



Ensuring Access to Quality Healthcare: Network Adequacy

OVERVIEW

Ensuring access to quality healthcare is one of the major goals of health reform efforts like the Affordable Care Act (ACA). Accessing quality healthcare is dependent upon consumers' access to affordable health insurance that covers a meaningful set of benefits. In addition, consumers must have access to an adequate number and type of nearby health care providers to deliver care.

Inadequate provider networks are a major impediment to insuring access to quality healthcare. The American Heart Association has long heard from patients about obstacles to accessing the care they need. While the ACA sought to address network adequacy issues, narrow networks that prevent consumers from accessing healthcare, leaving them vulnerable to high out-of-pocket costs, still exist. Federal and state policymakers should consider additional enforcement of ACA network adequacy requirements as well as expanded network adequacy protections and oversight mechanisms to ensure all consumers have strong provider networks from which they can receive quality healthcare.

ENSURING BASIC ACCESS

Strong provider networks include an array of providers that deliver a broad 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 is not 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.

Meanwhile, Avalere Health found in a study commissioned by the Association that, while inclusion of Comprehensive Stroke Centers (CSC) in networks varied widely across the 10 regions studied, 23% of QHPs did not include a single CSC in their 2014 plan network.¹ Research published in the *Journal of the American Medical Association* found that 13% of the qualified health plans sampled completely lacked an in-network specialist within a 100-mile radius for at least one specialty.² In some cases, not a single cardiologist or neurologist was available in-network within 100 miles.²

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-network. This is often not the case, particularly for certain types of providers. Research suggests that, among hospitals in-network for a large commercial insurer, 20% of elective surgeries among hospitals in-network for a large commercial employer, including coronary artery bypass graft surgery, with in-network primary surgeons and hospitals accrued out-of-network bills.³ The same study found a slightly higher risk of out-of-network bills among those enrolled in marketplace plans compared to non-marketplace plans.³

FINANCIAL IMPLICATIONS

Patients may be subject to significant and unexpected costs when their health plans' networks lack adequate numbers of participating providers. When patients are unable to obtain covered services from an in-network provider and must seek care from an out-of-network provider, their insurers may pay only a fraction of their medical bills – or nothing at all. An analysis by the Robert Wood Johnson Foundation found plans with out-of-network benefits were already rare and have become even more so over the past several years; just 29% of plans offered on the individual market offered out-of-network benefits in 2018, down from 58% in 2015.⁴

FACT SHEET: Network Adequacy.

Using a non-preferred provider in a tiered network plan can also have significant financial ramifications for patients. When patients receive care from an out-of-network provider, they may be subject to staggering out-of-pocket costs, either in the form of high copayments for out-of-network services or “balance billing.”

Although the ACA prohibits insurers from charging additional copayments for out-of-network emergency department care, these protections do not prevent balance billing by physicians.⁵ 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 are a significant cause for consumer concern. A survey by *Families USA* found that 44% of respondents received a bill where their plan paid much less than expected or nothing and of those who received a surprise medical bill nearly half (48%) had to pay more than \$1,000.⁶

Consumer knowledge, or lack thereof, around healthcare networks is a major contributor to surprise medical billing. According to a 2016 Kaiser Family Foundation survey, 70% of patients charged unaffordable out-of-network bills did not know they were seeing an out-of-network provider at the time of care.⁷

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 reliable, up-to-date information about which providers participate in a health plan’s network and are accepting new patients, and an accurate understanding of the type of network they are choosing. In recent years, marketplaces have implemented numerous efforts to improve the transparency of network and coverage information. However, suboptimal plan selection due to “unfamiliar terminology, complicated trade-offs between coverage and premiums, and multiple plan options” remain concerns.⁸

Complicated transparency tools can exacerbate patient confusion during the plan selection and enrollment process. Customers need to understand up-front what they are buying and if there are any trade-offs in access. However, the ways in which the ACA marketplaces present plans can obscure relevant information for patients to consider.

For example, some marketplace web layouts that give priority to premium costs may obscure network adequacy information like which hospitals and providers are covered under a plan.⁸ Provider directories may also be incorrect or out-of-date and lead to patients going to out-of-network doctors. More than half of physicians surveyed by the American Medical Association said they saw patients with health insurance issues due to inaccurate directory information,⁹ and 52% of network directories published by Medicare Advantage plans had at least one inaccuracy.¹⁰ Because of this, consumers may be led away from the plans that are most protective and best suited to their health needs.

