Implementation of the Affordable Care Act: Cross-Cutting Issues

Six-State Case Study on Network Adequacy

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During the transition to new health plans and new marketplaces under the Affordable Care Act (ACA), many insurers revamped their approach to network design, and many now offer narrower provider networks than they have in the past. In this study for the Robert Wood Johnson Foundation's project to monitor ACA implementation, researchers assessed network changes and efforts at regulatory oversight in six states: Colorado, Maryland, NewYork, Oregon, Rhode Island, and Virginia. Researchers found that insurers made significant changes to the provider networks of their individual market plans, both inside and outside the marketplaces, and that insurers took varying approaches to network design. Across all six states, insurers and state officials alike reported consumer and provider confusion about which plan networks included which providers, but most have received few consumer complaints about their ability to obtain in-network services. While three of the six states have taken action to improve provider directories, it appears unlikely that state legislatures, officials and regulators will dramatically change network adequacy standards, at least in the short-term.

Introduction

The advent of new health insurance exchanges (also called "marketplaces") and new consumer protections under the Affordable Care Act (ACA) have sparked dramatic and rapid changes in health care markets. In the wake of intensive efforts to stand up the marketplaces and encourage enrollment, states are increasingly turning their attention to these market changes and to understanding how consumers are faring now that they are enrolled in coverage. One issue that has risen to the fore is the adequacy of health plan provider networks, as well as whether these networks can deliver on the benefits promised.

In many states, insurers revamped their approach to network design in preparation for 2014. Though their approaches varied, most were motivated to cut costs and to offer plans with a competitive premium. Before implementation of the ACA's market reforms, individual market plans could keep costs low by denying policies to people with pre-existing conditions; excluding coverage of benefits such as maternity services, prescription drugs and mental health services; and charging more based on health status.[1] The ACA prohibits all of these strategies, causing insurers to turn to other cost drivers—such as provider prices—to deliver more affordable premiums.

Simultaneously, the ACA sets the first national standard for network adequacy, at least for plans being sold through the marketplaces. Some states also have pre-existing network adequacy rules for commercial health plans, or they have implemented new standards for certifying plans on the state-based marketplaces.[2] But in most states, and in the federally facilitated marketplaces, insurers were given considerable flexibility in meeting the ACA's network adequacy requirements.[3]

The ACA also requires marketplace insurers to make a provider directory available to consumers for their plans. Insurers must indicate in their provider directories when one of their providers is not taking new patients.[4] During 2014 open enrollment, however, many consumer advocacy organizations and providers reported widespread confusion about which providers were in which networks, and many directories were found to be out-of-date or inaccurate.[5]

This paper describes plan networks offered in the health insurance marketplaces and state responses to changing provider networks in six states: Colorado, Maryland, New York, Oregon, Rhode Island, and Virginia. We chose these states after an environmental scan found that network changes in these states broadly represent changes taking place across the country.[6] These six states also have different approaches to network adequacy review and oversight, ranging from reporting requirements for insurers to more prescriptive standards. This paper draws from information within both publicly available sources, such as state law and marketplace documents, and telephone interviews with insurers and regulators in each of the six states.

Observations From Six States

Significant Network Changes for Individual Market Plans; Small Group Plans Had Fewer Changes

In four of the six states studied, individual market insurers modified or changed their plan networks in preparation for 2014, compared to the networks they were offering in the individual market, before full implementation of the ACA's market reforms. In the two states that did not see insurers make significant network changes for 2014 (Maryland and Rhode Island), at least some insurers have narrowed or changed their network design to offer lower premiums for their 2015 plans. Insurers' approaches to network design varied depending on the market, provider availability and consolidation, and expectations about consumer demand and use of services. All insurers were heavily focused on the pricing of their plans, and many used network design changes to deliver a lower premium to individual market consumers. One insurer told us, "when we ran consumer surveys to see what people wanted in a health plan, we learned that they were willing to trade off access to care for a lower premium."

Insurers generally did not report any efforts to design a network built on providers' performance on quality metrics or patient outcomes; price was the determining factor for whether a provider was included or excluded from most networks. However, insurers in New York and Oregon reported an interest in maintaining narrower, "more tightly managed" networks in order to promote a patient-centered medical home delivery model.

