

ACA Implementation—Monitoring and Tracking

Ensuring Compliance with Network Adequacy Standards: Lessons from Four States

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With support from the Robert Wood Johnson Foundation (RWJF), the Urban Institute is undertaking a comprehensive monitoring and tracking project to examine the implementation and effects of the Patient Protection and Affordable Care Act of 2010 (ACA). The project began in May 2011 and will take place over several years. The Urban Institute will document changes to the implementation of national health reform to help states, researchers and policymakers learn from the process as it unfolds. Reports that have been prepared as part of this ongoing project can be found at www.rwjf.org and www.healthpolicycenter.org.

EXECUTIVE SUMMARY

Since the launch of the health insurance marketplaces under the Affordable Care Act (ACA), many health insurers have competed for customers by offering plans with narrow provider networks at lower costs than plans with broader networks. All marketplace health plans are required to provide their enrollees with access to covered services “without unreasonable delay,” but the increased reliance on narrow provider networks has raised concerns over whether consumers have timely access to needed health care. Previous studies have analyzed the different network adequacy standards states use to regulate provider networks; this study addresses the systems state regulators use to analyze, evaluate, and monitor compliance with network adequacy standards. These systems likely will become increasingly important. In February 2017, the Trump administration proposed to loosen federal network adequacy standards in the federal marketplace and delegate more responsibility to state regulators for network adequacy review. Some states may respond by adapting their network adequacy standards and systems to address the evolving nongroup market.

Regardless of what system emerges from the initiative to repeal and replace the Affordable Care Act, insurers are expected to continue to rely on narrow provider networks to compete for customers in the nongroup market.¹ With less federal regulation of the nongroup market, state regulation of network adequacy will become increasingly significant and more states may consider whether to increase their regulation and oversight of provider networks. As states consider how to ensure that

consumers get timely access to necessary care through increasingly narrow provider networks, this study offers some cross-cutting observations from four states with experience overseeing health plan compliance with network adequacy standards: California, Colorado, Illinois, and Nevada.

Collectively the four study states have many years of experience analyzing, monitoring, and enforcing network adequacy standards. Although their standards and systems for reviewing compliance with those standards differ, some common themes may provide lessons for policymakers and regulators nationwide:

- Quantitative standards and related metrics help regulators evaluate network adequacy, but regulators need flexibility in applying those standards.
- A combination of standardized forms and narrative submissions help regulators analyze network adequacy.
- States vary in the extent to which regulators require insurers to change or supplement proposed networks.
- States vary in their transparency about insurer network submissions and regulators’ review of those submissions.
- Challenges remain in assessing and monitoring network adequacy. These include
 - » ensuring the accuracy of provider directories,

- » addressing the needs of rural communities,
- » evaluating network adequacy when multiple plans count the same providers to meet state quantitative standards, and
- » strengthening the systems for gathering and using consumer complaints and grievances to monitor and identify current network adequacy problems.

As the nongroup market evolves, state standards and state regulators will become increasingly important in ensuring that health plans' provider networks meet the health care needs of their enrollees.

BACKGROUND

The Affordable Care Act has transformed the health insurance market and enabled millions of Americans to obtain coverage through qualified health plans (QHPs) in the marketplaces. During the 2016 open enrollment period, approximately 12.7 million people selected or were automatically re-enrolled in marketplace plans.² Under the ACA, insurers³ must include a broad array of essential health benefits in their plans and may not deny coverage or charge consumers higher premiums based on health status. Thus, insurers have had to find new ways—other than limiting benefits or charging higher premiums to people with pre-existing health conditions—to compete for market share. One method insurers have used to reduce premiums is to limit their provider networks and negotiate relatively lower reimbursement rates with the providers they include in those networks. Narrow provider networks may help lower costs, but they also raise the risk that consumers will not get timely access to the care they need. Moreover, consumers who go out-of-network to obtain coverage often face large medical bills and lose the advantages of the cost-sharing reductions and limits on out-of-pocket expenses that the ACA provides to make insurance affordable.

The emergence of narrow provider networks in the marketplaces has garnered significant attention and has led to increased interest in strengthening network adequacy standards at the national and state levels. Previous research addressed the history of narrow networks, the tensions inherent in regulating network adequacy in the marketplaces, the role of narrow networks in select states, and the role of new hospital networks in QHPs and related impacts on premiums.⁴⁻¹¹ This study focuses on the systems state regulators use to analyze, evaluate, and monitor compliance with network adequacy standards.

The use of selective provider networks began long before the ACA. The increased reliance on limited-network health maintenance organizations (HMOs) in the 1980s and early 1990s in employer-sponsored plans led to a call for minimum network adequacy standards in the 1990s. No national standard was adopted, but states began to regulate managed care plans,

and the National Association of Insurance Commissioners (NAIC) developed a model state network adequacy law for managed care plans.¹² Health plan networks broadened for a few years, but when premiums began to increase substantially, narrow networks reappeared in employer-sponsored plans as a mechanism to control costs.

Today, insurers are using narrow networks to gain leverage to negotiate lower reimbursement rates with health care providers and to move away from traditional fee-for-service payment models. Narrow networks also are emerging outside of traditional HMOs. Preferred provider organizations (PPOs), exclusive provider organizations (EPOs), and point-of-service (POS) plans are among the plan designs offered to consumers in the marketplaces.⁴ Tiered physician networks are also becoming more common; these networks sort providers into tiers based on quality and efficiency measures and require consumers to pay more to use providers in less preferred tiers.

