



Explainer

Insurer Provider Networks

July 2015

Background

The Affordable Care Act (ACA)¹ has transformed the financing of, eligibility for, and access to health care insurance for millions of Californians. Insurers in the individual and small-group market are now required to cover a specific set of benefits — essential health benefits² — and can no longer price premiums based on pre-existing diagnoses, smoking, or gender.³

Meanwhile, insurers wishing to compete effectively for millions of new consumers purchasing health insurance through Covered California —California’s public health benefit exchange, or insurance marketplace — faced increased pressure to limit premium prices and premium increases.⁴ One of the strategies used by insurers has been to selectively contract with physicians, hospitals, and medical specialists to reduce costs. In some cases, this results in a narrower provider network when some higher-cost providers and hospitals are excluded from plan networks in order to keep premiums lower.

The narrowing of provider networks has attracted attention from both policymakers and patient groups, who have raised concerns that narrow networks could adversely affect patients’ access to care and access to timely consumer information. Specifically, access concerns have centered on:

- Accuracy of information regarding participating network providers when enrollees are making insurance coverage decisions.

¹ The federal “Patient Protection and Affordable Care Act” (P.L. 111-148) and the “Health Care and Education Reconciliation Act” (P.L. 111-152) were enacted in March 2010. Together, these laws are referred to as the Affordable Care Act (ACA).

² Health insurance sold both inside and outside Covered California must provide 10 specified categories of essential health benefits (EHBs), as defined by the ACA. Those benefits are ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care. [ACA Section 1302(b)].

³ People shopping for health insurance now only see variation in premiums based on where they live, their age, family size, insurance company, type of plan, and level of cost sharing.

⁴ The ACA requires the establishment of health insurance exchanges, referred to as health insurance marketplaces, in every state, either set up and run by the state itself or by the federal government.

⁴ ACA Section 1302.

- Limited access to primary care providers, specialty physicians, and hospitals.
- Limited access to providers with expertise in treatment of rare chronic or acute conditions, where such access is associated with better outcomes, and disruption of existing relationships with physicians and other providers for patients with chronic illnesses.

On the other hand, health insurance purchasers and payers say narrow networks create pressure on providers and hospitals to practice more efficiently, re-evaluating their clinical and business practices to find cost savings, thus rewarding higher-performing and lower-cost providers. This is accomplished by negotiating with providers to accept lower reimbursement for care in order to be included in the network or restricting access to certain providers.

This explainer will explore California’s existing regulations related to measuring the adequacy of provider networks, and begins to re-evaluate questions of network adequacy in light of new state and federal laws and new health care business models and practices.

Provider Networks in Health Care

Historically, the concept of provider networks applied primarily to Health Maintenance Organizations (HMOs) or managed care organizations, which arrange care for enrollees by pre-negotiating a set amount that it would pay medical professionals for providing an array of covered services to their enrollees. These networks were seen as an alternative to then-typical fee-for-service⁵ insurance arrangements. Commercialization and explosive growth of enrollees in HMOs,⁶ coupled with consumer backlash against the perception that HMOs denied health services for profit, then helped to maintain relatively broad provider networks for consumers. In the 1980s, Preferred Provider Organizations (PPO)⁷ in the individual market often included broad networks of providers, though some health insurers did offer some “narrow networks” that differed substantially by product.

Since implementation of the ACA, narrow networks have emerged among PPOs and in the commercial insurance market, the Exclusive Provider Organization (EPO). For instance, prior to implementation of the ACA, the Blue Shield Preferred Network and BLUE Card program was available in both the individual and employer market. Starting in 2014, it was not available to Blue Shield PPO customers in the individual market. Additionally, within Covered California, health insurers such as Blue Cross have a narrower roster of health providers than are available to enrollees in non-Covered California plans.

Existing Definitions for Network Adequacy

Existing state and federal law and regulations provide a picture of how provider network adequacy has been defined and measured: (1) quantity of network providers; (2) proximity of those providers to enrollees; and (3) how long it takes enrollees to see those providers.