Insurers took widely varying approaches to network design. Some, such as a leading insurer in Colorado, screened out high-priced hospital providers and excluded them from the networks of their 2014 plans. Physicians that had been in-network for the insurer but are aligned with out-of-network hospitals are now no longer in-network. Other insurers shifted from offering both PPO (preferred provider organization) and HMO (health maintenance organization) plan offerings to only HMO offerings for their individual market products, both on and off the marketplace. "The HMO strategy is a major part of what's happening on the marketplace," a Virginia health plan representative told us. Insurers in other states told us they were successfully able to use both the new marketplaces and the promise of new paying customers to negotiate lower rates with providers. In New York, insurers participating in the marketplace employed a range of strategies. Some insurers reduced the number of network providers relative to their off-marketplace plans; others entered into an exclusive or semi-exclusive alignment with a particular hospital system. New York insurers also shifted away from PPO-style plans that offer an out-of-network benefit. One marketplace official told us, "there were virtually no out-of-network products in the individual market [for 2014]." This was in part because of a marketplace requirement that insurers offering an out-of-network benefit outside of the marketplace also offer an out-of-network benefit inside the marketplace.[7] Rather than comply with this requirement, most individual market insurers decided not to offer out-of-network benefits anywhere.

Another insurer strategy among our study states was provider "tiering," meaning that members face lower cost-sharing when they obtain care from an inner tier of preferred providers and higher cost-sharing for care obtained from another tier of less-preferred (but still in-network) providers. Other insurers did not make significant network changes but indicate likely changes in 2015 plans and beyond. For example, officials and insurers in Colorado, New York, Oregon, Rhode Island and Virginia report interest in tiered-network strategies

Table 1. Types of Network-Based Products[8]

Health Maintenance Organization (HMO)	Preferred Provider Organization (PPO)	Exclusive Provider Organization (EPO)
Consumers receive health care services from providers that the HMO employs or contracts with to provide services. An HMO product generally does not cover services that a consumer receives outside of the HMO.	Health care services are provided by a network of contracted providers who agree to provide services at a lower price than out-of-network providers. Consumers can go out of network, but have to pay higher cost-sharing amounts.	EPOs, like HMOs, contract with providers and do not reimburse for out-of-network care. Unlike HMOs, they often do not require enrollee assignment to a primary care provider or referral to see a specialist.

for their 2015 plans. A New York official told us, "there are plans with tiered networks now, mostly upstate, and I think they'll spread." In Rhode Island, a major individual and small-group market insurer will be offering a tiered network for the first time.

Network design strategies also differed between regions within states, with insurers almost universally reporting that attempting to achieve lower premiums through a "narrow" network strategy was really only possible in large urban markets with a robust supply of providers. In many rural areas where there is less provider density, insurers report that networks are by necessity "limited" and it is difficult or impossible to negotiate prices with providers in these communities. For example, in some counties there may be only one hospital, in which case the insurer is effectively required to include it in the network. In other areas, provider specialty groups have consolidated to the extent they have become effective monopolies in their region.

In addition, insurers operating in rural areas reported less competition among carriers than in urban areas; thus, they had less incentive to lower premiums to attract price-conscious consumers. For example, one Colorado health insurer told us that they maintained their "broad" network plans in all parts of the state except for the Denver area. "In Denver, because there are more carriers, we have two different tracks. We have a very specialized narrow network product [in addition to our more traditional broad network product]."

Though insurers implemented changes to their individual market plans both inside and outside the marketplaces, they made fewer changes to their offerings to small businesses. For example, although New York's individual market insurers declined to offer plans with out-of-network benefits, state officials told us they were widely available in New York's small-group market. This is likely in part because employers have generally preferred broader provider networks and have, at least historically, been willing to pay for them. At least one insurer, however, noted an increased interest among their employer customers in the use of network design to reduce premium costs, predicting that the trend toward narrow networks would soon extend to the group market.

Though insurers appeared to use the shift to new market rules and the new marketplaces as their rationale for excluding certain providers or moving them to a less-preferred network tier, at times it was providers themselves that initiated a network change. In other words, both health plans and providers saw 2014 as an opportunity to rethink strategic alliances. As one New York health plan representative put it, "providers were making conscious decisions to participate with specific insurers that might, for example, exclude their competitors." In other states, hospitals joined forces with particular insurers to form more integrated systems.[9] When they did so, they often were less inclined to offer favorable rates to competing insurers.

Officials in all six states report an expectation that insurers will narrow networks even further in 2015, and one insurance company official predicted, "I think you're going to see a lot of experimentation among carriers in the first years." In Oregon, for example, although there were 11 insurers competing in the nongroup marketplace, Moda Health Plan garnered 76 percent of the enrollees.[10] Many observers suggested they were able to achieve this market share because of their lower premiums, attributable at least in part to their narrower network offerings. A state marketplace official noted, "if plans want to compete with Moda [in 2015], they will have to come down in price, and networks are the easiest thing to fiddle with to do this."

