PennState

PENNSYLVANIA OFFICE OF RURAL HEALTH

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Insights

HEALTH INSURANCE NETWORK PROVIDER ADEQUACY:

Implications to Consumers for Access to Care

Network adequacy refers to a health plan's ability to deliver the benefits promised by providing reasonable access to in-network primary care, specialty physicians, and all services included under the terms of the contract. Health insurance carriers who offer a qualified health plan (QHP) on either a Federally Facilitated Marketplace (FFM) or a state-based marketplace are required to establish and maintain network adequacy and are subject to regulatory oversight to ensure they meet adequacy standards. However, insurers are generally able to define and adjust the number, qualifications, and quality of the providers in their networks. They may also limit the number of in-network providers to conserve costs or coordinate care. If an insurance plan's network is populated by an inadequate number of providers, consumers may experience limited access to needed care or incur costs if they seek care outside of the network.

Federal standards for network adequacy apply only to QHPs offered on the federal Marketplace (healthcare.gov). Standards differ for private insurance plans offered by employers and for state-based marketplaces, and those standards are typically regulated by state agencies. Consumers who receive their health insurance through a Medicaid or Medicare managed care organization (MCO) are subject to yet another set of standards which also are typically governed by state agencies. Currently, seventeen states and the District of Columbia operate their own state-based marketplaces, while the rest rely on healthcare.gov to connect consumers to insurance providers. Pennsylvania is one of the states that administers its own health insurance marketplace, Pennie,™ which was launched in November 2020. In 2022, 371,516 residents in Pennsylvania enrolled in a health insurance plan through Pennie.

What are the Standards of an Adequate Health Insurance Network?

By definition, insurance networks of qualified health plans must be "sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay." Federal statute also requires that essential community health care providers (ECPs) be included in the provider network, that network directories be kept up-to-date and readily available, and that out-of-network cost sharing be regulated. In 2023, the Centers for Medicare & Medicaid Services (CMS) resumed regulating quantitative time-and-distance minimum standards for QHPs in the federal marketplace and in 2024, CMS will begin regulating minimum standards for patient wait-times as well.

For providers to meet the standard of providing care without unreasonable delay, both federal and state statutes set minimum time-and-distance standards for patients to receive care from different provider types. Pennsylvania's time-and-distance regulations are generally more lenient than the federal standard. The PA code states that: "A plan shall provide for at least 90% of its enrollees in each county in its service area, access to covered services that are within 20 miles or 30 minutes travel from an enrollee's residence or work in a county designated as a metropolitan statistical area (MSA) by the Federal Census Bureau, and within 45 miles or 60 minutes travel from an enrollee's residence or work in any other county." Federal standards are a bit more stringent because their time-and-distance standards vary across different provider specialty types and across a more narrowly defined set of population densities.

Beyond these minimum quantitative standards, other network adequacy standards are vaguely worded by statute, leaving interpretation and enforcement to state agencies. More importantly, federal and Pennsylvania statutes do not mandate a minimum number of providers available in a given specialty area (i.e., a provider/enrollee standard ratio), which allows insurers to offer QHPs in the Marketplace that may have a shallow provider pool, especially among secondary and tertiary care providers. This may result in consumers being denied care or needing to go out-of-network to receive care, potentially incurring substantial costs.

In Pennsylvania, the Department of Insurance regulates provider network adequacy for health insurance plans offered through Pennie based

on laws enacted in 2001. Those twenty-year-old statutes do not include quantitative standards for appointment wait-times or availability of providers, which many neighboring states have adopted, and which will be included in the federal marketplace beginning in 2024. Maryland, for example, adopted new regulations in 2018 in which both quantitative wait-time standards (including for mental and behavioral health providers) and provider-to-enrollee ratios were included in network adequacy standards.

How Can Network Provider Adequacy Standards Be Improved?

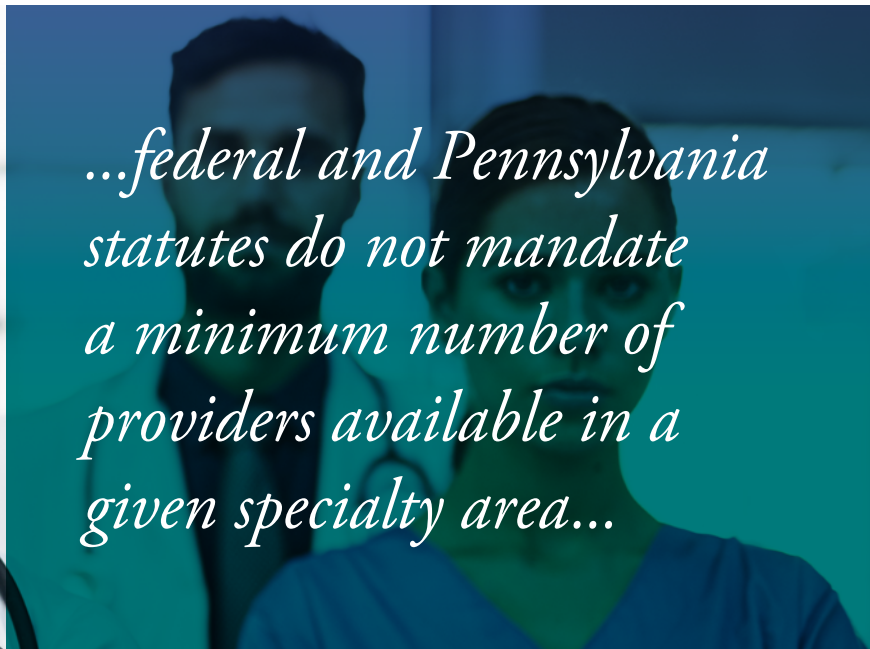
The majority of Americans receive their health insurance through their employer or through Medicare and Medicaid. Only a fraction of the population opts to enroll in a QHP through the federal Marketplace or a state-based exchange like Pennie. Employer-sponsored insurance plans sometimes feature broader provider networks than federal or state-based marketplace plans because increased competition among insurers can lead to more consumer-friendly outcomes. Conversely, Medicare and Medicaid MCOs are regulated by a more rigidly defined set of standards. Consumers who purchase their insurance either through a federal or state-based marketplace—approximately 16.3 million people nationwide in 2022—fall into a gap between those two options, where their provider networks tend to be narrower and the regulations less rigid.

