

## FACTS

# Ensuring Access to Quality Care: Network Adequacy

### OVERVIEW

The Affordable Care Act (ACA) includes many reforms to make quality health care more affordable and accessible. In order for the ACA to fully meet its promise, consumers need three things: 1) affordable health insurance; 2) quality coverage, including essential benefits they might need; and 3) timely access to health care providers without having to travel unreasonable distances. Not surprisingly, the top priorities for consumers when choosing health care coverage are cost and their doctor's participation in a health plan's network.<sup>1</sup> Balancing these priorities goes to the heart of the current debate on whether health care networks can adequately provide quality care to patients when they need it.

The Association has long heard from patients about obstacles to getting the care they need, including due to inadequate provider networks. The ACA includes a number of new protections intended to help ensure that consumers can access needed care at the right time. However, more work is required by federal and state policymakers to implement and enforce these new requirements and to put in place additional protections and oversight to address the problems patients may experience in accessing providers.

### NEED FOR GREATER TRANSPARENCY

In order for patients with heart disease and stroke to choose the best health plan for themselves and their families, they need both reliable, up-to-date information about which providers participate in the network and are accepting new patients, and an accurate understanding of the type of network they are choosing. However, in 2014, consumers shopping for coverage often found that the provider directory was unavailable or not easily accessible. An April 2014 analysis by Avalere Health showed that a provider directory was very accessible for only 41% of qualified health plans (QHPs), while 16% of plans failed to make a provider directory available at all.<sup>2</sup> Availability of directories seems to have improved for consumers shopping for coverage in 2015; however, accuracy of directory information continues to be a concern.

Transparency is also important when consumers are shopping for a plan. They need to understand up-front what they are buying and if there are any trade-offs in access and quality. For example, some consumers may find so-called "narrow network" or "tiered" plans appealing due to advertised cost savings. However, a narrow network may exclude a substantial number of hospitals, primary care physicians, and specialists, including

cardiologists or neurologists, serving an area. This can limit consumer choice. The large cost of going out-of-network may also be largely or totally borne by the patient and may result in forgoing treatment altogether.

Today, it's hard for consumers to understand what is meant by a narrow or tiered network, much less whether the plan they are buying has one. According to a McKinsey Center for U.S. Health System Reform study, plans with narrow networks made up nearly half of the choices available through the health insurance exchanges in 2014.<sup>3</sup> However, only 42% of consumers surveyed who had enrolled in an ACA plan indicated they had chosen a plan with a narrow network, while 26% were unaware of the network type they had selected. In a 2010 study, only half of the respondents enrolled in tiered-network plans in Massachusetts had prior knowledge of the tiered-network nature of their health plan, and fewer than one-fifth knew which tier one of their doctors was in.<sup>4</sup>

### ENSURING BASIC ACCESS

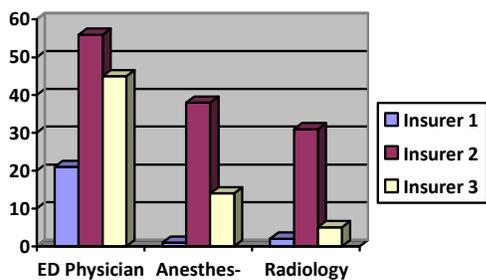
A fundamental concern for both consumers and policymakers should be whether a plan's network can adequately provide the range of covered services a patient might need – including care they might not have anticipated – in a timely and reasonable manner. While insurance companies should not be required to contract with every hospital or every provider in an area, they should have sufficient numbers and types of providers included in their network to provide covered services in a reasonable amount of time and within a reasonable travel distance.

Unfortunately, this isn't always the case. For example, the American Heart Association has heard from parents of children born with a congenital heart defect that there are no pediatric cardiologists included in their plan's network, or the only pediatric cardiologist is hundreds of miles away. In addition, Avalere Health found in a study commissioned by the Association that, while inclusion of Comprehensive Stroke Centers in networks varied widely across the 10 regions studied, 23% of QHPs (seven out of 30) did not include a single CSC in their network.<sup>5</sup> Another study found that 41% of the plans sold through health insurance exchanges had physician networks that were small or very small, meaning that they included 25% or less of the doctors practicing in the area.<sup>6</sup> One recent study found that 13% of the QHPs sampled completely lacked an in-network specialist within a 100-mile radius for at least one specialty. While rheumatologists, psychiatrists, and endocrinologists were most likely to be

excluded from networks, the researchers found at least one plan where not a single cardiologist or neurologist was available in-network within 100 miles.<sup>7</sup>

Of great concern, some health plan networks include inadequate numbers of hospital-based physicians practicing at in-network hospitals. Patients receiving care at an in-network hospital may reasonably assume that the hospital-based physicians caring for them are also in their health plan's network. However, this is often not the case, particularly for certain types of providers. An analysis by the Center for Public Policy Priorities found that in Texas, there was not a single in-network emergency department physician in nearly half of the hospitals covered by two of the largest insurers<sup>8</sup>. One of the insurers also reported that 38% of their in-network hospitals had no in-network anesthesiologists and 31% had no in-network radiologists.<sup>8</sup>

**Percentage of In-Network Hospitals with No In-Network Provider Type, by Physician Specialty, Texas**



Source: Center for Public Policy Priorities<sup>8</sup>, September 15, 2014.