Network adequacy standards vary considerably, with states using qualitative standards, a wide variety of quantitative standards, or some combination of both.⁴ Qualitative standards are worded differently across jurisdictions but establish a general standard for insurers to design networks providing plan enrollees with access to the health care they need. Qualitative standards use language such as “sufficient” and “reasonable” and may refer to “timely” access to providers, access to “covered” benefits, and/or different provider specialties to clarify that a given reference to “access” includes access to particular specialty care.

Such qualitative language can be interpreted differently in different contexts, giving regulators flexibility to address diverse markets and communities, but it also can be subjective and difficult to apply consistently. Thus, many states have required insurers to meet quantitative standards or recommended benchmarks to assess the adequacy of a provider network. Such standards include (1) minimum provider-to-enrollee ratios (e.g., one primary care provider for every 1,500 enrollees), (2) maximum travel time and/or distance to providers (e.g.,

enrollees should have access to a primary care provider within 30 miles or 30 minutes of their home), (3) a minimum percentage of contracted providers that are accepting new patients, (4) maximum wait times for an appointment with a provider, and (5) hours of operation requirements (e.g., plans must contract with a certain percentage of nonemergency providers that are available after normal business hours and/or on weekends).

The National Association of Insurance Commissioners Model Act

The 1996 NAIC Managed Care Plan Network Adequacy Model Act contained a broad qualitative network adequacy standard, provided that network sufficiency be determined by reference to “any reasonable criteria *used by the carrier* [emphasis added],” and required insurers to submit an “access plan” to the state insurance commissioner. The original Model Act only applied to managed care plans.

In November 2015, the NAIC revised the Model Act after an 18-month process involving diverse stakeholders and numerous drafts. The NAIC modified the language of the qualitative standard, applied the revised Model Act to a broader variety of health plans, and clarified that the insurance commissioner shall determine the sufficiency of a network by reference to “any reasonable criteria” that the commissioner (rather than the insurer) identifies. The NAIC declined to include mandatory quantitative standards in the revision, but the revised Model Act identifies specific quantitative criteria that the commissioner may use to determine sufficiency.¹³

Federal Network Adequacy Standards

The ACA established the first national network adequacy standard for the private health insurance market. The current standard for both state and federal marketplaces mirrors the qualitative standards contained in the original 1996 NAIC Model Act, requiring that all QHP issuers maintain a network of providers “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.”¹⁴ In addition, the ACA requires that each QHP ensure a “sufficient number and geographic distribution of essential community providers (ECPs), 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 ...”¹⁵ The Centers for Medicare & Medicaid Services (CMS) use a quantitative standard to implement the ECP requirement in the federally facilitated marketplace (FFM) by requiring QHPs to contract with at least 30 percent of available ECPs in a

service area, subject to a justification process if insurers attest that they are unable to meet that standard. Some state-based marketplaces (SBMs) follow the CMS standard, but some states, including California, have developed their own ECP standards.¹⁶

CMS initially proposed (but subsequently declined to adopt) maximum travel time and distance network adequacy standards for all QHPs for plan year (PY) 2017.¹⁷ But CMS applied quantitative network adequacy standards to QHPs in the FFM in both the 2016 and 2017 plan years; in 2017, QHPs in 28 FFM states were subject to these quantitative standards.¹⁸ In its 2017 Letter to Issuers in the Federally-Facilitated Marketplaces, the CMS Center for Consumer Information and Insurance Oversight (CCIIO) published the quantitative network adequacy criteria it uses to assess the adequacy of QHP provider networks in the FFM. Specifically, CMS published maximum travel time and distance network adequacy standards, which are broken out into a number of provider types (primary care, dental, endocrinology, infectious diseases, oncology—medical/surgical, oncology—radiation/radiology, mental health [including substance use disorder treatment], rheumatology, hospitals, and outpatient dialysis) and county types (Large, Metro, Micro, Rural, and “Counties with Extreme Access Considerations”).¹⁹ CMS reviews each plan’s data to “make sure that the plan provides access to at least one provider in each of the above-listed provider types for at least 90 percent of enrollees.”¹⁹ Insurers can offer justifications if they are unable to meet any of the quantitative standards.

Under the Obama administration, CCIIO published the 2018 Letter to Issuers in the Federally-Facilitated Marketplaces, which included the same quantitative network adequacy standards it applied in 2016 and 2017.²⁰ The Trump administration has proposed significant changes for PY 2018. On February 15, 2017, CMS announced a proposed new rule that, if adopted, would significantly change network adequacy and essential community provider standards for plans offered in states using the FFM in PY 2018.²¹ CMS would eliminate the time and distance standards it currently uses to evaluate network adequacy for QHPs offered in states using the FFM. The agency also proposes to defer to state regulators for the network adequacy review if a state has a standard that is “at least” equal to the current federal reasonable access standard and the state has the “means to assess issuer network adequacy.” If a state does not meet those requirements, CMS will assume that network adequacy standards are met if the insurer has been accredited by one of three named accreditation entities. Additionally, CMS will consider the ECP network adequacy standard met in the FFM if a QHP includes a minimum of 20 percent—instead of the current 30 percent—of ECPs in the plan’s service area.

State Network Adequacy Standards

Although the ACA regulations establish federal network adequacy standards for all marketplace plans, states may adopt network adequacy requirements more stringent than federal standards. Oversight of federal network adequacy standards also varies depending on the type of marketplace and applicable state laws. States that use the FFM and exercise plan management over the QHPs offered in their marketplaces (e.g., Illinois) can either apply the FFM approach or use different mechanisms at their discretion.

