

NETWORK ADEQUACY

ENSURING ACCESS TO PEDIATRIC PRIMARY CARE MEDICAL HOMES,
MEDICAL SUBSPECIALISTS, AND SURGICAL SPECIALISTS

Advocacy Action Guide for AAP Chapters

Efforts to ensure health insurance plan network adequacy have increased significantly as plans move to restrict network size. This resource provides detailed guidance for AAP chapters on engaging in the state-level debate on network adequacy regulation.

Overview

- In recent years, private health insurance plans—particularly qualified health plans (QHPs) sold in marketplaces but increasingly employer sponsored plans—have been offered with “narrow networks” of physicians, hospitals, and other health care providers. Marketed as less expensive insurance products, narrow network plans can create significant barriers for patient and family access to care, particularly with respect to [pediatric medical subspecialists and pediatric surgical specialists](#).
- States have historically retained authority to regulate insurance plan network adequacy. Current state oversight of network adequacy [varies considerably](#) among states, and states that currently have network adequacy laws may not apply them to all insurance products, or uniformly.
- The number of narrow network health plans has grown significantly in recent years. Noted studies released in 2015 document narrow network offerings [in marketplaces](#), with respect to [physician network size](#), and [hospital participation](#). Notably, some network plans have been offered without access to a children’s hospital.
- **Surprise balance billing** is a related concern. With surprise balance billing, families are charged for out-of-network care, even when provided at in-network facilities (ie, out-of-network anesthesiology services at an in-network hospital). In many instances, surprise balance bills can be financially crippling for families. A number of states [have enacted laws](#) to protect consumers from surprise balance billing.
- The National Association of Insurance Commissioners (NAIC) worked to revise its [Health Benefit Plan Network Access and Adequacy Model Act](#) in 2014-2015. This document was approved by the NAIC in November 2015, and will serve as model network adequacy legislation for state policymakers to consider. The model act calls for carriers to create an “access plan” to demonstrate network adequacy.
- The AAP actively participated in this NAIC revision of its model act as an interested party. While improvements suggested by the AAP were included, concerns remain with some provisions. State

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policymakers may use the NAIC model act as a starting point for deliberations on this issue, or introduce their own legislation or proposed regulations.

- For states with [federally-facilitated marketplaces \(FFM\)](#), the US Department of Health and Human Services (HHS) required FFMs to choose an acceptable network adequacy quantitative standard for QHPs beginning in 2017. HHS detailed the acceptable network adequacy standards for FFMs in its February 2016 [Final Letter to Issuers](#). Should a state not choose from this list of acceptable standards, FFMs would be required to review network adequacy using time and distance standards, with specificity by specialty. In its proposed [2019 Notice of Benefit and Payment Parameters](#), HHS now proposes to allow states that have the authority to enforce network adequacy in a manner that is at least equal to the “reasonable access standard” to do so.
- CMS is also considering additional efforts to support transparency and informed decision making when enrollees select health insurance plans by requiring consumer notifications of insurance plan network breadth in marketplaces. States may take steps to require this in advance of a federal requirement.
- With respect to Medicaid managed care, CMS issued a [final rule](#) on May 6, 2016 that, for the first time, required states to establish network adequacy standards for Medicaid managed care plans. CMS indicated that these standards for Medicaid managed care plans must, at minimum, establish time and distance requirements for adult and pediatric primary care and enumerated specialties. The [AAP Advocacy Action Guide | Medicaid Managed Care](#) provides guidance on these network adequacy provisions. Of note, on June 30, 2017, HHS [announced it was delaying implementation](#) of most provisions of the Medicaid managed care rule, while it conducted a systemic review of the rule itself.
- State policymakers will continue to consider network adequacy standards as this issue plays out at the state level. They now have the opportunity to create strong standards that protect patients and families, and ensure access to pediatric care.

Why does this matter to the AAP and AAP chapters?

