COMMUNITY CATALYST

Finding Common Ground: Network Adequacy Principles

One of the significant ways the success of the Affordable Care Act (ACA) 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.

Timely access – 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, but are not limited to: geographic accessibility (i.e. time and distance); appointment waiting times (including ability to communicate with providers during non-typical office hours including after 5 p.m. and on weekends); office waiting time; timely access to life-threatening emergency care, including care for substance use and mental health emergencies; and emergency access to pediatric services and specialists.

Sufficient choice of providers – 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] It is important to develop criteria that measure provider capacity to ensure meaningful access to health care services for all enrollees regardless of their health status, race, gender, sexual orientation, disability, immigration status or age (with particular attention to pediatric age or older adults). The metric for determining appropriate numbers of providers should account for (1) the range of services offered by participating providers, (2) whether providers are accepting new patients, and (3) providers have the capacity to provide culturally and linguistically appropriate services. Each year the criteria should be reviewed and updated based on utilization patterns and clinical needs, and to account for provider capacity.

Affordability – Robust network adequacy should not result in unaffordable health insurance costs. While there is no gold standard for defining 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 feedback data, such as those from the Quality Rating System (QRS) could be used to assess overall quality and accessibility of networks.[4] Quality standards must focus on measures that matter most to patients and are presented in a way that is meaningful. Measures should also focus on outcomes and on reducing health disparities.[5]

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, easy 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. Lastly, it is important that a network's provider quality standards are meaningfully presented to consumers when choosing plans.

Authored by,
QUYNH CHI NGUYEN, POLICY ANALYST

---

[1] Community Catalyst (2013). Essential Health Benefits: Issues to Watch. http://www.communitycatalyst.org/resources/publications/document/EHB-Issues-to-Watch-Final-12-17-13-pdf.pdf

[2]McKinsey & Company (December 2013). Hospital Networks: Configurations on the exchanges and their impact on premiums. http://www.mckinsey.com/~/media/mckinsey/dotcom/client_service/healthcare%20systems%20and%20services/pdfs/hospital_networks_configurations_on_the_exchanges_and_their_impact_on_premiums.ashx

[3] Ibid.

[4] Sabrina Corlette (May 2013). PowerPoint Presentation: Quality Improvement and Quality Rating for Consumers: Opportunities for Exchanges. Presented at the National Health Insurance Exchange Summit. http://www.ehcca.com/presentations/hixsummit1/corlette_ms14.pdf Retrieved 01/29/2014

[5] Community Catalyst (2014). Comments on CMS-3288-NC: Patient Protection and Affordable Care Act; Exchanges and Qualified Health Plans, Quality Rating System (QRS), Framework Measures and Methodology. http://www.communitycatalyst.org/resources/comment-letters/document/CC_Quality_framework_Exchange_comments_FINAL.pdf