Network adequacy standards vary considerably from state to state,²² as do the systems used by state regulators to ensure compliance with those standards. In 2014, the consumer representatives to the NAIC commissioned a survey of state

departments of insurance (DOIs); 38 states responded to the survey. The results showed that (1) many states used different standards and systems to regulate HMOs and PPOs, (2) most state DOIs relied on complaint data to monitor network adequacy, and (3) state DOIs rarely took enforcement actions for violations of network adequacy requirements.²³ The survey showed that states were conducting network adequacy reviews for HMOs and regulating HMOs more extensively than PPOs. Such differentiation made sense when only HMOs were offering limited provider networks, but it has less justification today. The NAIC moved toward eliminating the differential treatment of HMOs and PPOs by revising the Model Act to apply to a variety of health plans, not just managed care plans. However, some states still have separate standards for HMOs and other types of plans.²²

METHODOLOGY

For this study, we reviewed the literature on limited provider networks and analyzed several states' network adequacy requirements and systems. We identified several states where regulators have experience analyzing and reviewing insurers' provider networks before plans are offered to the public. We selected states with different marketplace structures: California and Colorado operate their own SBMs and use their own information technology platforms; Illinois operates a state partnership marketplace, retaining responsibility for plan management over plans offered to residents through the federal platform; and Nevada operates a state-based marketplace while relying on the federal marketplace platform for consumers to shop and select plans (SBM-FP). We also selected states with different network adequacy standards and states where regulators oversee a mix of quantitative and

qualitative standards.²⁴ Because we focused on state regulatory systems, we did not select any FFM states; CMS has been conducting the network adequacy reviews for those states.

We analyzed the statutory, regulatory, and insurance guidance in each study state and conducted interviews with diverse sets of stakeholders, including insurance regulators, health plan representatives, consumer advocates, and marketplace officials. Our research focused on the network adequacy standards, documentation requirements, systems for reviewing and monitoring provider access, and system transparency. We did not study the complex set of issues surrounding the adequacy and accuracy of provider directories or the use of corrective actions or other enforcement actions.

NETWORK ADEQUACY STANDARDS AND REGULATORY SYSTEMS IN THE FOUR STUDY STATES

The four study states vary considerably in the size and characteristics of the populations they serve and the markets they regulate. They also adopted different network adequacy standards, although all four states use at least some quantitative standards. The SBMs in California, Colorado, and Nevada rely on regulators to conduct the network adequacy review, but staff at the SBMs and regulatory agencies meet regularly and discuss development of standards and reporting requirements for QHPs.

The appendix contains detailed information about each study state's standards and systems for analyzing and evaluating network adequacy, including references to applicable statutes, regulations, and other regulatory guidance. Table 1 summarizes the marketplace type and the network adequacy standards in place in each study state for PY 2017.

Among the study states, **California** has the most extensive network adequacy standards and insurer reporting

Table 1: Network adequacy standards and requirements in California, Colorado, Illinois, and Nevada for qualified health plans for plan year 2017

State	Type of Marketplace	Regulatory Agency	Geographic Access Standards	Provider-to-Enrollee Ratios	Timely Access Standards
California*	SBM	Department of Managed Health Care (DMHC), for most QHPs and approximately 90 percent of the individual and small group market; California Department of Insurance (CDI)	Yes	Yes	Yes
Colorado	SBM	Colorado Division of Insurance	Yes	Yes	Yes
Illinois	State Partnership Marketplace	Illinois Department of Insurance	Yes	Yes	No
Nevada	SBM-FP	Nevada Division of Insurance	Yes (FFM standards)	No	No

Sources: State statutes, regulations, and regulatory guidance.

Notes: FFM = federally facilitated marketplace; SBM = state-based marketplace; SBM-FP = state-based marketplace using the federal marketplace platform. *California has two different regulatory systems with somewhat different legal standards and requirements.

requirements. Although standards differ between the state's two regulatory agencies, the Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI), recent legislative and regulatory changes have aligned the agencies' network adequacy standards significantly. In 1997, **Colorado** adopted a network adequacy law that was substantially similar to the 1996 NAIC Model Act and required insurers to submit network access plans to the state DOI. In 2016, following extensive public input, Colorado's DOI also adopted quantitative network adequacy standards, which are in effect for PY 2017. **Illinois**, which has a state partnership marketplace and exercises plan management functions over QHPs, uses more stringent network adequacy standards than those required by CMS for issuers in the FFM. For PY 2017, the

Illinois DOI published network adequacy recommendations and suggested maximum travel distance or time standards, as well as specific provider-to-enrollee ratios for various facilities, primary care providers, and specialty providers. In 2014, the **Nevada** DOI adopted temporary network adequacy standards while soliciting public input on approaches for regulating network adequacy. The temporary standards applied in PY 2015 and PY 2016 and included time and distance standards as well as provider-to-enrollee ratios that varied by provider type and geographic area. In April 2016, Nevada eliminated those quantitative standards for plans to be offered in 2017 and instead adopted the CMS PY 2017 network adequacy criteria for issuers in the FFM.

OBSERVATIONS FROM THE STUDY STATES

The following observations emerged from our interviews in the study states.

Quantitative standards help regulators evaluate network adequacy, but flexibility is needed in applying those standards.

