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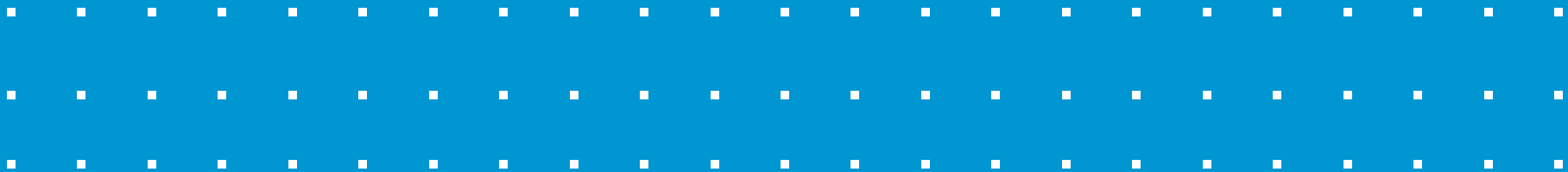
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Ensuring Patients Have Access to Timely Care in Medicaid and Private Insurance: The Role of Network Adequacy Requirements

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The Urban Institute

Founded in 1968 as a private, nonprofit corporation in Washington, D.C., the Urban Institute is nationally known for its objective and nonpartisan research and educational outreach on the nation's social, economic, and governance challenges. Through broad conceptual studies, program evaluations, and administrative and technical assistance, Urban helps public and private decision makers address these problems and strives to raise citizens' understanding of policy issues and trade-offs.



The Urban Institute's Health Policy Center

For nearly 40 years, Urban's health policy scholars have helped lawmakers understand the scope of the country's health care problems and costs, evaluated how public policies affect lives and communities, and provided insights about payment and service delivery reforms. Urban's research tools allow us to track and predict trends and outcomes rigorously and accurately. HPC researchers study employer-based coverage, Medicare and Medicaid, the health care safety net, and state and local initiatives to improve population health to help policymakers and decisionmakers address health problems in America.



50 researchers in Urban Institute's Health Policy Center

- Develop, maintain and use a health insurance policy simulation model to estimate the impact of major health coverage policies on health insurance coverage, costs for federal and state governments, and the impact on employers and consumers.
- Analyze data from major federal surveys to identify trends in health care coverage, costs, access, and quality.
- Collect and analyze qualitative data through case studies and conduct our own surveys to track health insurance coverage and health outcomes in real time.
- Provide technical assistance to state and local policymakers as they put policies and programs into practice.
- Study disparities in access to care—by race and ethnicity and socioeconomic status, across states, and between public and private insurance—identifying where gaps exist and how to close them.

Urban Institute Published Studies related to today's presentation

- Wishner, J and Marks, J, "Ensuring Compliance with Network Adequacy Standards: Lessons from Four States." Washington: Urban Institute (March 2017). <http://www.urban.org/research/publication/ensuring-compliance-network-adequacy-standards-lessons-four-states>
- Kenney, G, Gifford, K, Wishner, J, Forsberg, V, Napoles, A, and Pavliv, D, *Proposed Medicaid Access Measurement and Monitoring Plan*. Washington, Urban Institute, (August 2016). http://www.urban.org/sites/default/files/publication/88081/2001143-medicaid-access-measurement-and-monitoring-plan_0.pdf
- Wishner, J, Solleveld, P, Rudowitz, R, Paradise, J, Antonisse, L, *A Look at Rural Hospital Closures and Implications for Access to Care: Three Case Studies*. Washington: Kaiser Family Foundation (July 2016). <http://kff.org/medicaid/issue-brief/a-look-at-rural-hospital-closures-and-implications-for-access-to-care/>

Overview of Presentation

- What does it mean for a consumer to have an “adequate” provider network in a health plan?
 - What happens if a patient has to go out of network for care?
- History of regulating network adequacy: When and why did government get involved?
- Different types of regulatory approaches to network adequacy
- Network Adequacy in multiple coverage systems
 - Network Adequacy in Medicaid managed care
 - Network Adequacy in Private Insurance regulated by states
- Emerging Trends in Network Adequacy Regulation
- Observations from Network Adequacy Case Studies
- Ongoing Challenges in ensuring access to care
 - Rural health care access is particularly challenging

What is an “adequate” provider network?

