAOs) to have enough providers to ensure beneficiaries can have access to care within specific distances and timeframes.

To measure MAOs' network adequacy for each region of the country, CMS established provider network criteria¹⁷ for MAOs to meet as measured by:

- minimum enrollee-to-provider ratio
- maximum travel times to the closest provider
- maximum distances to a provider
- average number of enrollees in service areas

These criteria vary by types of specialty provider, health care facilities and county types (Large Metro, Metro, Micro, Rural or Counties with Extreme Access Considerations (CEAC)). Each MAO must demonstrate that 90 percent of its provider network meets the established distance and time requirements. CMS reviews a subset of MAO provider contracts at the time of application and regularly monitors beneficiaries' access to care.¹⁸ However, a health plan can request an exemption if it fails to meet these requirements.¹⁹ Similar to Medicaid MCOs, health plans participating in the Medicare Advantage program must comply with applicable federal nondiscrimination rules.

Key issues for consumer advocates to watch

There are no consistent network adequacy standards. Because standards set by the ACA are broad and general, they give states the opportunity to become more prescriptive by, for example,

limiting travel times, distances, and appointment waiting times. However, network adequacy should not only focus on issues of accessibility, such as how far consumers must travel to receive treatment. When setting network adequacy standards, states should encourage greater consumer protections by taking into account the issues of quality of care and affordability, including enrollees' out-of-network cost-sharing. We recommend consumer advocates focus on the following areas when advocating for stronger network adequacy.

1. Adopt in-network cost sharing levels for care that can only be obtained out-of-network to prevent unexpected and often prohibitively costly medical bills. When provider networks are inadequate, consumers may have no choice but to seek care outside their health plan's network. In those cases, insurers often require enrollees to pay a greater share of the cost for out-of-network care, and the insurer is not required to count those costs toward annual out-of-pocket maximums under the ACA. As a result, consumers may face thousands of dollars in charges by out-of-network providers. Consumers may also face extra charges due to "balance billing," in which providers charge the consumer for the balance of the cost that the insurer does not pay. To protect consumers from excessive medical charges, it is important that health plans arrange for consumers to receive timely and accessible care out of network at no extra cost when needed care is unavailable in network.

2. Require strong standards on the inclusion of ECPs to ensure timely access to health care for vulnerable populations. The majority of Marketplace enrollees will be low-income and racially diverse.²⁰ It is important that QHPs maintain a sufficient number of ECPs with experience providing quality care to consumers from diverse backgrounds and low-income families with the greatest health needs. ECP inclusion is especially crucial in states that will use Medicaid funds as premium assistance to purchase coverage in the Marketplace for individuals with income at 100 percent of the federal poverty level or lower.²¹ In addition, in a geographically large rural county, one health center located in a corner of the county may not be accessible for those who reside on the other side of the county. Low standards on ECP inclusion will fail to ensure reasonable and timely access to needed care for low-income and medically underserved individuals.

3. Implement nondiscrimination provisions to ensure consumers have access to health care that is culturally and linguistically appropriate. Advancing health equity is a major premise of the ACA. Network adequacy standards should include nondiscrimination provisions addressed in Section 1557 of the ACA as well as other applicable federal regulations including the Americans with Disabilities Act, Section 504 of the Rehabilitation Act, and Title VI of the Civil Rights Act of 1964. This is an important step to ensure timely access to trusted sources of care for racial and ethnic minorities, LGBT communities, and other vulnerable populations with the greatest health needs.

4. Apply network adequacy standards both inside and outside Marketplaces to eliminate adverse selection. The ACA does not impose network adequacy requirements on health plans outside the Marketplace. However, if network adequacy standards vary between plans outside and inside the Marketplace, it could potentially cause adverse selection, and result in significantly high health care costs for consumers who are not eligible for advanced premium tax credits.²² In many cases, consumers make their purchasing decisions based on their medical

conditions and the availability of providers that offer care within a network.²³ For example, a young and healthy consumer might be less concerned about the availability of specific providers, and therefore, elect to pay a lower rate for a plan with a narrower network.²⁴ However, an older consumer with pre-existing conditions probably opts to pay more for a plan with a broader network.²⁵ To minimize adverse selection, and ensure that all consumers have a minimum level of benefit coverage, states should set the same network adequacy standards across insurance markets.