Depending on the health insurance product,⁸ California health plans and policies are regulated by one of two state regulators:

- Department of Managed Health Care (DMHC)⁹ regulates 92.6% of the state-regulated market, and 97.6% of enrollees with Covered California health insurance.
- California Department of Insurance (CDI)¹⁰ regulates 7.4% of the state-regulated market, and about 2.4% of enrollees with Covered California health insurance.

CDI passed regulations this year that align its definitions of network adequacy to those of DMHC.

Number of Providers

California regulations specify that health plans or policies ensure at least one full-time physician per 1,200 enrollees;

⁵ In fee-for-service arrangements, providers are paid separately for each service.

⁶ HMO enrollment increased from 3 million in 1970 to 80 million in 1999. Interstudy Extra, Vol. 1, Issue 4 (December 2000) p. 1.

⁷ Preferred Provider Organizations allow enrollees relative freedom to choose providers they want to visit, but offer “preferred” pricing for those providers that are “in-network.”

⁸ Self-insured health insurance plans (enrolling 9.4% of Californians) are not regulated by the state and therefore not subject to these rules.

⁹California Health Benefits Review Program, 2015 population model.

and one full-time primary care physician per 2,000 enrollees.^{10,11}

The ACA and subsequent regulations also generally require Qualified Health Plans (QHPs) contracting with state insurance marketplaces such as Covered California to maintain “a network that is sufficient in number and types of providers...to assure that all services will be accessible without unreasonable delay.”¹² Additionally, the ACA requires the inclusion of “essential community providers” in the contracted network to ensure “reasonable and timely access...for low-income, medically underserved individuals in the QHP’s service area.”^{13,14}

Geographic Proximity

California regulations^{15,16} also lay out the maximum distance in-network providers must be from enrollees. Specifically, the regulations require:

- Primary care within 30 minutes¹⁷ or 15 miles;
- Specialists within 60 minutes or 30 miles;
- Mental health professionals within 30 minutes or 15 miles; and
- Hospitals within 30 minutes or 15 miles.

Timely Access

California regulations also define “timely access” to care,^{18,19} based on the urgency of the visit and whether the service requires prior authorization from the insurance carrier. Timely access is defined as utilization of:

- Urgent care

¹⁰ 10 California Code of Regulations (CCR) § 2240.1 (c)(1)

¹¹ 28 CCR §1300.67.2 (d)

¹² 45 Code of Federal Regulations (CFR) § 156.230

¹³ Essential community providers are defined as those that serve predominantly low-income, medically underserved individuals. (45 CFR Section 235). This is specifically defined as 340B entities, Disproportionate Share Hospitals (DSH), federally qualified health centers (FQHCs); federally designated 638 Tribal Health Programs and Urban Indian health organizations; providers licensed as community or free clinics.

¹⁴ In addition to CMS’ definition of “essential community providers,” California has also allowed providers participating in Medi-Cal’s HI-TECH Electronic Health Records (EHR) Incentive Program to be defined as an “essential community provider.”

¹⁵ 10 CCR § 2240.1

¹⁶ 28 CCR § 1300.51 (H)

¹⁷ Regulations do not specify a mode of transportation.

¹⁸ DMHC regulations found at 28 CCR §1300.67.22.

- Within 48 hours if no prior authorization is required;
- Within 96 hours if prior authorization is required.
- Non-urgent care
 - Within 10 days for primary care;
 - Within 15 days for specialty care.

Additionally, beginning in December 2015, SB 964 (Chapter 573, 2014) will require DMHC to perform annual reviews separately for Medi-Cal Managed Care plans and health plans sold in the individual market to assess whether health plans are meeting the timely access standards in both market segments.²⁰

Emerging and Evolving Issues

The ACA has expanded the number of Americans with health insurance coverage by 14.1 million²¹ in 2015 (in California nearly 2.5 million Californians have gained coverage through the ACA²²). As more enrollees use their newly acquired coverage, increasing attention is being paid to how and whether enrollees have sufficient provider access.

New Research on Provider Networks

With the first full year of implementation now complete, researchers are seeking to better understand the effects of narrower networks on enrollment and enrollee behaviors.