Quantitative standards and related metrics provide a baseline to help regulators assess the adequacy of provider networks. They enable regulators to compare apples to apples over time and increase insurer accountability for network design. One regulator respondent explained, "It's important to have [quantitative network adequacy] standards. I think the more specific the standards, the better, in terms of generating networks that actually provide good access. I think most

jurisdictions are moving that way." The four study states all use quantitative standards, although Nevada scaled back its accessibility standards to align with FFM standards for PY 2017.

Respondents reported that analysis of geographic access standards requires investment of resources in customizable software systems and/or contracts with vendors or consultants with expertise in analyzing such data. Regulators in all four study states reported using independent vendors or consultants to assist with some aspects of their network adequacy analysis, particularly geographic mapping and calculation of provider-to-enrollee ratios.

Although quantitative criteria can help regulators evaluate provider networks more efficiently and establish clear

standards to review for compliance, stakeholders agreed that regulators need some flexibility in applying those standards to specific situations, such as areas with significant provider workforce shortages or topographic/geographic barriers. A bright-line standard cannot resolve every case. One respondent said, “In rural or mountain parts of the state, you can have all the access standards you want, but if there is not a provider in that specialty, then you’re dealing with a provider shortage.”

Exceptions and waivers from quantitative standards or benchmarks are an essential element of network adequacy review and provide the flexibility needed to address issues in particular service areas. But regulators need resources and time to investigate individual plans and explore options such as telemedicine in different service and rating areas in their state.^{25,26}

Each study state currently uses some quantitative measures in their network review and grants exceptions to those standards, but the processes for granting exceptions vary, and some study states appear to be more engaged than others in a give-and-take with insurers over their proposed networks. This may be in part because the agencies we studied had different resources available to them. Additionally, the more experience regulators have reviewing provider networks, the more they can engage with insurers over the composition of their networks. One regulator explained, “We know there are areas where there are shortages of mental health providers. We look at why they need an exception. Is it because there aren’t providers available? Is it because they’re not willing to pay enough for providers to be in their network? Or is it a variety of other reasons? For example, the carrier is expanding to new areas and . . . maybe they didn’t have all of their provider contracts in place. There are lots of reasons that we look at. And then we look at the population in the areas. . . . We look at what . . . is available to the consumer in a reasonable amount of time. That’s a long way of telling you: There is no perfect answer.”

Some regulators also use historical aggregate data to help them determine whether a request for an exception from a quantitative standard is reasonable. For example, California’s DMHC uses retrospective data from insurers’ annual timely access reports when it analyzes prospective provider networks, particularly when an insurer seeks an exception from the quantitative standards. The DMHC analyzes historical data by comparing networks and enrollment by all insurers in the same service area against the proposed network. This can help show the nature of the local provider market and enables the DMHC staff to evaluate provider-to-enrollee ratios by using actual enrollment numbers from a past year. Nevada also compiles historical aggregate data to assess the reasonableness of each proposed provider network. One Nevada DOI respondent said,

“We consolidate all of the provider and facility templates that we receive so that we can get a marketwide look at where and with whom our carriers are contracting. If a given provider is below average, we will often provide them with that data and ask directly for an explanation as to why their network is below average.”

A combination of standardized forms and narrative submissions help regulators analyze network adequacy.

Requiring insurers to use standardized forms and submissions can facilitate a more efficient and consistent review of provider networks, but additional documentation helps regulators assess the adequacy of provider networks. CMS requires issuers in the FFM to use standardized spreadsheets (templates) to list all contracted providers in each QHP network, including the provider’s national provider identifier, first and last name, specialty and facility type, street address, city, state, county, and ZIP code. CMS uses separate provider templates and ECP templates to identify in-network providers.

All four study states use standard provider templates and attestation forms, and some have standard documentation requirements for other aspects of insurer network adequacy submissions. Nevada’s DOI previously allowed insurers to customize their network adequacy templates, but beginning in PY 2017, Nevada insurers must use the standard federal templates. Illinois provides standard templates for insurers to list contracted providers and to report anticipated enrollment by county and rating area. Before the ACA, Colorado required insurers to prepare network access plans but allowed each insurer to develop and document its methods for ensuring adequacy internally. After the ACA, Colorado began to standardize required insurer submissions. Colorado’s DOI used the criteria from the NAIC Model Act as a starting point; during the rulemaking process, these criteria were further refined based on stakeholder feedback to develop the specific information all carriers must now file.

California’s experience with its timely access standards shows the difficulty of consistent enforcement without standardized reporting by the health plans. California’s timely access standards had been in place for over 10 years, but a standard reporting mechanism was not required by law. Beginning in 2011, plans were required to submit annual compliance reports, but each plan could develop its own reporting format; this yielded incomparable data.²⁷ In 2014, California adopted Senate Bill 964, which authorized the DMHC to develop a standard methodology for all plans to use for their annual timely access reports. Once the new methodology is finalized, plan comparability should improve. The DMHC is also working to make the data easier to search, use, and compare.

Although the study states increasingly use standardized templates and reporting, regulator respondents also emphasized the importance of reviewing narrative descriptions of how insurers create their networks and documentation of insurers' provider access-related policies and procedures (e.g., out-of-network referral procedures, network design methodology, and telemedicine policies). Some states specify the types of narratives that must be included. Although review of such material can be more time-consuming for regulators than a bright-line quantitative standard, such information can deepen regulators' understanding of a network's design and limitations. Regulators reported that a careful review of such information can help them determine the adequacy of provider networks.

