



Assessing and Ensuring Health Plan Provider Network Adequacy

FORUM SESSION ANNOUNCEMENT

A DISCUSSION FEATURING:

Danielle Moon

Director

Medicare Drug & Health Plan Contract Administration Group
Centers for Medicare & Medicaid Services

David Parrella

Consultant

Alicia Smith and Associates (Washington, DC)

Brian Haile

Deputy Director

Tennessee Division of Benefits Administration (Nashville)

FRIDAY, FEBRUARY 26, 2010

11:45AM–12:15PM—Lunch

12:15PM–2:00PM—Discussion

LOCATION

Reserve Officers Association
One Constitution Avenue, NE
Congressional Hall of Honor
Fifth Floor

*(Across from the Dirksen
Senate Office Building)*

REGISTER NOW

Space is limited. Please
respond as soon as possible.

Send your contact information
by e-mail to:

nhpfmeet@gwu.edu

National Health Policy Forum

2131 K Street, NW
Suite 500
Washington, DC 20037

T 202/872-1390
F 202/862-9837
E nhpf@gwu.edu
www.nhpf.org

Judith Miller Jones
Director

Sally Coberly, PhD
Deputy Director

Monique Martineau
Publications Director

Forum Session Manager
Kathryn Linehan
Principal Policy Analyst

The National Health Policy Forum is a nonpartisan research and public policy organization at The George Washington University. All of its publications since 1998 are available online at www.nhpf.org.

OVERVIEW

An insurer's provider network can influence the quality of care it can provide and its ability to control costs. On the one hand, narrow provider networks may allow health plans to control costs and use but may limit access to providers; on the other hand, broad provider networks do not restrict access to providers but may constrain plans' ability to control costs and use of services. For health plan enrollees, the number, type, location, and availability of network providers affect access to timely and quality care. Ensuring network adequacy and providing information about the network is especially important when patients face higher cost sharing or different coverage rules when going outside a plan's network. To ensure access to services, government purchasers and regulators require health plans' networks to meet adequacy requirements. Current requirements for health plans' networks—including the number, type, and location of providers—vary by type of plan and by jurisdiction. This session will address how networks can affect the cost and quality of health care and will examine network adequacy requirements, metrics, and oversight.

BACKGROUND

A health insurer's network is the pool of physicians, hospitals, and other providers who contract with the insurer to provide services to the plan's enrollees at negotiated rates. Health plans may then create incentives, such as lower cost sharing, for beneficiaries to use these providers. In exchange for being included in a plan's network, providers may agree to an insurer's performance conditions as well as payment rates. Insurers may pass on a portion of savings from price and utilization controls to employers, consumers, or government purchasers in the form of lower premiums, or may keep the savings as profit.

Insurers' use of networks is shaped by consumer demand, regulation, and provider leverage. With the exception of certain markets with long histories of managed care, consumers and providers are considered to have largely rejected insurance products with narrow provider networks since the late 1990s. In response, many states passed "any willing provider" laws that curtailed plans' ability to limit coverage to a set of contracted providers. Local health care delivery markets also shape insurers' abilities to define their networks.

In some markets, a dominant hospital system or single specialty physician group practice may have significant leverage over insurers. In this case, the insurer may need to contract with the dominant provider without getting the provider to agree to its terms and the providers may insist that all members of a system be included. These so-called “must-have” providers might also be able to negotiate exclusive provider agreements with insurers to direct volume to their facility or practice and exclude competitors.

A plan’s network can also influence consumers’ selection of health insurance products and affect the amount an enrollee pays out of pocket. Excluding certain facilities or specialists from the network, or imposing much higher cost sharing for “non-preferred” or out-of-network providers (for example, charging high copayments for out-of-network oncologists), could deter enrollment of people with high-cost health care needs. For this reason, regulators and purchasers have an interest in ensuring that networks have adequate numbers and types of health care providers and that consumers are informed about the coverage and cost implications of seeking care outside the network.

When Medicare Advantage (MA) plans apply to participate or expand their service area, the Centers for Medicare & Medicaid Services (CMS) reviews plans’ networks to determine whether plans are in compliance with applicable requirements such as the number and type of providers, travel distance, and travel time to providers. CMS has historically reviewed applications using the same basic criteria, but beginning in 2011, the agency will use an automated system to assess applicants’ networks. An exceptions process will allow for variation under limited circumstances. The requirements vary by specialty type (such as cardiology, ophthalmology) and geographic area (for example, metropolitan, rural). At this time, the minimum number of providers has not been established for most of the facilities and services (with the exception of acute care hospitals), but maximum travel time and distance criteria have been established for most facilities and services.¹ For example, plans serving beneficiaries in Wharton County, Texas (a “micro” county), must demonstrate that 90 percent of their network cardiologists are within 30 miles and 30 minutes of beneficiaries; 90 percent of skilled nursing facilities must be within 60 miles and 60 minutes.