Though Maryland's insurers did not move to narrow networks in 2014, and the insurer with the largest share of the individual market did not expect to modify their network for their 2015 plans, marketplace officials reported that at least one insurer expects to offer a narrower network in 2015. In Rhode Island, both marketplace and insurance department officials have encouraged—if not required—the state's insurers to narrow their networks to help make plans more affordable. Specifically, in 2013 the insurance commissioner issued new rate approval conditions for small group insurers to submit 2015 plans that are 15 percent lower in price than a plan with comparable benefits.[11] Insurers interpreted this condition as a legal obligation for plans to reduce their provider costs. Rhode Island's largest health insurer has proposed new plans in the individual and small-group markets with a tiered network that they intend to offer at a lower premium than their traditional PPO plan.[12] Another achieved the 15 percent reduction by asking its participating providers to accept reduced reimbursement. In both cases the health insurance commissioner's office and the marketplace worked closely with the insurers to ensure they met network adequacy standards and have encouraged "aggressive" consumer education around this issue. The state's two other insurers indicated they would not

be able to meet the new 15 percent requirement and received one-year waivers from the state.

Limited Federal and State Oversight of Plans' Provider Networks

Federal rules require plans participating in the marketplaces to maintain a network that is "sufficient in numbers 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."[13] The law also requires marketplace plans to post a provider directory online and to include in their networks essential community providers that primarily serve low-income, medically underserved patients.[14] In the first year of implementation, federal regulators largely deferred either to state recommendations on the adequacy of insurers' networks or to insurers' accreditation by an approved accreditation agency.[15] For 2015, however, the federally facilitated marketplace has indicated it will conduct its own assessment of provider networks using a "reasonable access" standard. The federally facilitated marketplace will focus particularly on areas that have caused past concerns about provider access such as hospital systems, mental health providers, oncology providers, and primary care providers.[16] Federal regulators have further signaled that they may add to the reasonable access standard with other standards like time and distance requirements in future rulemaking.

State Network Adequacy Standards Pre-Marketplace

Before the ACA, all of the study states except Oregon had established a network adequacy standard for managed-care plans, HMOs or both. These state standards differed in their scope and application. In the case of Colorado, Maryland, Rhode Island and Virginia, the network adequacy standard was largely subjective; it required, for example, the insurer to maintain a network that is "sufficient" to meet the needs of policyholders without "unreasonable" delay.[17] These states did not define in statute or regulation what would constitute a "sufficient" network or an "unreasonable" delay for a consumer.

New York has historically had a bifurcated network adequacy review for HMOs and managed care plans like exclusive provider organizations (EPOs) and PPOs. HMOs have received greater scrutiny for adequate provider networks by the Department of Health. The Department of Financial Services, which oversees EPOs and PPOs, has lacked the statutory authority to assess and to enforce network adequacy.[18] Oregon has not had a network adequacy standard for commercial insurers but requires network-based plans (managed care and PPOs) to submit a report to the Department of Insurance summarizing the scope and adequacy of their networks and their efforts to monitor enrollees' access to covered services on an annual basis.[19]

Table 2. State Network Adequacy Standards, Pre-ACA

State	Network Standard	Applies to
Colorado	Network must be "sufficient" to ensure benefits "accessible without unreasonable delay."[20]	Managed-Care Plans
	An HMO must ensure an "adequate" number of providers to ensure services without "unreasonable delay."[21]	HMOs
Maryland	Network must be "sufficient" to meet health care needs of enrollees.[22]	Insurers
	An HMO network must ensure that covered services are "accessible."[23]	HMOs
New York	Network must be "adequate" to meet needs of its enrollees and the state Department of Health must determine that (a) providers are geographically accessible; (b) there are at least three primary care providers within time and distance limits; (c) there are sufficient specialists to meet enrollees' needs; (d) no class of appropriately licensed providers is excluded; and (e) contracts don't transfer financial risk to providers or penalize them for serving a sicker population.[24]	HMOs
Oregon	Insurer required to submit an annual report to the Division of Insurance summarizing the "scope and adequacy" of the network and efforts to monitor access for enrollees.[25]	Managed-Care Plans
Rhode Island	Insurers must maintain a network that assures the "availability, accessibility, continuity, quality" of services.[26]	Insurers
Virginia	Network must have a "sufficient number and mix of services, specialists, and practice sites" to meet enrollees' needs, and must include providers that serve high risk populations.[27]	Managed-care plans

Colorado, New York and Virginia also require managed-care plans that do not have an available and accessible in-network provider to meet the particular needs of a policyholder to allow that person to see an out-of-network provider at no additional cost.[28] When asked about the state's pre-ACA approach to network adequacy, one Colorado official reported, "we have provisions that if the plan does not have a provider within reasonable access to the consumer, then the carrier has to basically ensure that the consumer can get to a provider as if they were in-network."