- What does it mean for a consumer to have an “adequate” provider network in a health plan?
 - Fulfilling the goal of providing the right care at the right time
 - Making sure a patient can get her covered benefits
- Is a necessary provider available in network?
 - Primary Care Providers, specialists and subspecialists
- What if providers are in the plan’s network, but:
 - Far away from the consumer
 - Don’t take new patients
 - Consumers can’t get an appointment for a long time
- Network Adequacy standards are created to address these and other similar questions

What happens if a consumer goes out of network for care?

- Consumer may have to pay all costs of care or much higher out-of-pocket costs
 - Varies depending on the type of plan (e.g., “closed panel” HMO, PPO, tiered plans)
- Surprise Billing (balance billing)
 - Consumer reasonably assumes (incorrectly) provider is in network (e.g., emergency care, hospital specialists)
 - Gets hit with a bill for full fee (not a reduced fee negotiated with the insurer or public payer)
- Under ACA: Using out-of-network provider if enrolled in a qualified health plan (Exchange plan)
 - No cost-sharing subsidies available to consumer
 - Consumers’ payments aren’t counted for calculating caps on out-of-pocket spending

History of network adequacy regulation

- Private insurance used to cover care wherever consumer obtained it
- Late 1970's & 1980's: HMOs used in large employer market to help control costs:
 - employed or contracted with providers to develop their own managed care networks (usually closed networks)
 - Consumers and providers pushed back based on access problems
 - Advocated for "patients' bill of rights" including network adequacy
- 1996: NAIC model network adequacy law *for managed care plans*
- Large employers moved away from HMOs for awhile
- Recent years, greater reliance on selective or limited provider networks in insurance plans (costs more to use out-of-network providers, sometimes a lot more)

Different approaches to regulating network adequacy

- ***Qualitative standards***: language varies across jurisdictions
 - Establish an overall standard carriers must meet when designing provider networks
 - Must ensure “sufficient” # of providers and/or access within “reasonable” time or “without unreasonable delay”
- ***Quantitative standards*** vary as to both type and content
- Some states use ***a mix*** of qualitative and quantitative standards
- States have different systems for ***monitoring & enforcing*** standards
 - Some rely on carrier attestation of compliance
 - Some require network access plans
 - Some conduct independent analysis of quantitative standards (geoaccess maps)
 - Extent of monitoring/review varies – need agency resources to conduct extensive upfront review and ongoing monitoring

Different types of quantitative standards

- Maximum Time & Distance to travel to a provider
 - E.g., enrollees must have a provider w/in 30 miles or 30 minutes
 - Usually differentiate between urban and rural standards
 - different standards for primary care providers and specialty providers, including behavioral health providers (some states only address primary care providers)
- Minimum Provider-to-enrollee ratios
 - E.g., 1,500 enrollees to 1 primary care provider
 - Differentiate between urban and rural standards
 - Most frequently for primary care providers, but some states include specific types of specialists
 - Sometimes combined with time & distance standards
- Minimum percentage of providers accepting new patients
- Maximum wait times for an appointment
- Hours of operation requirements (e.g., evenings, weekends)

Network Adequacy in Multiple Systems

- Provider networks are “regulated” in multiple coverage systems
 - Large employers – through contracts with Third-Party Administrators (want to save money but ensure access)
 - Medicare Advantage plans (CMS oversees Medicare rules and has access to enrollment and claims data – large numbers participate so different than other systems)
 - Tricare (for uniformed services members & their families)
- Three areas where states have significant role
 - State (and potentially local government) employee plans – government *is* the large employer
 - Medicaid managed care
 - Private health plans regulated by state agencies