## FINANCIAL IMPLICATIONS

Lack of transparency about the health plan network and an inadequate number of participating providers can result in significant and unexpected costs for patients. When they are unable to obtain covered services from an in-network provider and therefore, must seek care from an out-of-network provider, the insurer may pay a fraction of the medical bill – or nothing at all. This is no small problem. According to Avalere Health analysis, more than half of the plans offered through the health exchanges in 2015 had no out-of-network coverage.<sup>9</sup> In addition, using a non-preferred provider in a tiered network plan can also have significant financial ramifications for patients. A study examining hospital choices of consumers enrolled in tiered-network plans in Massachusetts found significant variation in the cost-sharing owed: For each hospital admission, average cost-sharing was \$1,070 for non-preferred hospitals, \$360 for hospitals in the middle tier, and \$170 for preferred hospitals.<sup>10</sup>

In the end, patients may be subject to staggering out-of-pocket costs, in the form of higher cost-sharing and “balance billing.” Balance billing occurs when out-of-network providers bill consumers for the portion of their charges not paid by the insurer. These “surprise” medical bills from out-of-network providers are a significant cause for consumer complaints. In New York alone, more than

10,000 complaints related to out-of-network bills had been filed in the state since 2008.<sup>11</sup> A recent survey by *Consumer Reports* found that 30% of privately insured Americans have received a bill where their plan paid much less than expected.<sup>12</sup>

## THE AHA/ASA ADVOCATES

The American Heart Association/American Stroke Association urges policymakers to support the following policy recommendations for improving network adequacy and access to quality health care:

- Require states to set quantitative standards for measuring network adequacy;
- Require prior approval of insurance company network access plans;
- Comprehensively address the issue of surprise medical bills;
- Ensure strong continuity of care protections for patients with chronic health conditions who lose access to their health care providers due to network changes or switching plans; and
- Ensure that network provider directories are updated at least monthly, accurate, and easily accessible and hold consumers harmless when directories are inaccurate.

<sup>1</sup> See for example: Pacific Business Group on Health, “Helping Consumers Choose the Right Health Plan for their Needs,” 2011, available at: <http://www.pbgh.org/storage/documents/PBGHIssueBriefChooser.pdf>.

<sup>2</sup> Avalere Health, “Exchange Consumer Experience Analysis,” April 2014, available at: <http://avalerehealth.net/expertise/managed-care/insights/avalere-analysis-exchange-consumer-experience>.

<sup>3</sup> McKinsey Center for U.S. Health System Reform, “Hospital Networks: Updated National View of Configurations on the Exchanges,” June 1, 2014, available at: <http://healthcare.mckinsey.com/hospital-networks-updated-national-view-configurations-exchanges>.

<sup>4</sup> Sinaiko AD and Rosenthal MB. Consumer Experience With a Tiered Physician Network: Early Evidence. *AmJMGdCare*. Published online Feb. 5, 2010, available at: [https://ajmc.s3.amazonaws.com/\\_media/\\_pdf/AJMC\\_2010febSinaiko\\_123to130.pdf](https://ajmc.s3.amazonaws.com/_media/_pdf/AJMC_2010febSinaiko_123to130.pdf).

<sup>5</sup> Avalere Health, “Access to Comprehensive Stroke Centers & Specialty Physicians in Exchange Plans,” September 26, 2014, available at: [http://www.heart.org/icc/groups/public/@wcm/@adv/documents/downloadable/ucm\\_468318.pdf](http://www.heart.org/icc/groups/public/@wcm/@adv/documents/downloadable/ucm_468318.pdf).

<sup>6</sup> Weiner J and Polsky D. “The Skinny on Narrow Networks in Health Insurance Marketplace Plans.” Leonard Davis Institute of Health Economics and Robert Wood Johnson Foundation. June 2015, available at: [http://www.rwjf.org/content/dam/farm/reports/issue\\_briefs/2015/rwjf421027](http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2015/rwjf421027).

<sup>7</sup> Dornier SC, Jacobs DB, and Sommers BD. Adequacy of Outpatient Specialty Care Access in Marketplace Plans Under the Affordable Care Act. *JAMA*. 2015; 314:1749-1750.

<sup>8</sup> Stacey Pogue, “Surprise Medical Bills Take Advantage of Texans: Little known practice creates a “second emergency” for ER patients,” Center for Public Policy Priorities, September 15, 2014. Available at: [http://forabettertexas.org/images/HC\\_2014\\_09\\_PP\\_BalanceBilling.pdf](http://forabettertexas.org/images/HC_2014_09_PP_BalanceBilling.pdf).

<sup>9</sup> Avalere Health, “Fewer PPOs Offered on Exchanges in 2016,” November 2015, available at: [http://avalere-health-production.s3.amazonaws.com/uploads/pdfs/1446739748\\_20151105\\_Exchange\\_Networks\\_Analysis\\_FINAL.pdf](http://avalere-health-production.s3.amazonaws.com/uploads/pdfs/1446739748_20151105_Exchange_Networks_Analysis_FINAL.pdf).

<sup>10</sup> M. B. Frank, J. Hsu, M. B. Landrum et al., “The Impact of a Tiered Network on Hospital Choice,” *Health Services Research*, published online Mar. 9, 2015.

<sup>11</sup> “An Unwelcome Surprise: How New Yorkers are Getting Stuck with Unexpected Medical Bills from Out-of-Network Providers,” New York State Department of Financial Services. Available at: <http://www.governor.ny.gov/assets/documents/DFS%20Report.pdf>.

<sup>12</sup> Consumer Reports National Research Center. “Surprise Medical Bills Survey.” May 2015, available online at: <https://consumersunion.org/wp-content/uploads/2015/05/CY-2015-SURPRISE-MEDICAL-BILLS-SURVEY-REPORT-PUBLIC.pdf>.