- Narrow network plans limit access to primary, specialty, and subspecialty care. Network adequacy becomes particularly important as plans that provide out-of-network care (such as Preferred Provider Organizations, or PPOs) [become less available](#), and such plans that do exist [provide significantly less out-of-network coverage](#).
- Studies have demonstrated that families have difficulties [understanding health insurance plans](#) and [assessing specific characteristics of QHPs](#) when selecting coverage in a marketplace. Families may easily and inadvertently select a narrow network plan and not realize it.
- Families in narrow network plans increase the risk that they will utilize out-of-network care. Families may not be able to select all in-network providers for planned procedures, or may fall victim to scheduling changes or other facility contingencies, resulting in out-of-network care. Subsequent surprise balanced billing can mean unexpected and exorbitant charges for families.
- Narrow networks threaten to disrupt existing relationships families have with their [medical homes](#) and limit access to primary care pediatricians, pediatric medical subspecialists, and pediatric surgical specialists, replacing such care with available adult specialists and subspecialists. Limiting access to

academic medical centers and children's hospitals will be harmful for children with special health care needs (CSHCNs). Plans must be required to ensure that children have appropriate access to all pediatric primary, specialty, and subspecialty care they need. Efforts must be taken to ensure existing physician-patient relationships are maintained whenever possible. Also, plans must make appropriate transitions to in-network care in any new network.

- With the spread of narrow networks, issuers will have increased leverage in contract negotiations with physicians. Limiting network size and coverage for out-of-network care will create a disincentive for insurance carriers to contract with physicians at market payment rates.
- Narrow network plans and plans with high deductibles erode the quality of health insurance products in the marketplace. Recently, [no QHPs were found to be Children's Health Insurance Program \(CHIP\)-comparable](#) in terms of benefits coverage or out-of-pocket cost sharing for children. Steps should be taken to strengthen private health insurance products, including strengthening network adequacy requirements to ensure children have true access to the services they need.

What can states do to ensure network adequacy?

- States can pass legislation and/or implement regulations to require adequacy of health plan networks, and take steps to ensure ongoing monitoring so that networks found to be inadequate are corrected.
- States may act to protect consumers from surprise balance billing in network adequacy legislation/regulation, or they may do so in another law or regulation. Surprise balance billing concerns will continue to grow as narrow networks proliferate and as out-of-network care continues to generate unexpected bills for families.

What can AAP chapters do on this issue?

- Work with state medical societies and other physician organizations on network adequacy legislation/regulation in your state. Although all physician groups may not agree on all facets of this issue, a concerted effort on mutually acceptable provisions will help counterbalance the influence of insurance companies seeking to limit care through expanded use of narrow networks.
- Work with families and patient/family advocacy groups to identify examples of narrow networks limiting access to care in your state. Identify opportunities for patients to obtain needed care and help families advocate for state network adequacy standards that will ensure needed care in the future.
- Compare proposed state bills/rules with AAP guidance found on the following pages of this document to advocate for improvements. This AAP guidance speaks to many issues important to pediatrics, components of the NAIC model act deliberations, as well as the experiences of other state laws on the subject. Considering the unique characteristics of the delivery of pediatric health care in your own state can further enhance your input.
- Highlight the unique needs of children when creating network adequacy standards, including the need to document access to pediatric primary, pediatric medical subspecialty, and pediatric surgical specialty care.

Additional Resources

- AAP: [Annotated Bibliography: Benefits of Pediatric v Adult Subspecialty Care](#)
- NAIC: [Health Benefit Plan Network Access and Adequacy Model Act](#)
- Health Management Associates: [Making Affordable Care Act Coverage a Reality](#)
- Commonwealth Fund: [Implementing the Affordable Care Act: State Regulation of Marketplace Plan Provider Networks](#)

AAP Guidance on Network Adequacy Legislation and Regulation

Scope

- Legislation or regulation of insurance plan network adequacy should apply to all private health insurance plans sold in and regulated by the state.
- Limited service plans (ie, dental or vision only) may have separate standards but should not be exempt from documenting network adequacy.

