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 meet network adequacy standards. These criteria ensure that consumers have access to needed care in a timely manner.[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 as outlined in the ACA for qualified health plans (QHPs) as well as 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 marketplace QHPs.

Federal 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 criteria[3] aim to ensure:

- Sufficient choices of providers;
- Inclusion of essential community providers (ECPs) to serve predominately low-income and medically underserved individuals; and
- Availability of providers to new patients.

While HHS releases annual guidance through the Notice of Benefits and Payment Parameters rule and Letters to Issuers participating in the Federally Facilitated Marketplace (FFM), which touch aspects of network adequacy, states have considerable flexibility to establish their own standards. For instance, QHPs are required to design provider networks that are "sufficient" in number and types of providers, including those that specialize in mental health and substance use disorder services, so enrollees can access covered services without "unreasonable" delay.[4] However, there is no explicit definition of the terms "sufficient" and "unreasonable delay," thereby leaving the implementation of specific standards either to insurers or the states.

The most recent federal guidance, released in early 2016, states that HHS intends to label each QHP network's breadth as compared to other QHP networks on HealthCare.gov and make this information available to consumers. In addition, despite the lack of minimum quantitative network adequacy thresholds, HHS will use quantitative time distance standards detailed in its Letter to Issuers in its review of QHPs on the FFM for 2017. Their review will focus on the

following specialties: hospital systems, dental providers (if applicable), endocrinology, infectious disease, mental health, oncology, outpatient dialysis, primary care and rheumatology.[5]

Other Network Adequacy Standards Applied in the 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.[6]

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. 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.[7] 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.

Recently, the National Association of Insurance Commissioners (NAIC) revised its Network Adequacy Model Act #74 to help states set network adequacy standards for all managed care plans. The revision – the Health Benefit Plan Network Access and Adequacy Model Act – contains many important consumer protections, including:

- Ensuring enrollees have access to covered services;
- Protecting enrollees from surprise medical bills from out-of-network providers at in-network facilities; and
- Ensuring provider directories contain necessary and accurate information.[8]

HHS encourages states to adopt NAIC's Network Adequacy Model Act provisions and associated standards to meet the needs of their residents.[9]

Medicaid Managed Care Plans[10]

Medicaid managed care plans such as managed care organizations (MCOs) must meet a combination of federal and state requirements. According to federal Medicaid law[11], 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 on 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; and
- 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.[12] These provisions, such as the Americans with Disabilities Act, 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 Plans[13]

The Centers 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 criteria[14] for MAOs to meet as measured by:

- Minimum enrollee-to-provider ratio;
- Maximum travel times to the closest provider;
- Maximum distances to a provider; and
- Average number of enrollees in service areas.

These criteria vary by types of specialty providers, 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.[15] However, a health plan can request an exemption if it fails to meet these requirements.[16] 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

Because the ACA's network adequacy standards are so broad, there is a lack of consistency among state standards especially as it relates to access standards like 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, but should also 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.[17] 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.[18] 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, Title VI of the Civil Rights Act of 1964 and the Mental Health Parity and Addiction Equity Act. 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.[19] In many cases, consumers make their purchasing decisions based on their medical conditions and the availability of providers that offer care within a network.[20] 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.[21] However, an older consumer with pre-existing conditions probably opts to pay more for a plan with a broader network.[22] 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.

Authored by,
QUYNH CHI NGUYEN, POLICY ANALYST

[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] HHS Notice of Benefit and Payment Parameters for 2017. https://www.federalregister.gov/articles/2016/03/08/2016-04439/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2017. 2017 Letter to Issuers in FFMs, https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2017-Letter-to-Issuers-2-29-16.pdf
[6] 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
[7] 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.
[8] Family USA (November, 2015). National Association of Insurance Commissioners (NAIC) Network Adequacy Model Act Summary of Key Provisions. http://familiesusa.org/sites/default/files/documents/Families-USA-NAIC-Network-Adequacy-Summary.pdf
[9] Department of Health and Human Services (February, 2016). Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2017. https://www.federalregister.gov/articles/2016/03/08/2016-04439/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2017
[10] 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
[11] C.F.R. § 438.207(a),(b)(1)(2)
[12] National Health Law Program (September 2013). Network Adequacy in Medicaid Managed Care: Recommendations for Advocates.
[13] 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
[14] 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
[15] Ibid. footnotes 7, 8 and 9.
[16] Ibid.
[17] The Henry J. Kaiser Family Foundation (March 2011). A Profile of Health Insurance Exchange Enrollees. http://www.kff.org/healthreform/upload/8147.pdf
[18] 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

[19] 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
[20] 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
[21] Ibid. footnotes 18 and 19
[22] Ibid. 18 and 19