Contracts between a state and Medicaid health plans² must contain provisions requiring plans to maintain a network of appropriate providers that “is sufficient to provide adequate access to all services covered under the contract” according to federal regulations.³



States are required to ensure that Medicaid plans assess several factors when evaluating their networks, such as enrollment, characteristics and needs of the plans' population, the number of providers required to provide contracted services, and distance and travel time.⁴ Federal regulations do not specify the metrics to be used or the number of providers that indicate adequacy. States have faced legal challenges, both in managed care and in fee-for-service, as to whether the fees offered to providers are "sufficient to enlist enough providers so that services under the plan are available to recipients at least to the extent that those services are available to the general population."⁵ CMS must review and approve health plan contracts. The agency may require states to demonstrate that they are holding plans to the terms of the contract and may request and review documentation that states require MCOs to submit to demonstrate compliance with the contract.⁶

For state-regulated health insurance plans (individual and group health plans that are not self-funded), requirements for network adequacy vary from state to state, as does the oversight that state agencies provide, and the definitions of plans to which requirements apply. States have historically regulated health insurance plans separately from HMOs (health maintenance organizations) and PPOs (preferred provider organizations), but "as the use of managed care has proliferated among non-HMO state-licensed health insuring organizations (e.g., insurers offering PPO-type coverage)...states have extended HMO-type standards to other entities offering managed care and have generally increased their regulatory scrutiny in this area."⁷

States typically require insurers to submit information about their products' provider networks to be licensed to sell the product in the state. North Carolina, for example requires HMOs to report the number of enrollees by county and the number of providers broken out by primary care providers, pediatricians, obstetrician/gynecologists, specialists, inpatient and outpatient facilities, and mental health providers. HMOs must also report provider-to-enrollee ratios for their entire service area as well as plan enrollees' driving distances to providers. But the state's regulations do not specifically define or mandate the ratios. Rather, they require insurance carriers to develop and comply with their own accessibility standards. Regulations say that plan members cannot be penalized or subject to out-of-network benefits "unless contracting health care providers able to meet health needs of the insured are reasonably available to the insured without unreasonable delay,"⁸ although the regulations do not specifically define "reasonable" or "unreasonable."

In January 2010, California's Department of Managed Health Care (DHMC) announced that it will be the first state in the nation to require health plans (HMOs and PPOs) to provide access to providers within specified time frames that vary by urgency, provider type, and whether pre-authorization is required. The new requirements are added to existing geographic accessibility standards that plans must meet for licensure, such as "all enrollees have a residence or workplace within 30 minutes or 15 miles of a contracting or plan-operated primary care provider in such numbers and distribution as to accord to all enrollees a ratio of at least one primary care provider (on a full-time equivalent basis) to each 2,000 enrollees."⁹ The DMHC says that the new requirements, effective in 2011, mean that "plans must have a strong and varied provider network to ensure that appointments can be made within the specified timeframes."¹⁰

SESSION

This Forum session will examine the role of purchasers and regulators in overseeing health plan networks. Speakers will discuss the development and enforcement of network adequacy requirements and the effect of health plan networks on the cost and quality of care. **Danielle Moon**, director of the Medicare Drug & Health Plan Contract Administration Group at the Centers for Medicare & Medicaid Services (CMS) will discuss the agency's role in network oversight of Medicare Advantage (MA) plans. Specifically, she will explain CMS's quantitative criteria for assessing networks, the agency's automated network review process, and its efforts to increase transparency and consistency of network review. **David Parrella**, with the consulting firm Alicia Smith and Associates and the former director of Connecticut's Medicaid program, will discuss federal requirements for Medicaid managed care plans, state responsibility for assessing and monitoring those plans, and the resources needed at the state level to oversee plan networks and enforce contract requirements. He will also discuss the factors that shape plan and provider leverage in the development of Medicaid managed care organization (MCO) networks with examples from Connecticut's experience. **Brian Haile**, deputy director of the Tennessee Division of Benefits Administration, which manages state-provided insurance benefits for over 270,000 state, city, and county employees and their families, will discuss the role of provider networks in efforts to improve quality and control spending for a privately insured population. He will discuss some of the challenges that state employee plans face in their efforts to control spending while ensuring access to care.

KEY QUESTIONS

- What are the benefits of networks to payers, providers, consumers, and insurers?
- How is the adequacy of a plan's provider network measured?
- How do network adequacy standards account for specific needs of subpopulations, such as children, or for certain services, such as behavioral health care?
- What information is required to establish adequacy standards and assess plans against those standards? How are adequacy standards enforced?
- How do requirements for different plans attempt to balance consumer protections for access with cost control efforts and innovative service delivery models?
- What other consumer protections are needed to complement network adequacy measurement?

ENDNOTES

1. Centers for Medicare & Medicaid Services, "2011 CMS Medicare Advantage Network Adequacy Criteria Development Overview"; available at www.cms.hhs.gov/MedicareAdvantageApps/Downloads/2011_MA_Network_Adequacy_Criteria_Overview.pdf.
2. "Medicaid health plans" is used here to refer to the plans subject to these requirements in federal regulation: managed care organizations, prepaid inpatient health plans, and pre-paid ambulatory health plans. See 42 CFR § 438.206.
3. 42 CFR § 438.206(b).
4. 42 CFR § 438.206.
5. 42 CFR § 447.204.
6. 42 CFR § 438.207.
7. Kaiser Family Foundation, "How Private Health Coverage Works: A primer, 2008 update," April 2008; available at www.kff.org/insurance/upload/7766.pdf.
8. North Carolina General Statute §58-3-200(d); available at www.ncga.state.nc.us/enactedlegislation/statutes/pdf/bychapter/chapter_58.pdf.
9. California Code of Regulations § 1300.51, Item H; available at <http://wpso.dmhc.ca.gov/regulations/09CCRp/09CCRp.htm>.
10. California Department of Managed Health Care, "The Doctor Will See You Now! New rules make California first state in the nation to shorten the waiting time for an appointment," press release, January 20, 2010; available at www.healthhelp.ca.gov/library/reports/news/prta.pdf.