STATE NETWORK ADEQUACY LAWS: ACCESS TO SPECIALIST PROVIDERS

Background

Network adequacy refers to a health insurer's capacity to deliver the full scope of a plan's benefits to beneficiaries by providing timely access to a sufficient number of in-network providers. The Affordable Care Act (ACA) established the first federal standard for network adequacy for Qualified Health Plans (QHPs) offered on the Exchange marketplaces. QHPs must "maintain a network that is sufficient in number and types of providers…to assure that all services will be accessible to enrollees without unreasonable delay."[1] The ACA also gives states latitude to create additional standards. However, pre-dating the ACA, many states had network adequacy requirements in place, and, only a handful of states have moved to strengthen network adequacy requirements following the ACA.[2]

State reviews of network adequacy standards often focus on access to primary care providers.[3,4,5] However, the sickest patients also need access to specialists. Access to specialist care is particularly important for patients with complex, chronic, or life-threatening diseases that require regular appointments with health care providers with expertise beyond primary care. Patients that do not have access to an adequate specialist network may find it difficult to schedule appointments, experience long-wait times to see a specialist, or be required to travel long distances to see the appropriate specialist.

This brief reviews the network adequacy standards for specialists in the 50 states and the District of Columbia.[6]

State Standards for Specialist Network Adequacy

State efforts to regulate network adequacy vary considerably. Some states have broad standards for network adequacy. For example, Maryland requires health insurance carriers to maintain a panel of in-network providers that is "sufficient in numbers and types of available providers to meet the health care needs of enrollees."[7] Other states have imposed more particular standards, requiring carriers to provide access to specific providers within certain time or distance standards.

As of July 2015, 31 states have statutory or regulatory standards addressing network adequacy for specialists. 17 states have specific time and/or distance standards; 13 states have both (see map).

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[1] 45 C.F.R. 156.230(a)(2)

[2] Commonwealth Fund. Implementing the Affordable Care Act State Regulation of Marketplace Plan Provider Networks. May 2015. http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2015/may/1814_giovannelli_implementing_aca_state_reg_provider_networks_rb_v2.pdf.

[3] Commonwealth Fund. Implementing the Affordable Care Act State Regulation of Marketplace Plan Provider Networks. May 2015. http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2015/may/1814_giovannelli_implementing_aca_state_reg_provider_networks_rb_v2.pdf.

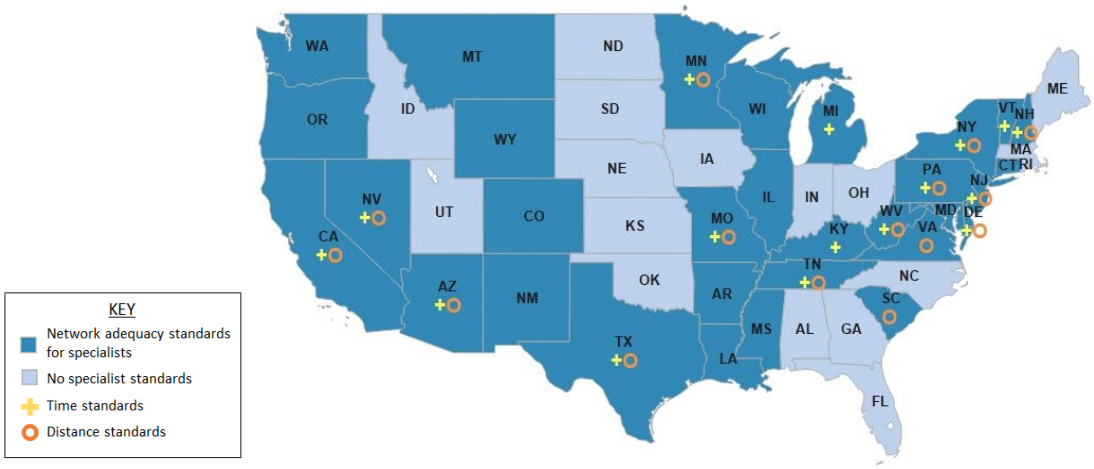
[4] Georgetown Health Policy Institute. ACA Implications for State Network Adequacy Standards. Robert Wood Johnson Foundation. August 2013. http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2013/rwjf407486.