In Massachusetts, which passed its own health care reform in 2006, MIT economist Jonathan Gruber

¹⁹ 10 CCR § 2240.15 (b) (5). These are newly approved emergency regulations for CDI that align CDI’s regulations to those of DMHC, the ACA, and the ACA’s subsequent regulations.

²⁰ These new requirements do not apply in to health insurance policies regulated by the California Department of Insurance.

²¹ Assistant Secretary for Planning and Evaluation (ASPE), U.S. Department of Health and Human Services, “Health Insurance Coverage and the Affordable Care Act,” May 5, 2015, Accessed May 21, 2015 at http://aspe.hhs.gov/health/reports/2015/uninsured_change/ib_uninsured_change.pdf.

²² UCLA Center for Health Policy Research, UC Berkeley Center for Labor Research and Education, *Report: CalSIM Version 1.91 Statewide Data Book, 2015-2019*, May 2014. Accessed June 30, 2015 at <http://healthpolicy.ucla.edu/publications/search/pages/detail.aspx?PubID=1283>.

evaluated enrollment and spending data from the Massachusetts Group Insurance Commission for enrollees who were offered financial incentives to switch to narrower network health insurance. Among the findings, the study suggests many enrollees who switched to narrower networks were able to retain their primary care provider. Additionally, for enrollees who switched plans, primary care office visits increased, while visits to specialists and emergency departments decreased. The change in utilization resulted in an overall reduction in health care costs of about 4%.²³

A study by McKinsey & Company, a business consulting firm, evaluated the networks of all 501 rating areas in the U.S. and found that enrollees in 2014 had nearly equal access to both broad and narrow provider networks (90% and 92%, respectively). Narrow networks made up 48% of exchange networks in the U.S.²⁴ The study found that premiums for health insurance with broader networks were 13% to 17% higher than for narrower networks. Finally, of enrollees who reported enrolling in an ACA plan, 26% were unaware of the type of network they had chosen.

While these early studies help inform consumer behavior when confronted with narrower provider networks, additional research studies are needed in the California setting, and that account for potential selection bias in choice of types of plans.

In December 2014, AcademyHealth, a national health services research and health policy organization, convened federal policymakers for a discussion on provider networks, and striking the balance between consumer and enrollee access to providers and insurer flexibility. Policymakers suggested heightened transparency around the selection of providers into a network, with consideration for the cost and quality of providers. Additionally, policymakers believed consumers needed better education and awareness about their network options.²⁵

²³ Gruber, Jonathan and Robin McKnight. "Controlling Health Care Costs Through Limited Network Insurance Plans: Evidence from Massachusetts State Employees." NBER Working Paper Series. National Bureau of Economic Research. Working Paper 20462. September 2014.

²⁴ McKinsey&Company. Hospital networks: Updated national view of configurations on the exchanges. *McKinsey Center for U.S. Health System Reform*.

²⁵ Summer, Laura. "Research Insights. Health Plan Features: Implications of Narrow Networks and the Trade-Off between Price and Choice," AcademyHealth. December 2014.

²⁶ Bodenheimer and Smith, 2013

Issues Affecting Provider Networks

Issues related to or that could affect provider networks include:

- Evolving definitions for care delivery, and
- Provider directory accuracy.

Evolving Care Delivery

As previously described, current definitions of network adequacy and measurement center on physical geographic boundaries or a physician delivering care. However, pressure to reduce the cost of delivering medical services along with advancing technologies enable a wider range of medical providers to provide health services outside a traditional medical office, therefore potentially augmenting provider capacity.

Healthcare Workforce

Over the past several decades, physician offices and clinics have begun using more nonphysicians, such as pharmacists, physician assistants, nurse practitioners, registered nurses, and medical assistants to substitute for or augment care that physicians have traditionally provided.²⁶ However, as noted in the previous section, existing methods for assessing provider network adequacy focus narrowly on ratios of physicians to enrollees. Incorporating additional health professionals such as nonphysicians into the regulatory definition of the number of providers available to meet patient needs would result in measures of adequacy that better reflect contemporary means of care delivery. Policymakers have also recently passed legislation that would expand the scope of work for nurse practitioners, physician assistants, licensed midwives, and pharmacists in certain circumstances.²⁷

Retail Clinics

Retail clinics provide basic health care services²⁸ in drug stores, supermarkets, or other retail outlets. Health care provided at these clinics is convenient for patients, less

²⁷ In the 2013-14 Legislative Session: AB 154 allows nurse practitioners, certified nurse midwives, or physicians assistants to perform abortions; AB 1308 removes physician supervision for licensed midwives in certain circumstances; AB 1535 allows pharmacists to dispense naloxone hydrochloride.