Health plan respondents also emphasized the importance of submitting narrative explanations for their networks. One health plan respondent explained, "You can't [regulate network adequacy] in a vacuum without appreciating the market dynamics at play. It should be a fuller list of questions or considerations that take into account the difficulties around some of the provider consolidation, some of the monopolies that are created in certain areas, some of the difficulty with provider shortages—or allow for that narrative to be given context within the network adequacy filings."

States vary in the extent to which regulators require insurers to change or supplement proposed networks.

Regulators often engage with insurers when insurers request an exception to a quantitative standard or when the regulators' understanding of the provider market in a particular service area raises questions about compliance with overall reasonable access standards. Regulator respondents in all four study states reported that upon receipt of initial network filings, they had instructed an insurer to alter a proposed network or offer "alternative access accommodations" to ensure the adequacy of a proposed provider network. One regulator emphasized the importance of communicating with insurers, despite how time-consuming it can be, because "it is not just a numbers game." But the frequency of these communications appears to vary widely, as does the nature of the give-and-take between regulators and insurers. For example, one regulator reported that staff often have to address the accuracy of insurer-submitted documentation (e.g., related to provider directories, benefits/service area templates, access plans), but they do not have lengthy back-and-forth with insurers over their networks. In contrast, another regulator reported having frequent discussions with insurers to address the adequacy of their provider networks.

Some of these variations may be attributed to the varying levels of resources available to each regulatory agency. With the exception of California's DMHC, which regulates the largest market in the country, none of the study states have full-time staff whose sole function is to conduct network adequacy reviews. The other agencies use staff who have multiple functions, "borrow" staff from other divisions, and/or contract components of the network review process (particularly analysis of geographic access standards) out to a consultant. Several regulator respondents described their agency's network review process as "cyclical," meaning that such work primarily takes place during certain periods each year (e.g., when plans are certified or recertified as QHPs) and requires additional staff to assist with the reviews. Respondents in some study states also reported limited resources to conduct an extensive review of insurers' network filings, notably because network adequacy is only one element of the regulators' review of health plans.

States vary in their transparency about insurer network submissions and regulators' review of those submissions.

Although most of the regulatory agencies in the study states make at least portions of insurer submissions available to the public, regulators are not very transparent about how they evaluate provider networks and enforce network adequacy standards. This is particularly true of insurer requests for exceptions from quantitative network standards.

The four study states offer varying degrees of public transparency with respect to network-related insurer submissions. In general, insurer-submitted network filings are only accessible through public records requests. None of the four study states publishes any regulator-insurer correspondence on the adequacy of a proposed provider network ahead of certification/recertification, or before a plan is otherwise sold to the public. In California, Colorado, and Nevada, certain categories of submissions (e.g., related to a QHP's written policies and procedures, rates, and/or prescription drug formularies) are published in redacted form on the relevant regulatory agency's website and/or the System for Electronic Rate and Form Filing (SERFF).

Respondents generally supported making network adequacy data available to researchers and consumer advocates, but many, including some consumer advocates, did not consider the "raw data" provided by insurers to be particularly useful to the general public. However, consumer advocates wanted to better understand how state regulators evaluate network adequacy and oversee the exceptions process. In the study states, exceptions processes are not transparent and may not be well understood by the public. One consumer advocate said, "We haven't heard of problems, but that doesn't mean they're not

happening. I feel like we're in a little bit of a black box. We don't really know what [the state DOI] does [...] to judge a provider network's adequacy."

In California, the DMHC is required to issue findings from its review of plan-reported compliance with the state's timely access requirements and make recommendations for changes that will further protect enrollees. In Colorado, the DOI publishes data on the complaints received in the previous plan year.

Although insurer submissions may not be routinely available to the public, consumer advocates praised state regulators for making information available through public records requests, holding public hearings, and soliciting comments when they developed their network adequacy guidelines and regulations. Colorado respondents in particular described extensive efforts by the state's DOI to solicit stakeholder input on its draft regulations and insurer-facing guidance documents, and noted the department's willingness to open its regular meetings with health plans to other interested stakeholders.

Challenges remain in assessing and monitoring network adequacy.

The interviews illuminated several ongoing challenges regulators face in evaluating and monitoring network adequacy.

Ensuring the accuracy of provider directories remains a significant challenge.

Although it was not a focus of our study, numerous respondents cited the difficulty of ensuring the accuracy of provider directories, including confirming whether listed providers are accepting new patients. California will implement a new set of provider directory requirements in 2017, and some states are requiring insurers to update their provider lists more frequently than federal regulations require. Given the fluid nature of provider networks and markets and the need to obtain information from health care providers who are beyond the direct regulatory authority of state DOIs, this remains a challenging area and one worthy of additional study as new state standards are implemented. Multiple respondents discussed the difficulty of obtaining accurate provider information, and some suggested that a single national database—for example, one standardized with unique provider identifiers that are regularly updated and validated—would be more efficient for providers, health plans, and regulators.

Rural communities present unique challenges in assessing network adequacy.