Medicaid Managed Care

- New federal Medicaid managed care regulations (2016) included new network adequacy standards & related provisions (with future effective dates) that address how states and managed care entities ensure timely and adequate access to services:
 - Require states to develop time & distance standards for specific types of providers, including for long-term supports and services to whom the beneficiary travels, if provided through managed care
 - Require managed care entities to document annually how they meet availability of service requirements
 - Did not include provider-to-enrollee ratios, maximum wait times for appointments or secret shopper standards, but states may include such requirements
- New Mexico (based on review of contracts 2 years ago) uses time & distance standards, provider-to-enrollee ratio for primary care providers, time-to-appointment standards, & requires MCO's to submit quarterly network adequacy reports to HSD

Individual Health Insurance Plans

- ACA established network adequacy standard for all QHPs:
 - Network of providers 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.”
 - Also required inclusion of a “sufficient number and geographic distribution of essential community providers, where available, to ensure reasonable and timely access to a broad range of such providers for low-income individuals or individuals residing in Health Professional Shortage areas. . . .”
 - CMS used a quantitative standard in the federal exchange to implement this requirement: must contract with at least 30 % of available ECPs (new policy is 20%)
- New Mexico’s Office of the Superintendent of Insurance has used quantitative standards in its network adequacy requirements and is currently in a process of revising those regulations (OSI representative will address specifics)

Emerging trends

- Use of common or similar standards for both managed care plans and health insurance plans
 - OSI's new network adequacy draft regulations address this
- Increasing use of quantitative standards
 - Time and distance standards and provider-to-enrollee ratios most common
 - Time to an appointment getting increasing attention but measuring and monitoring this is not as well developed (e.g., secret shopper audits)
- Greater focus on assuring accuracy of provider directories
- Recent federal efforts to align private insurance standards with public coverage standards (Medicaid, Medicare) where appropriate
- Increasing state efforts to address surprise billing
- Increasing focus on the nature and consistency of reporting by health plans on provider networks and access

Observations from Case Studies on Network Adequacy

- Quantitative standards & metrics help regulators evaluate network adequacy but some flexibility is needed to grant exceptions (e.g., no providers of a certain type in the area)
- Combination of standardized forms and individualized narratives help regulators evaluate network adequacy
- States vary in the extent to which they require carriers to change or supplement proposed provider networks
- States vary in their transparency about carrier network submissions and regulators' review and responses to those submissions
- More work is needed to strengthen systems for gathering (and educating consumers about submitting) complaints and grievances to monitor and identify current network adequacy

Ongoing Challenges

- Inaccurate provider directories
- Need more consumer education around networks
- Multiple carriers “count” the same providers to meet quantitative standards: a plan may look sufficient on its face, but some mechanisms may be needed to address the multiple counting of a provider by numerous health plans
- Underlying health care workforce shortages are a challenge that other policies will need to address (not insurance regulations)
- Insurance regulators report relying on consumer complaints and grievances to identify network adequacy problems, but:
 - Many regulators do not have organized systems for monitoring, summarizing and responding to this information
 - Consumers do not know about these systems or how to use them or choose not to use them

Rural Communities Present Unique Challenges

- Different types of rural communities – geographic, demographic, economic and cultural differences
- Health care workforce development will be limited (e.g., cannot have an oncologist in every community)
- Need to address transportation systems and needs
- Network adequacy standards may help, but cannot solve underlying rural health care access challenges
 - Regional and/or state planning to address rural health care needs & conduct community needs assessments
 - Policy decisions regarding investment in health care workforce and incentivizing professionals to work in rural communities
 - Assistance to local government leaders in understanding changing health care systems and help in negotiations with health care systems

Urban Institute/Kaiser Family Foundation Case Studies of 3 Rural Hospital Closures

Numerous findings in our study of 3 rural hospital closures but I wanted to conclude today with one in particular that supports your work in developing a Rural Health Care Plan for New Mexico:

“Regional planning efforts and technical assistance could help to educate and engage local residents, support assessments of community health care needs, improve the ability of communities to negotiate with large health systems, and promote integrated systems of primary care, referral centers for specialty care, and rational allocation of health care resources overall.”

Questions?

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