State Standards for Marketplace Plans

In preparation for 2014, most of our study states either adopted the federal marketplace standard for network adequacy or simply extended their own state standards to marketplace plans.[29] For example, Oregon, which does not have a state network adequacy standard for commercial insurers, adopted the federal standard for plans participating in the marketplace. Only New York and Rhode Island implemented standards beyond the federal minimum. New York's marketplace extended the state's requirements for HMOs to marketplace plan networks to require them to include at least one hospital in each county, at least three primary-care physicians in each county, and at least two specialists within required specialty categories in each county. Marketplace plans were also required to meet time and distance standards, which vary between urban and rural areas. In urban areas, primary care providers must be accessible within 30 minutes by public transport or car; in rural areas, within 30 minutes or 30 miles by car. Insurers are allowed to exceed the standard if they provide justification for doing so.[30] State regulators noted that, in two instances, insurers applying to the marketplace did not meet its network standards within a few counties, and were thus barred from marketing there in 2014. In 2014, New York passed legislation extending the authority that the Department of Health has had over HMO plan

Table 3. State Network Adequacy Standard for Certifying Marketplace Plans

State	2014 Standard	Did Standard Change for 2015 Plans?
Colorado	Qualified health plans (QHPs) must comply with federal and pre-existing state standards.[31]	No[32]
Maryland	Insurers will "self-define" network adequacy standards.[33]	No*
New York	QHPs must maintain a network consistent with federal and pre-existing state standards.[34] QHP networks must: • Include a hospital in each county • Include core provider types and meet provider-enrollee ratios, by county • Provide choice of three primary care physicians in each county • Include at least two of each required specialist type in each county • Meet time and distance standards: - In metropolitan areas, 30 minutes by public transport or car to primary-care physician - Non-metropolitan areas, 30 min or 30 miles by car for primary-care physicians - In rural areas, time or distance may exceed standard if justified.	No**
Oregon	Must comply with federal standard.[35]	No
Rhode Island	Must comply with state network adequacy standards.[36]	No
Virginia	Must comply with federal requirements.	No

**The Maryland Health Benefit Exchange indicates that the Exchange will assess adequacy of networks and publically report on provider accessibility for 2015 plans. Maryland Health Benefit Exchange. Carrier Reference Manual, Release 2.0. Maryland Health Benefit Exchange, 2013, http://marylandhbe.com/exchange-partners/plan-users/ (accessed August 2014).*

***There is a slight change for issuers offering plans in Erie, Monroe, Nassau, Suffolk, Westchester, Bronx, Kings, Manhattan and Queens; they must include at least three hospitals in their network. Also note that plans participating in the marketplace must comply with the requirements of S.B. 6914, which requires all health plans in New York (regardless of where they are sold) to hold harmless consumers that seek out-of-network care if their health plan does not have an appropriate in-network provider. New York State of Health. Invitation and Requirements for Insurer Certification and Recertification for Participation in 2015. Albany: New York State of Health, 2014, http://info.nystateofhealth.ny.gov/invitation (accessed August 2014).*

networks to the Department of Financial Services; thus, networks will soon be subject to greater scrutiny across types of network products, both inside and outside the marketplace.[37]

Rhode Island's network adequacy standard requires insurers both inside and outside the marketplace to maintain within their networks a minimum percentage of primary-care practices open for evening or weekend hours (25 percent) and offering behavioral, mental health and substance abuse services (10 percent) within each county.[38]

Network Changes: Consumer and Regulatory Responses

At Least Initially, Few Consumer Complaints

The significant network changes have triggered widespread media coverage and concern among providers, policymakers and consumer advocates about policyholders' ability to access timely, appropriate care.[39] However, insurers and regulators in our six study states report receiving few complaints from consumers. One insurer told us that "it's been pretty silent" when asked about network adequacy complaints from consumers. Every insurer we spoke with reported a similar lack of reported problems. At the time of our interviews, however, informants cautioned that it was too early to attempt to assess consumers' access to care.

Insurers with significant enrollment in this first year did report some concerns about provider capacity, particularly in rural areas where adequate provider supply has been a perennial challenge. Others noted that their state's Medicaid expansion was "exacerbating" supply problems. Regulators and insurers also reported hearing complaints from providers and provider groups about not being included in some plans' networks.