Respondents consistently pointed to rural communities to explain the need for exceptions policies and flexibility in network adequacy standards. Although waivers are sometimes

needed in urban areas, one regulator noted that rural areas frequently have higher health plan premiums and worse network adequacy issues "by far." A variety of factors contribute to this disparity, including workforce shortages (particularly for certain specialties) and the ability of a small number of providers to negotiate higher reimbursement rates from insurers when there are few providers available in a service area. The study states developed systems for adapting network adequacy standards to meet the needs of diverse rural communities, but rural access to health care is a much broader and more complex challenge than the narrow question of network adequacy review in those areas. Some states are trying to address provider shortages in rural and other underserved communities through policies promoting telemedicine, such as requiring that insurers cover telemedicine and/or that reimbursement rates for telemedicine be at parity with reimbursement rates for face-to-face encounters with patients.²⁶ If certain conditions are met, Medicare reimburses for some services provided to patients through interactive videoconferencing in rural areas that have documented physician shortages, but one study noted that telemedicine does not constitute a significant portion of Medicare expenditures and that few Medicare Advantage insurers are using telemedicine.²⁶

Evaluating network adequacy is complicated when multiple plans count the same providers to meet quantitative standards.

Often a given provider will contract with multiple health plans during the same plan year, thereby reducing its capacity to serve the enrollees of any one plan. In states using quantitative network adequacy standards, the inclusion of the same provider in multiple plans could mask significant access issues, even though each plan individually has complied with the standard. This issue can be compounded if the same provider is also included in other public (Medicaid and Medicare Advantage) and private (employer-sponsored insurance) plans. Regulator respondents acknowledged this issue and the challenges of addressing it. Some respondents cited efforts undertaken in Medicare Advantage and in some state Medicaid programs as potential models for improvement.²⁸

Respondents discussed two approaches to addressing the inclusion of a provider in multiple plans. One is to focus more intensively on timely access standards and mechanisms for ensuring that providers listed as accepting new patients are in fact doing so. So far this approach has relied largely on consumer complaints and/or provider surveys, which can be costly to implement and do not enable regulators to assess network adequacy before the plans are offered to the public.

The second approach is to aggregate data from all plans to compare provider networks. This approach requires annual

reporting and analysis of plan enrollment and provider network data. California's DMHC has developed an analytic tool to account for the inclusion of the same provider in multiple networks when it evaluates provider-to-enrollee ratios. California's Knox-Keene Health Care Service Plan Act requires one full-time equivalent (FTE) primary care provider for every 2,000 enrollees and one FTE physician (including specialists) for every 1,200 enrollees. The DMHC takes the data it receives from each network's timely access review for the previous plan year and aggregates the data. It determines the number and nature of the networks a given provider contracted with during the previous year and adjusts that provider's FTE percentage for the new plan year accordingly. The DMHC continues to refine its approach to determining FTE value to better account for health plan market share and expected enrollment assignment to each provider.

Consumer complaints and grievances help regulators monitor network adequacy, but systems for gathering and using that information remain limited.

Respondents in the study states reported that complaints are among the best mechanisms for monitoring access issues during the plan year, but systems for gathering, analyzing, and sharing complaint information within regulatory agencies remain limited. Regulators also reported that few consumers raise provider access issues and that when they do, the most common complaint is that a specific provider is not in the plan's network. Consumer advocate respondents stated that complaints and grievances are an important mechanism for monitoring provider access issues, but they raised concerns that consumers generally do not understand how or where to file complaints. A recent study noted that "complaints, on their own, might be of limited utility in evaluating adequacy, given that many consumers do not understand their right to complain and do not know who they should complain to."^{4,29}

In all four study states, consumer complaints are handled by staff separate from those who review provider networks. Regulators who address network adequacy compliance reported that they communicate with those staff and believe they are informed if a significant access issue arises, but communication within regulatory agencies in the study states ranges from formal sharing of reports and complaint summaries (Illinois and California) to more informal communication (Colorado and Nevada). Respondents in all study states reported that while complaints about access issues are infrequent or rare, regulators do contact health plans if significant access issues arise mid-year. However, the frequency and nature of those contacts are not generally recorded. One regulator explained, "It depends on the nature and scope of the complaint. For example, is the problem in a specific geographic area? Is it limited to a provider? We go to the carrier and say, 'Here's the specific problem we're hearing of. If it's pervasive across the network, it might result in a market

conduct review. If it's limited to a provider, it might result in some phone calls and letters back and forth. It depends on the gravity of the situation."

Both Illinois and California have developed more formal systems for monitoring and sharing complaint and grievance data during the plan year. The Illinois DOI has a complaints unit that processes written complaints electronically and a separate call center that handles broader inquiries. Illinois requires HMOs to report complaint data and publishes summaries of the total number of complaints against particular HMOs and a list of the broad types of complaints against each HMO, but this system does not apply to all health plans.³⁰ One Illinois DOI respondent observed, "On an ongoing basis, I'm hearing about the trends in the type of complaint or the carriers that the complaints may be against. Annually, there's a compilation of the complaint numbers, and we have another area that looks at that data more closely: our market conduct area. Market conduct is looking at the complaint ratios at least quarterly. If they had concerns about a carrier, we would have a discussion between our areas. It's not a precise answer, but yes, there is an ongoing review regarding whether a particular carrier seems to be having issues serving consumers."

California's DMHC has the most extensive system for plans to categorize and report grievances and complaints received from consumers. Under California Senate Bill 964, health plans are required to submit consumer complaint data to the DMHC on a regular basis. The DMHC has developed a detailed template for health plans to use when reporting complaints and grievances related to timely access and network adequacy, including specific codes for different types of complaints.³¹ Section 10133.5(e) of the California Insurance Code requires insurers to give CDI annual reports on complaints about timely access to care, and requires CDI to review the information and make it public.

The use of codes and a common template makes it easier for regulators to identify relevant complaints and compare data across plans, but challenges remain. For example, it is difficult to determine, based on one or two complaints, whether a network issue exists; this is particularly true if consumers do not file grievances or complaints when they experience access issues. Also, it can be difficult to categorize consumer complaints consistently. For example, what seems like a network adequacy issue may be an issue with delay in a prior authorization or a referral.