Further, “narrow network” or “tiered” plans are becoming more common and prominent in the marketplaces. In 2020, narrow network plans made up 78% of all plans available in the market.¹¹ These plans may, on their face, appeal to some consumers because they tend to offer lower premiums.¹² 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 and may set patients up to receive surprise bills and high out-of-pocket costs from out-of-network providers.¹¹

False information about which providers are covered by a patient’s health plan may be especially damaging for those with narrow network plans, misleading patients to believing their plan is more robust than it really is and inviting higher out-of-pocket costs. A 2018 class-action lawsuit against Centene alleged that the insurer misrepresented the breadth of its provider network.¹³ In 2019, Anthem policyholders sued Anthem after the health insurer failed to disclose that it planned to narrow its network as individuals shopped for its plans, which trapped policyholders in plans that did not cover providers in their area.¹⁴ Although nearly all states regulate network adequacy to some extent, oversight is inconsistent and may not ensure transparency.

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:

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- 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. Directories should be accurate and easily accessible, and health plans should hold consumers harmless when directories are inaccurate.

¹ Avalere Health. Access to Comprehensive Stroke Centers & Specialty Physicians in Exchange Plans. American Heart Association. September 26, 2014, available at: http://www.heart.org/idc/groups/public/@wcm/@adv/documents/downloadable/ucm_468318.pdf.

² Dorner 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.

³ Chhabra KR, Sheetz KH, Nuliyalu U, Dekhne MS, Ryan AM, Dimick JB. Out-of-Network Bills for Privately Insured Patients Undergoing Elective Surgery With In-Network Primary Surgeons and Facilities. *JAMA*. 2020;323(6):538–547.

⁴ Hempstead K. Marketplace Pulse: Percent of Plans with Out-of-Network Benefits. Robert Wood Johnson Foundation. October 4, 2018, available at: <https://www.rwjf.org/en/library/research/2018/10/percent-of-plans-with-out-of-network-benefits.html>.

⁵ Sun EC, Mello MM, Moshfegh J, Baker LC. Assessment of Out-of-Network Billing for Privately Insured Patients Receiving Care in In-Network Hospitals. *JAMA Intern Med*. 2019;179(11):1543–1550.

⁶ Surprise Medical Bills: Results from a National Survey. Families USA. November 2010, available at: <https://familiesusa.org/wp-content/uploads/2019/11/Surprise-Billing-National-Poll-Report-FINAL.pdf>.

⁷ Pollitz K. Surprise Medical Bills. Kaiser Family Foundation. March 17, 2016, available at: <https://www.kff.org/private-insurance/issue-brief/surprise-medical-bills/>.

⁸ Charlene A. Wong, Daniel E. Polsky, Arthur T. Jones, Janet Weiner, Robert J. Town, and Tom Baker. “For Third Enrollment Period, Marketplaces Expand Decision Support Tools To Assist Consumers.” *Health Affairs* 2016 35:4, 680-687

⁹ Physicians, Health Plans Must Collab for Network Directory Accuracy. American Medical Association. February 27, 2018, available at: <https://www.ama-assn.org/physicians-health-plans-must-collab-network-directory-accuracy>.

¹⁰ Online Provider Directory Review Report. Centers for Medicare and Medicaid Services. 2018, available at: https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/Downloads/Provider_Directory_Review_Industry_Report_Year2_Final_1-19-18.pdf.

¹¹ Sloan C. 2020 Exchange Plan Networks are the Most Restrictive Since 2014. Avalere Health. 2019. Available at: <https://avalere.com/press-releases/2020-exchange-plan-networks-are-the-most-restrictive-since-2014>

¹² Dafny LS, Hendel I, Marone V, Ody C. Narrow Networks On The Health Insurance Marketplaces: Prevalence, Pricing, And The Cost Of Network Breadth.” *Health Affairs*. 2017;36(9): 1606-1614.

¹³ Keith K. Consumers Sue Centene Over Network Adequacy, Transparency. *Health Affairs Blog*. Jan 15, 2018. Available at: <https://www.healthaffairs.org/doi/10.1377/hblog20180115.627515/full/>.

¹⁴ Haefner M. Patients file class-action lawsuit against Anthem over WellStar dispute. *Beckers Hospital Review*. Feb 6, 2019. Available at: <https://www.beckershospitalreview.com/payer-issues/patients-file-class-action-lawsuit-against-anthem-over-wellstar-dispute.html>.