²⁸ Typical retail clinic services include treatments for minor burns and rashes, urinary tract infections, strep throat and vaccinations. Bohmer, Richard. "The Rise of In-Store Clinics – Threat or Opportunity?" *New England Journal of Medicine*, 356; 8. February 22, 2007. Accessed on May 21, 2015 at <http://www.nejm.org/doi/pdf/10.1056/NEJMp068289>.

expensive for both patients and payers, do not require appointments and tend to have short wait times.²⁹ They are typically staffed by nonphysicians.³⁰ The number of retail clinics is expected to double between 2012 and 2015.³¹ While in the past, traditional medical offices have been concerned that such clinics would disrupt the relationship between the patient and primary care provider, retail clinics are now being viewed as a way to augment primary care access. In late 2014, Kaiser Permanente and Target stores announced a new partnership with the opening of four in-store clinics. Existing regulations count access to primary care by distance. Some consideration of the services that retail clinics provide could potentially complement the services provided at primary care physicians' offices.

Telehealth

Over the past decade, communication technology has also evolved rapidly, making the use of electronic communication in health care more accessible and commonplace. For instance, patients may e-mail their providers with questions, photos, or video. Live videoconferencing may occur through specialized cameras and screens at clinics and hospitals, or through laptop cameras and equipment that patients have in their own homes. Videoconferencing, telephone calls, and emails are sometimes used as a substitute for in-person visits — either as a convenience for patients who want a quick primary care visit,³² or to provide access to specialists not available in local communities. The

increase in use of these technologies may reduce demand for in-person visits.^{33,34} The National Association of Insurance Commissioners is in the process of drafting model legislation that recognizes the potential contributions of telehealth in health care.³⁵ Acknowledging and incorporating advancements in telehealth technology would broaden the definition of provider accessibility beyond distance- or geographic-based measures.

Accuracy of Provider Directories

Some enrollees seeking to use their new Covered California health insurance discovered that physicians listed³⁶ by their insurers either did not accept their health insurance, or were not at the location listed in the directory. DMHC subsequently performed telephone surveys and found deficiencies in Anthem Blue Cross' and Blue Shield of California's provider directories.³⁷ Staff working at front desks of health providers are also sometimes unaware of the types of health insurance accepted and the status of contracts.³⁸ All this can result in difficulties finding in-network providers, confusion about network membership, and in some cases, can result in surprise bills to consumers. California Policymakers are now aiming to ensure the accuracy of provider directories. SB 137 (Hernandez) requires health insurers to furnish regulators with updated provider directories weekly.³⁹ Recently adopted emergency regulations at CDI, proposed federal regulations,⁴⁰ along with a draft National

²⁹ Bohmer, Richard. "The Rise of In-Store Clinics – Threat or Opportunity?" *New England Journal of Medicine*, 356; 8. February 22, 2007. Accessed on May 21, 2015 at <http://www.nejm.org/doi/pdf/10.1056/NEJMp068289>.

³⁰ Mehrotra, Attev, Margaret Wang, Judith Lave, John Adams, and Elizabeth McGlynn. "Retail Clinics, Primary Care Physicians, And Emergency Departments: A Comparison of Patients' Visits," *Health Affairs*, 27, no. 5 (2008): 1272-1282. Accessed on May 18, 2015 at <http://content.healthaffairs.org/content/27/5/1272.full.pdf+html>.