Finally, more consumer outreach and education may be needed to help consumers understand complaint and grievance systems and how to use them. The consumer representatives to the NAIC noted, "Unfortunately many consumers don't realize they have a department of insurance and that the department can help resolve their insurance issues. The visibility of this process must

be raised via marketing, mandatory notices on provider bills and health plan explanations of benefits, and other means.”²³

The development of network adequacy standards and regulatory assessment of network plans is evolving, and states can learn from each other.

States will continue to design their own standards and systems for network adequacy review that meet the needs of their populations and address the unique combination of factors (including demographic, geographic, financial, and market issues) affecting both the health care provider and insurer markets. Despite their differences, however, states can learn from each other. Network adequacy standards, templates, and software systems are being tested and refined throughout the country, which could make future development of standards

and systems easier and more efficient. Experienced third-party vendors may be able to help smaller states develop their review apparatus in a cost-effective manner, while state regulatory staff deepen their own expertise and knowledge over time through the implementation of network adequacy standards. States can also continue to develop policies promoting the use of telemedicine, such as requiring insurers to cover telemedicine and requiring parity in reimbursement for telemedicine and face-to-face encounters. The revised NAIC Model Act requires insurers to describe how telemedicine is being used in their network access plans. But although telemedicine may help improve access to certain types of providers, it is not a panacea for resolving network problems. Some health care requires a face-to-face encounter with a patient, and some areas lack providers and technical infrastructure to support telemedicine.²⁶

CONSIDERATIONS FOR 2017 AND BEYOND

Although narrow provider networks have become increasingly common in the marketplaces, most states have not adopted new network adequacy standards since 2014.¹ Whether this is because the federal government has been monitoring and enforcing network adequacy in most states or because of other reasons, state responsibility for network adequacy review will increase if the Trump administration’s proposed rule is adopted. With the diminution of federal oversight and insurers’ continued reliance on narrow provider networks, more states may decide to follow the lead of the NAIC and adopt new or revised standards and systems to ensure that consumers are able to access needed care.

The four study states have enforced network adequacy standards more extensive than those codified under the ACA, and some have many years’ experience evaluating provider networks. Still, all of them are continuing to reassess their network adequacy standards and modify and adapt the processes and systems they use to ensure compliance with

those standards in response to a changing environment. California, Colorado, and Nevada adopted new standards in 2016, and several regulator respondents emphasized that their systems for evaluating accessibility continue to evolve to keep pace with health care market developments in their respective states.

This adaptability will be particularly important as Congress and the Trump administration move to repeal and replace the ACA. Even in a less regulated nongroup market, insurers likely will continue to rely on narrow networks, and lessons learned about measuring and reporting network adequacy will be relevant as state DOIs work to ensure consumers’ access to necessary care through their health plans. As policymakers and regulators consider how best to design and enforce network adequacy standards in a changing nongroup market, the experiences of these four states may provide useful lessons to stakeholders across the country.

APPENDIX

Network Adequacy Standards and Systems in California, Colorado, Illinois, and Nevada

California

California operates its own state-based marketplace. Two separate agencies regulate health plans in the state. Under the Knox-Keene Health Care Service Plan Act of 1975,³² the California Department of Managed Health Care regulates “health care service plans,” which cover nearly 90 percent of California’s individual and small group enrollees; the California Department of Insurance regulates “health insurance,” which covers the state’s remaining individual and small group enrollees. Almost all QHPs offered through the California Health Benefit Exchange, marketed as “Covered California,” are regulated by the DMHC. However, CDI regulates one insurer’s EPO QHPs and some qualified dental plans.

The DMHC and CDI have different statutory and regulatory systems, but recent legislative and regulatory changes have aligned the agencies’ network adequacy standards substantially.³³ These changes were made partly in response to highly publicized issues with provider access and provider directory accuracy in 2014.^{34,35}

Under both regulatory systems, California has network adequacy standards and insurer reporting requirements that are more detailed than any of the other study states’. Plans regulated by the DMHC and CDI are subject to geographic access (time and distance) standards, provider-to-enrollee ratios, and timely-access-to-care requirements. California also has appointment waiting time standards that apply to plans in both regulatory systems.^{36,37} In 2014, the California legislature adopted Senate Bill 964, which amended Knox-Keene to (1) require detailed annual reporting by insurers, (2) authorize the DMHC to develop a standard methodology for all plans to use in reporting annually on compliance with the timely access standards, and (3) require the DMHC to publish an annual summary of insurers’ timely access compliance submissions.^{38–40}

Covered California also has provider network requirements and related reporting requirements for QHP insurers. As an “active purchaser,” it determines which plans can be offered and establishes reporting requirements through its application requirements and contracts with insurers. Covered California conducts the network adequacy review for ECPs using a standard different from the FFM standard, but it otherwise relies on CDI and DMHC to make network adequacy determinations for QHPs.

Since the passage of Senate Bill 964, which requires an annual, retrospective network review, the DMHC has been reviewing every provider network under its regulatory jurisdiction on an annual basis; this review includes all QHP networks. In 2016, the DMHC conducted a retrospective network review of 92 health plan networks, representing 37 full-service and behavioral health plans. Such retrospective data help to establish a snapshot of the market, which can be used by the DMHC to evaluate prospective filings. The DMHC also is responsible for reviewing all health plan networks, including QHP networks, that make changes to the geographic area covered by the plan or experience significant network changes (e.g., creating a new network, applying for a new health plan license, terminating a major medical group or hospital, or changing the providers participating in the network). Health plans that are required to file networks for network adequacy review with the DMHC are generally required to submit the following: (1) a description of the service area, (2) provider lists identifying all fully contracted providers, and (3) enrollment figures.