Documenting network adequacy

- Any documentation of network adequacy must ensure that the network maintains a comprehensive range of primary, specialty, and subspecialty care--and for children, pediatric primary, specialty, and subspecialty care--in sufficient numbers and types of providers, including those that serve predominantly low-income, medically underserved individuals, to assure that all needed services are available without unreasonable delay or travel.
- Emergency services should not be considered out-of-network.
- For tiered networks, network adequacy standards should be applied to the lowest cost-sharing tier to ensure a full range of providers for all covered services.
- Documentation should include details on benefits, authorization of services, referrals, grievances and appeals, changing providers, updates to provider directories, factors used to build the network, and the process the plan uses for ongoing monitoring of network adequacy and how it will ensure enrollees have all health care needs met.

Definitions

- The NAIC model act and any other state network adequacy legislation/regulation will include defined terms used throughout the text.
- Such definitions may correspond to other statutory language from existing state law or may instead create newly defined terminology.
- Review definitions closely to ensure they are appropriate and meaningful for children. For example, the NAIC model act definition of "emergency medical condition" (for purposes of excluding such care from in-network requirements) includes mental and behavioral health conditions, which may be more comprehensive than existing state statutes on this subject.

Review and Approval

- Network adequacy requirements must ensure that plans are actively reviewed and approved by the Insurance Commissioner or other agency with appropriate state oversight of insurance.
- The NAIC model act calls for carriers to create an "access plan" to demonstrate network adequacy--proposals in your state may take various forms.
- In any proposal, substantive network adequacy review and meaningful approval must be obtained before a given insurance product is sold.
- The state process for determining network adequacy should be transparent and publicly available.

Objective Measures

- States should require the use of objective measures to document network adequacy.
- Measures may include time/distance standards; minimum provider/covered person ratios for primary, specialty, and subspecialty care; maximum allowable appointment wait times; and others.
- Measures should document the ability of the network to meet the needs of all covered persons, including children and adults with special health care needs, those in low-income families, and those with limited English proficiency (LEP).
- Measures may be unique to each state but should be objective and demonstrable, and ensure meaningful access to all types of providers.
- Policymakers should consider a number of factors when assessing network adequacy, including geographic considerations; provider availability and hours of operation (including after-hours care); admitting privileges; availability of technological services required for children with special health care needs; as well as any quality measures that might be used to determine whether a provider will be accepted in-network (if applicable).

Pediatric Focus

- Studies demonstrate the positive outcomes and quality impacts of care provided by pediatric medical subspecialists and surgical specialists, versus adult specialists and subspecialists for the pediatric population.
- Network adequacy standards for children must document access to pediatric primary care as well as pediatric medical subspecialty and surgical specialty care.

Non-discrimination

- Selection and/or tiering of physicians and other health care providers must not be done in a manner that discriminates against high risk populations by excluding or tiering physicians or other providers who, acting within the scope of their license, are more likely to treat higher cost or higher utilizing enrollees.

Telehealth care

- In documenting network adequacy, legislation/regulation may take into consideration use of telehealth care in establishing a given plan network.
- However, telehealth care should augment, and not substitute for, a robust in-person network of pediatricians, pediatric medical subspecialists and surgical specialists, and other health care providers.
- Use of telehealth care should be balanced with safety, quality, licensing and certification standards, and must take place within the context of or in support of a medical home.

Tiering

- Plans are increasingly using provider tiering, requiring greater cost sharing for families utilizing more specialized services.
- Network adequacy standards should be applied to the lowest cost-sharing tier of any tiered network, in order to ensure that a full range of providers and covered services are available in the lowest cost-sharing tier.

Substitution of Review

- State Insurance Commissioners should actively review and approve network adequacy of plans.
- States should not allow outside agency accreditation to substitute for state review, and should not accept insurer attestation as the sole indication of network adequacy.