³¹ Accenture. "Insight driven health: Retail Clinic Counts Will Double Between 2012 and 2015 and Saving \$800 Million per Year," Accenture 2014. Accessed on May 18, 2015 at <http://www.accenture.com/SiteCollectionDocuments/PDF/Accenture-Retail-Medical-Clinics-From-Foe-to-Friend.pdf>

³² California health insurers, such as Aetna, Blue Shield of California, and Cigna HealthCare, are increasingly contracting with telehealth providers, such as RelayHealth, to provide enrollees with around-the-clock access to physicians via telephone or live videoconferencing through the internet. Kaiser Permanente has greatly increased use of both email and telephone for patient encounters (Pearl 2014).

³³ Weiner JP, Yeh S, and Blumenthal D. "The impact of health information technology and e-health on the future demand for physician services," *Health Affairs*. 2013 Nov; 32 (11); 1998-2004.

³⁴ Gagnon MP, Pollender *et al.*, "Supporting health professionals through information and communication technologies: a

systematic review of the effects of information and communication technologies on recruitment and retention," *Telemed J E Health* 2011 May; 17(4): 269-74.

³⁵ The National Association of Insurance Commissioners (NAIC) is considering model legislation that would encourage health insurers to describe how "the use of telemedicine or telehealth or other technology may be used to meet network access standards." NAIC Model Statute, November 12, 2014, Section 5 (F).

³⁶ Anthem Blue Cross or Blue Shield Terhune, Chad. "Top insurers overstated doctor networks, California regulators charge," *LA Times*, November 19, 2014. <http://www.latimes.com/business/la-fi-obamacare-network-probe-20141119-story.html#page=1>

³⁷ Both insurers have disputed the DMHC's findings. DMHC reports and health insurers' responses can be found at <http://www.dmhc.ca.gov/desktopmodules/dmhc/medsurveys/surveys/043fsnr111814.pdf> and <http://www.dmhc.ca.gov/desktopmodules/dmhc/medsurveys/surveys/303fsnr111814.pdf>.

³⁸ Non-routine surveys of Blue Shield of California and Anthem Blue Cross, November 7, 2014. <http://www.dmhc.ca.gov/desktopmodules/dmhc/medsurveys/surveys/043fsnr111814.pdf> and <http://www.dmhc.ca.gov/desktopmodules/dmhc/medsurveys/surveys/303fsnr111814.pdf>.

³⁹ SB 137 (Hernandez) as amended April 21, 2015.

⁴⁰ Federal Register November 26, 2014. Section 156.230 (b).

Association of Insurance Commissioners⁴¹ model statute, all emphasize the importance of accurate provider directories. Both propose to require health insurers post current provider directories for each of their networks, updated monthly.

Key Questions in Evaluating Provider Networks

Developing adequate measures for five core issues will be central in more contemporary evaluations of the adequacy of provider networks, taking into account ACA-related health insurance market changes, and evolutions in technology and medical practice (and scope of practice by supporting health professionals). Researchers around the nation are beginning to assess:

- **Network composition:** How have networks changed since the implementation of the ACA?
- **Consumer health plan selection:** Are there differences in the demographics or health risk of enrollees who select narrower versus broader network plans?

- **Access:** Are network lists accurate? Has access to care changed for enrollees who switched from broader to narrower network plans?
- **Quality of care:** How does quality of care compare for patients in narrow networks compared to broader networks?
- **Cost:** What is the difference in cost between narrow and broad networks?
- **Communication:** To what extent are enrollees aware that they are selecting a narrow network product? How can insurers and others better educate enrollees?

The dramatic shifts in regulation and purchasing of health insurance products have resulted in changes in how health insurers contract for and construct their provider networks. Simultaneously, healthcare delivery has changed in a manner that potentially expands provider capacity. This confluence of changes warrants re-evaluation of network adequacy and how it is defined and measured.

⁴¹ NAIC Model Statute, November 12, 2014, Section 5 (B).

ABOUT CHBRP

The California Health Benefits Review Program (CHBRP) was established in 2002. As per its authorizing statute, CHBRP provides the California Legislature with independent analysis of the medical, financial, and public health impacts of proposed health insurance benefit-related legislation. The state funds CHBRP through an annual assessment on health plans and insurers in California.

Detailed information on CHBRP's analysis methodology, authorizing statute, as well as all CHBRP analyses and other publications are available at <http://www.chbrp.org/>.

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