When conducting its network adequacy review, CDI also reviews a mix of narrative submissions and geographic access data, which show the location of providers through mapping tools. In 2015, CDI began implementing more extensive network adequacy regulations than it had in the past, and it is implementing new timely access standards for PY 2017.

Colorado

Colorado operates its own SBM, Connect for Health Colorado. The Colorado DOI produces and co-brands filing instructions in conjunction with Connect for Health Colorado and conducts the regulatory compliance review (including the network adequacy review) for QHP certification and recertification. All plans in Colorado, on or off the marketplace, are subject to the same regulatory standards, including network adequacy and ECP requirements.

In 1997, Colorado adopted a network adequacy law very similar to the 1996 NAIC Model Act.⁴¹ It required insurers to meet the same broad qualitative network adequacy standard through “any reasonable criteria” and, like the Model Act, listed the possible quantitative standards that an insurer could (but was not required to) use. The statute also required insurers to prepare a “network access plan” for each managed care network, and to make those plans available to the public upon request.⁴¹ Each insurer could develop its own internal standards for assessing the adequacy of its provider networks; some used quantitative standards, such as provider-to-enrollee ratios, to

do so. Before the implementation of the ACA, the Colorado DOI generally relied on a focused review of insurers' access plans when significant changes in network structure occurred or consumer complaints indicated issues with provider networks.

For plan years 2014 and 2015, Colorado DOI hired a consulting firm to conduct geographic access analyses of the state, including mapping of provider networks and drive times. In 2016, following extensive public input, Colorado DOI adopted quantitative network adequacy standards and issued a series of bulletins addressing different aspects of provider networks.⁴²⁻⁴⁵ The new network adequacy standards include (1) detailed maximum time and distance standards for nearly 50 types of facilities and providers, classified into five different types of geographic areas, (2) wait time standards for different types of care, and (3) provider-to-enrollee ratios for several categories of providers.⁴²

Illinois

Illinois has a state partnership exchange and exercises plan management functions over QHPs; it also uses more stringent standards than those required by CMS for issuers in the FFM. The Illinois DOI serves as the primary regulatory body with jurisdiction over the state's individual and small group commercial health insurance markets. The Illinois Department of Public Health is responsible for the network adequacy review of HMOs when they first enter the Illinois market or change their service area. Illinois DOI annually reviews all QHPs, including HMOs. One respondent reported that both agencies use the same network adequacy standards in reviewing network plans.

Illinois DOI publishes filing instructions in the form of "company bulletins"⁴⁶ and a QHP checklist.⁴⁷ The PY 2017 checklist for QHP insurers included state-specific "network adequacy general recommendations" and "suggested" maximum travel distance or time standards, as well as specific provider-to-enrollee ratios for various facilities, primary care providers, and specialty providers. These recommended standards are not spelled out by statute or regulation; consistent with the approach laid out in the NAIC Model Act, they are based on criteria developed by Illinois DOI. A respondent from Illinois DOI reported that QHP insurers have been largely compliant with the state's network design-related recommendations and that few exceptions requests are made by insurers.

Nevada

Nevada created the Silver State Health Insurance Exchange (SSHIX), which now operates as an SBM-FP. Before the implementation of the ACA, Nevada's network adequacy standards applied only to HMOs, and initial approval was provided by the state board of health in conjunction with the Nevada DOI. After CMS adopted network adequacy standards for QHPs, Nevada policymakers agreed that the adequacy of HMO and insurance network plans should be determined by one agency.⁴⁸ Effective January 1, 2014, state legislation transferred all network adequacy functions to the Nevada DOI and gave the agency sole authority to determine network adequacy compliance for all individual and small employer group plans in the state. Under that law, the Nevada DOI has 90 days from the date a network plan is submitted to make a determination regarding network adequacy.⁴⁹ The same statute also requires insurers to file an annual summary of information about network adequacy, as determined by the commissioner. In addition to the statutory change, SSHIX delegated the network adequacy function for QHPs to the Nevada DOI under a memorandum of understanding.^{48,50}

The Nevada DOI solicited public comments on approaches for regulating network adequacy and began to develop such regulations in 2014. Because insurers needed time to plan for PY 2015, in coordination with SSHIX, Nevada DOI also issued an insurance bulletin (14-005) in June 2014, setting temporary standards that were used for plan years 2015 and 2016.⁵¹ Bulletin 14-005 established time and distance standards and provider-to-enrollee ratios that varied by provider type and geographic area.

The Nevada DOI implemented these quantitative standards for two years while it continued to work with stakeholders on permanent regulations. In April 2016, after struggling to reach consensus among stakeholders, Nevada replaced Bulletin 14-005 with a new regulation (R049-14) that, beginning in PY 2017, adopted the CMS PY 2017 network adequacy criteria for issuers in the FFM.²⁴ Nevada DOI applies these standards to plans offered both on and off the marketplace. R049-14 also established the Nevada Network Adequacy Advisory Council and tasked it with making annual recommendations to the insurance commissioner to adopt "additional or alternative standards [from the CMS standards] for determining the adequacy of a network plan.

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