The Center on Health Insurance Reforms
Georgetown University Health Policy Institute

Regulation of Marketplace Health Plan Provider Networks: State Action Regarding Quantitative Network Adequacy Standards

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EXHIBIT DD - Health Care
Document consists of 5 pages.
Entire exhibit provided.
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Overview of Regulatory Framework for QHP Network Adequacy: Federal Law and Regulations

- The Affordable Care Act sets a national standard for network adequacy, applicable to qualified health plans (QHPs) sold on the health insurance marketplaces
  - Qualitative standard: QHPs must maintain a network that is "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." 45 C.F.R. § 156.230(a).
  - QHPs must also:
    - Include a "sufficient number and geographic distribution of essential community providers" that serve predominately low-income, medically-underserved individuals. 45 C.F.R. § 156.235.
    - Adhere to requirements regarding access to and accuracy of provider directories. 45 C.F.R. § 156.230(b).

QHP Network Adequacy Overview: 1 of 3

Overview of Regulatory Framework for QHP Network Adequacy: Federal Guidance (Plan Year 2016)

- QHPs offered through the federally facilitated marketplaces (FFM) must meet additional evaluation standards
  - Networks are evaluated by CMS using a "reasonable access" standard that focuses most closely on areas that have historically raised network adequacy concerns
  - Note, in 2017, the federal "reasonable access" review will specifically incorporate time and distance standards
    - Standards apply to 10 specialty areas and specify time and distance requirements for 5 different kinds of counties (e.g., large, metro, rural)

QHP Network Adequacy Overview: 2 of 3

Overview of Regulatory Framework for QHP Network Adequacy: State Action

- States retain traditional authority to develop (or maintain) their own network adequacy evaluation standards
- At the start of marketplace coverage in 2014, nearly all states had rules intended to promote network adequacy
  - Within states, rules often applied to certain types of health plans (e.g., HMOs), but not others
  - Across states, substantive standards varied significantly
  - 27 states had rules requiring at least some network-based plans to satisfy a quantitative measure of network sufficiency
- In late 2015, the National Association of Insurance Commissioners adopted an update to its Network Adequacy Model Act
- By 2016, fewer than 10 states have modified their network adequacy evaluation standards through law or regulation
  - Some additional movement has occurred through insurance department guidance or policy-making by state-based marketplaces
  - Separately, many states have considered changes to law/regulation governing provider directories and surprise medical bills (issues not included in this overview)

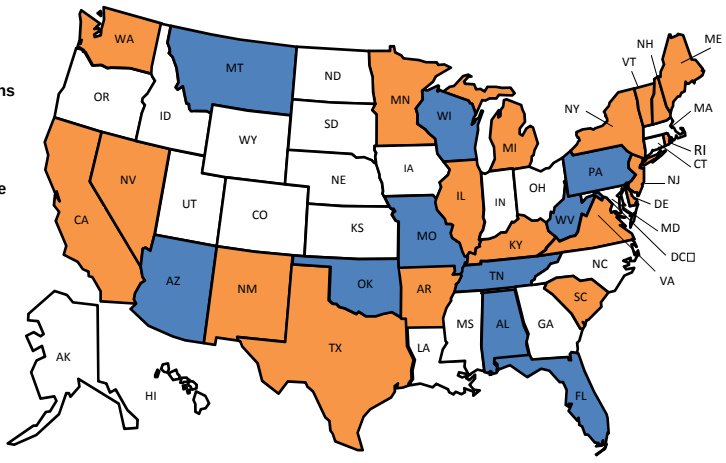
QHP Network Adequacy Overview: 3 of 3

States Where Marketplace Plans Are Subject to One or More Quantitative Standards for Network Adequacy (Plan Year 2016)

All marketplace plans subject to state quantitative standard: 19 states

Some marketplace plans subject to state quantitative standard: 10 states

State does not regulate marketplace plan networks using a quantitative standard: 21 states and DC



Notes: State network adequacy standards may apply broadly, to all network plans, or more narrowly, to specified network designs (e.g., HMOs) or plan types (e.g., qualified health plans, known as QHPs or "marketplace plans"). The 19 states identified in orange have one or more quantitative standards that apply to all marketplace plans, specifically, or to all network plans, in general. By contrast, the quantitative standards in effect in the 10 states identified in blue apply only to particular types of network plans (usually HMOs) and do not regulate all marketplace plans, generally.
Source: J. Giovannelli, K. Lucia, and S. Corlette, *Implementing the Affordable Care Act: State Regulation of Marketplace Plan Provider Networks* (New York: The Commonwealth Fund, May 2015); authors' analysis.

Quantitative Standards: Time and Distance (Plan Year 2016)

- The most common quantitative standard applicable to QHPs
  - Approximately 25 states
- Standards for primary care are most common, though many states specify travel limits for hospitals and/or other categories of providers
  - For example, Washington has established time and distance standards for primary care providers, hospitals, mental health and substance use disorder providers, and pediatric services, among other provider categories
- Time and distance requirements often vary within a state to reflect differences in population density or geography
  - In New Mexico, for example, plans serving areas with 50,000 or more residents must ensure that two contracted primary care physicians are within 20 minutes/20 miles of 90% of the enrolled population; for plans serving areas below that threshold, the standard is 60 minutes/60 miles

Quantitative Standards: Provider-to-Enrollee Ratios (PY 2016)

- Provider-to-enrollee ratios apply to QHPs in approximately 11 states
- Standards for primary care are most common, though some states specify ratios for other categories of providers
  - For example, California requires plans to have at least one full-time equivalent primary care physician for every 2,000 enrollees
  - In Washington, a plan's ratio of primary care providers-to-enrollees must meet or exceed the average ratio across the state for the prior plan year

Quantitative Standards: Appointment Wait Times (PY 2016)

- Appointment wait time requirements apply to QHPs in about 12 states
- These rules impose limits on how long enrollees can be made to wait for appointments for non-emergency services
  - For example, Montana requires managed care plans to ensure access to urgent care within 24 hours; non-urgent care with symptoms within 10 days; immunizations within 21 days; and routine or preventive services within 45 days

Quantitative Standards: Extended Hours of Operation (PY 2016)

- About 7 states have extended hours requirements that apply to QHPs
- These requirements attempt to ensure access to providers at flexible times or during extended office hours
  - For example, California requires some types of network plans to have in-network providers that offer non-emergency services until 10 p.m. at least one day per week, or for at least four hours each Saturday