In general, network provider adequacy suffers from the limitations of the standards themselves and a lack of real enforcement. The most significant issues with network adequacy standards include:

1. Time-and-distance standards require at least one participating provider be in proximity to most enrollees, but they do not assure that a sufficient number will be available.
2. While appointment wait-time standards do measure access to care, they typically apply to only three types of routine care, not to specialized or urgent care services. Mental and behavioral health services, in particular, are a specialty with long waiting lists and little meaningful availability in large and small communities. These providers will not be included in the new federal wait-time standards. Pennie, it's important to note, lacks these wait-time standards entirely.
3. There is a lack of quantifiable measurements for provider language and cultural competencies, accessibility for persons with disabilities, and access to specialized care for specified groups such as children, patients with chronic health conditions or other vulnerable populations.
4. Network adequacy statutes only nominally mention provider quality of care, and the term is not well-defined nor easily enforced. The only standards that are applied are quantitative and the provider's actual effectiveness is rarely factored into the scope of the network's offerings.
5. Marketplace enrollees do not have the right to switch plans between open enrollment periods if they find their network is too narrow, with rare exceptions. This is especially true in the spring of 2023, as emergency COVID-19 regulations that allowed for greater access to insurance marketplaces are discontinued by the federal government.

Network adequacy enforcement concerns include:

1. The minimum standards that CMS has issued for 2023-24 only apply to the FFM and not to the QHP networks in the seventeen states that operate their own Marketplaces. These state-based marketplaces can apply their own standards, which can be more or less robust than the CMS minimums.
2. Currently, health plans are not required to report how quickly providers schedule a visit for a patient. Although a health plan may be meeting the time-and-distance standards, the providers in the network could be heavily backlogged. Plans can present a network that appears adequate on paper, but has substantial access issues in reality.
3. Not every provider listed in a network provides services to a meaningful cohort of patients. Care may be concentrated among a small percentage of providers listed in a network, while others are only technically part of the network. For example, a recent report by the PA Coalition for Oral Health found that of the total number of general and specialist dentists participating in Medicaid in Pennsylvania in 2021, only 87.9 percent were billing over $10,000 a year. In some regions, the percentage of these "meaningful providers" was as low as 68.4 percent. In other words, the advertised



...federal and Pennsylvania statutes do not mandate a minimum number of providers available in a given specialty area...

provider network is often lacking nearly a quarter of its providers, exacerbating the challenges of access to health care, especially in rural areas.

4. While network provider data are subject to analysis by state agencies, the validity of the data is not verified.
5. Consumer complaints about provider issues are commonly treated as individual issues by insurers or regulatory agencies, and, as a result, network adequacy issues are not often flagged as such. This prevents network adequacy complaints from being aggregated and tracked in a way that would reveal deficits in a network and lead to meaningful reform.

A greater alignment of minimum standards is needed across states and different networks, including private insurers, federal or state-based marketplace plans or Medicare or Medicaid MCOs. The greater the number of available plans and regulations, the more difficult it is for consumers to understand their benefits and potential costs. Insurers that offer narrow network plans may leave consumers more likely to incur significant out-of-pocket costs. In Pennsylvania, it's critical that legislators update network adequacy regulations to ensure that, at a minimum, Pennie keeps pace with improving federal standards and comparable state-based marketplaces.

With Special Thanks To:
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RESOURCES

For Time and Distance Standards for QHPs, see Tables 3.1 & 3.2 in the CMS 2023 *Final Letter to Issuers in the Federally-facilitated Exchanges:* **cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2023-Letter-to-Issuers.pdf**

For a brief of Maryland's recently updated network adequacy standards, see: **mdpsych.org/wp-content/uploads/2018/07/Maryland-Network-Adequacy-Regulations_Issue-Brief-Jan-2018.pdf**

For the PA Oral Health Coalition's Access to Oral Health Workforce Report, see: **paoralhealth.org/wp-content/uploads/2022/05/PCOH-22-Workforce.pdf**

The National Association of Insurance Commissioners (NAIC): **content.naic.org**

The Kaiser Family Foundation: **kff.org**

Community Catalyst: **communitycatalyst.org**

The Center for Children and Families at Georgetown University: **ccf.georgetown.edu**

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