5. Develop data collection systems to evaluate provider networks and monitor health plans' compliance with network adequacy standards. Because it is difficult for DOIs to assess provider networks before plans are sold, it is important to collect data on networks and access. The ACA (Section 2715A) requires insurers to report to HHS and state Insurance Commissioners on enrollees' cost-sharing and payments with respect to any out-of-network coverage. Insurers are also required to make such information available to the public. Although there is not yet further guidance on how these data should be collected and reported, this will be a critical tool to assess, on an ongoing basis, whether networks are too narrow.

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¹ The State Health Reform Assistance Network (August 2013). ACA Implications for State Network Adequacy Standards. http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2013/rwjf407486

² Ibid.

³ ACA §§ 1301, 1311(c), 1311(g)

⁴ 45 CFR § 156.230 and § 156.235

⁵ Ibid. footnote 1

⁶ Department of Health and Human Services (April, 2013). Letter to Issuers on Federally-facilitated and State Partnership Exchanges. http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2014_letter_to_issuers_04052013.pdf

⁷ Ibid.

⁸ National Committee for Quality Assurance (NCQA) (February 2013). Network Adequacy & Exchanges: How delivery system reform and technology may change how we evaluate health plan provider networks. http://www.ncqa.org/Portals/0/Public%20Policy/Exchanges&NetworkAdequacy_2.11.13.pdf

⁹ The National Association of Insurance Commissioners (NAIC) (June 2012). Plan Management Function: Network Adequacy White Paper. http://www.naic.org/documents/committees_b_related_wp_network_adequacy.pdf

¹⁰ Georgetown University Health Policy Institute: The Center on Health Insurance Reforms (May 2012). Plan Management: Issues for State, Partnership and Federally Facilitated Health Insurance Exchanges. <http://www.rwjf.org/content/dam/farm/reports/reports/2012/rwjf72891>

¹¹ Ibid.

¹² Ibid.

¹³ States have traditionally provided people Medicaid benefits using a fee-for-service system. However, in the past 15 years, states have more frequently implemented a managed care delivery system for Medicaid benefits. In a managed care delivery system, people get most or all of their Medicaid services from an organization under contract with the state. Almost 50 million people receive benefits through some form of managed care, either on a voluntary or mandatory basis. For more information, visit <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Managed-Care/Managed-Care.html>

¹⁴ C.F.R. § 438.207(a),(b)(1)(2)

¹⁵ National Health Law Program (September 2013). Network Adequacy in Medicaid Managed Care: Recommendations for Advocates.

¹⁶ A Medicare Advantage Plan is a type of Medicare health plan offered by a private company that contracts with Medicare to provide Part A and Part B benefits to Medicare beneficiaries. For more information, visit

<http://www.medicare.gov/sign-up-change-plans/medicare-health-plans/medicare-advantage-plans/medicare-advantage-plans.html>

¹⁷ The Center for Medicaid and Medicare Services (unknown date). 2011 CMS Medicare Advantage Network Adequacy Development Overview. http://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/downloads/2011_MA_Network_Adequacy_Criteria_Overview.pdf

¹⁸ Ibid. footnotes 7, 8 and 9.

¹⁹ Ibid.

²⁰ The Henry J. Kaiser Family Foundation (March 2011). A Profile of Health Insurance Exchange Enrollees. <http://www.kff.org/healthreform/upload/8147.pdf>

²¹ The Henry J. Kaiser Family Foundation (December 2013). Medicaid Expansion Through Premium Assistance: Arkansas, Iowa, and Pennsylvania's Proposals Compared.

<http://kaiserfamilyfoundation.files.wordpress.com/2013/12/8463-03-medicaid-expansion-through-premium-assistance-arkansas-iowa-and-pennsylvania.pdf>

²² Urban Institute (November 2013). Stabilizing Premium Under the Affordable Care Act: State Efforts to Reduce Adverse Selection. <http://www.urban.org/UploadedPDF/412961-Stabilizing-Premiums-Under-the-Affordable-Care-Act.pdf>

²³ The National Association of Insurance Commissioners (NAIC) (2011). Adverse Selection Issues and Health Insurance Exchanges Under the Affordable Care Act. <http://www.naic.org/store/free/ASE-OP.pdf>

²⁴ Ibid. footnotes 18 and 19

²⁵ Ibid. 18 and 19