Network Directories

- Provider directories must be in clear language and updated very frequently (at least monthly, with an eventual goal of real time updates) and available in other languages for persons with limited English proficiency (LEP).
- Online directories must be searchable without entering a password or being a member/beneficiary.
- All directories should include: plan type; whether and how out-of-network care is covered and the methodology used to determine out-of-network care costs; an indication of network breadth; standards used for tiering of providers as well as the tier of any provider (if applicable); provider network status, contact information, specialty certifications, and facility affiliations, and whether the provider is accepting new patients; and a phone number/email address for sole use of identifying inaccurate directory information.
- Plans should be required to continually survey providers to confirm accuracy of network directory information, and plans must be required to proactively inform providers of those plans they are considered to be in-network.

Essential Community Providers (ECPs)

- ECPs serve predominantly low-income, medically underserved populations.
- CMS has established standard contract offerings and signing requirements for certifying QHPs operating in federally facilitated marketplace (FFM) states--included there is a requirement that plans contract with 30% of ECPs in each plan's service area.
- For network adequacy monitoring purposes, states should use this 30% requirement for QHPs in FFM as a floor, with the goal of requiring plans to contract with all ECPs in a given service area.

Children's Hospitals

- Children's hospitals must be included in network—including those in geographic areas beyond an existing plan network area where one is not readily available.
- In such instances, network adequacy standards may require inclusion of a children's hospital in a nearby state.

Assurance of Access

- Plans should detail how enrollees are to access covered services in instances when no in-network providers of such services are available.
- Such plans must detail explicit steps enrollees must take to obtain these services.
- Services should be covered at no greater cost sharing amount to the enrollee than they would if they had been provided by in-network providers.
- Such out-of-network arrangements should be the exception rather than the norm. Truly adequate networks should use such arrangements in rare circumstances, and plans must be monitored to ensure this process is used sparingly. More frequent use of such an out-of-network arrangement is an indication of an inadequate network and should be treated as such.

Continuity of Care

- Plans must be required to detail the manner in which continuity of care will be maintained should a contract with an in-network provider be terminated, in the case of plan insolvency, or other discontinuation of operations.
- Families should be notified when one of their providers leaves a network, and should be given the opportunity to continue an active course of treatment until the treating provider determines such care is no longer medically necessary, the patient is successfully transitioned to an in-network provider of the same specialty who is able to provide such care, or for up to 12 months, whichever is less.
- Continuity of care plans should also address material errors in provider directories that erroneously indicate a provider's in-network availability, and should cover such out-of-network care as "in-network" in these instances.

Enforcement

- State oversight must include provisions for ongoing monitoring of plan compliance with network adequacy standards.
- Enforcement mechanisms include ongoing surveys of consumers and providers; tracking of complaints; monitoring of provider churn; tracking of requests for out-of-network and emergency care; and others.
- States should publish data related to out-of-network care and make it publically available. States may need to enhance their data analytics capabilities to effectively monitor compliance with network adequacy standards.
- Insurance commissioners (or other appropriate state agencies with authority to regulate insurance) must be given the authority to require expansion of networks where network adequacy deficiencies are found.
- Regulators should also have the authority to impose fines or other financial penalties for plan violations of network adequacy standards.

Surprise Balanced Billing

- States may choose to address the issue of surprise balance billing in network adequacy legislation/regulation or tackle this issue separately. In either instance, the goals of any surprise balanced billing requirements must be to ensure that patients and families are held harmless for surprise balance bills, and to guarantee appropriate payment for out-of-network care.
- Balance billing provisions may require states to establish appropriate payment benchmarks for out-of-network care; meaningful notification of patient/family, plan, and provider responsibilities when seeking or providing out-of-network care; and explicit prohibitions on balance billing or hold harmless provisions for patients/families.
- States will likely have to establish an explicit mechanism for adjudicating payment for out-of-network care in such instances.