One common theme among the six states was confusion among both consumers and providers about which networks included which providers. Regulators reported situations in which consumers selected a plan without realizing that a long-standing provider was not in the network. "We have heard complaints [about a specific] provider not being in the network," an Oregon marketplace official told us, "but we [haven't heard] complaints about the networks in general." Similarly, a Virginia insurer told us that though they hadn't received any complaints about accessing providers, consumers and consumer assisters were asking for better, more-accurate and up-to-date information in the provider directories.

State Officials Not Planning Major Changes in Network Oversight

Although many insurers in our study states have changed their network design strategies, and are likely to continue to change them in order to offer more competitive premiums, only New York and Rhode Island modified their network adequacy standards for 2015. Regulators in Virginia expressed the more common view among state officials, noting that 2015 "is just the second year….everybody is still learning." Similarly, Maryland is collecting data on insurer networks and consumers' experience with 2014 plans but will not develop metrics for network adequacy with that data until 2016.[40]

New York's legislature did extend state network adequacy requirements to insurers outside the marketplace for the 2015 plan year, and Oregon and Colorado both indicated that they are reviewing their current standards. New York's marketplace is also "strongly encouraging"—though not requiring—plans to offer an out-of-network benefit in the marketplace.[41] marketplace officials told us that if insurers choose not to offer an out-of-network benefit, "they will be expected to have product options with robust networks that provide ample access to health care services." In Oregon, which doesn't have a network adequacy standard for insurers, officials attempted to establish a standard and strengthen their authority over plan networks with a legislative package during the 2014 session, but it was met with resistance from insurers. The Oregon Insurance Division is currently working with an advisory group to reach consensus on proposed legislation for the 2015 legislative session. Colorado regulators are considering whether they need more robust network adequacy standards to protect consumers, but noted "we have to be careful, because if we [make] major changes, we could impact the market to an extent we don't want to."

Rhode Island is one state that encouraged insurers to offer narrower—rather than broader— networks in 2015 so that plans can offer lower premiums. However, Rhode Island officials note that they are giving these new networks greater scrutiny to ensure they meet the state's standards. Such scrutiny includes a requirement

for greater consumer education about the nature of the network, including trade-offs between networks, premiums, and out-of-pocket expenses. Marketplace officials further comment that they are working to provide better consumer support tools to help them compare plans. Further, insurers both inside and outside the marketplace are required to report monthly on consumer complaints and their disposition.[42]

Few Changes Expected to Improve Provider Directories

For 2014, all six state marketplaces adopted the federal requirement that plans make a provider directory available to marketplace shoppers. But despite consumer complaints about inaccurate or out-of-date directories, only three our six states have taken action to improve provider directories. A fourth state, Oregon has not yet implemented new requirements, but a key goal of the state's efforts to draft consensus network adequacy legislation is to improve the transparency of plan networks. Among the three states that have adopted new rules for the 2015 plan year, Colorado's marketplace is requiring insurers to submit their provider directories on a monthly basis with a caveat that it may increase the frequency of submission so that information "is more accurate to customers during the shopping process."[43] The marketplace will also be monitoring the accuracy of provider information and require insurers who submit inaccurate information to participate in an improvement plan for data quality. Maryland is also using a database system to which insurers will be required to submit provider data. The Maryland marketplace indicates that it will be analyzing the data on a quarterly basis.[44] New York's marketplace has also enhanced its expectations of 2015 plans by requiring them to keep directories updated within 15 days of a network change. They are also attempting to upgrade an 18-year-old provider network intake system to allow the marketplace to better display network differences to consumers. For states with federally facilitated marketplaces, such as Virginia, plans do not face any new requirements for the accuracy of provider directories or display of network information.[46]

Conclusion

Insurers have used—and are likely to continue to use—network design to curb costs and offer customers a more affordable premium. This was a clear trend in the individual market as insurers approached the 2014 plan year, and some of our informants believe it will soon extend to the group market as employers look for ways to reduce premiums. However, despite concerns among some regulators, consumer advocates, and providers that overly narrow networks could harm quality of care and place consumers at significant financial risk, most of our study states are not planning to significantly change their oversight of plan networks. Though consumers reported problems with inaccurate provider directories and a lack of consumer-friendly, comparable information about the scope of plan networks, only half of our study states report requiring insurers to improve the information made available to consumers. At the same time, state officials and insurers also reported that consumers were generally not complaining about difficulty obtaining needed care from providers. Consequently, most state legislatures, officials and regulators are unlikely to change network adequacy standards, at least in the short-term.

ENDNOTES

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About the Authors and Acknowledgements

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