[5] Families USA. Standards for Health Insurance Provider Networks: Examples from the States. Nov 2014. http://familiesusa.org/sites/default/files/product_documents/ACT_Network%20Adequacy%20Brief_final_web.pdf.

[6] For purposes of capturing any standards for access to specialists, state requirements to ensure patient access to OB/GYNs and mental/behavioral health specialists were excluded.

[7] Md. Code Regs. 31.10.34.04, 31.10.34.05

States with Specific Standards for Specialist Network Adequacy



There are a handful of states that stand out as leaders in regulating specialist network adequacy. Missouri and Nevada, for example, regulate travel time and/or distance to providers and identify which type of specialist must be included in a health insurer's network. Concerning primary care, Missouri requires health maintenance organizations (HMOs) to ensure access to routine care, without symptoms, within 30 days; routine care, with symptoms, within five business days; urgent care within 24 hours; and emergency care available 24 hours per day, seven days a week. Missouri also mandates access to more than 20 types of specialists, including those practicing Cardiology, Dermatology, Endocrinology, Gastroenterology, Hematology/Oncology, Infectious Disease, Nephrology, Neurology, Obstetrics/Gynecology, Orthopedics, Otolaryngology, Physical Medicine/Rehab, Podiatry, Pulmonary Disease, Rheumatology, Psychiatric-Adult/General, Psychiatric-Child/Adolescent, Psychologists/Other Therapists, and Urology.[8]

Arizona and California do not identify which types of specialists must be covered by a health plan's network, although both states have regulations that limit the travel time and/or distance a patient must travel to reach a specialist, and implement a maximum appointment wait time for specialist providers. In California, health insurers must guarantee specialists are located within 60 minutes or 30 miles of a covered person's residence or workplace. Moreover, the state requires health insurers and managed care plans to make non-urgent specialist appointments available within 15 business days of the patient's request for an appointment.

[8] Mo. Code Regs. tit.20, § 400-7

Types of Standards

Access to Certain Specialists
Six states identify which types of specialists must be included in a health plan's network: Delaware, Michigan, Missouri, Nevada, New Hampshire, and Pennsylvania.

Appointment Wait Times
Four states specify the maximum amount of time a patient should have to wait to see a specialist. For example, Washington requires health plan enrollees be able to obtain a specialist appointment within 15 business days after referral, for non-urgent care.[9]

Provider to Enrollee Ratios
A few states also dictate provider to enrollee ratios for specialists. Nevada requires carriers to meet minimum provider to member ratios for 11 specialties (See Appendix I).[10] West Virginia's ratio requirements are less specific. The state requires the ratio for all specialist providers to be 1 specialist to every 2,000 beneficiaries.[11]

Time and Distance of Travel
Most states with standards for specialist network adequacy also require specialist providers be accessible by beneficiaries within a certain distance and/or travel time; thirteen states have time and/or distance standards. For instance, New Jersey requires health plans to have a sufficient number of in-network specialists to ensure access within 45 miles or one-hour driving time, whichever is less, for 90 percent of beneficiaries.[12]

In Minnesota, HMOs must limit the maximum travel distance/time to a specialist provider to be "the lesser of 60 miles or 60 minutes."[13]

State Spotlight: Nevada

Like many states, regulating network adequacy is not new in Nevada. Health maintenance organizations (HMOs) licensed in the state have been subject to some form of network adequacy standard since 1973. Most recently, the Nevada Department of Insurance (DOI) introduced draft Network Adequacy regulations for QHPs, in June 2014. The regulations were not finalized, however, and in May 2015, the DOI indicated that these standards would be used to determine network adequacy for the plan year 2016, with additional guidance forthcoming for plan year 2017. Nevada's network guidelines are among the most robust in the nation for ensuring access to specialist health care providers. In addition to specifying which specialty providers must be covered, Nevada requires health plans to meet time and distance standards depending on a patient's location in the state. For the 2015 and 2016 plan years, Nevada requires network plan issuers to meet minimum provider to beneficiary ratios for specialists (See Appendix I).

[9] Wash. Admin. Code § 284-43-200.
[10] Nevada Dept. of Insurance Bulletin 14-005.
[11] W. Va. Code § 33-25C-4.
[12] N.J. Admin. Code § 11:24A-4.10
[13] Minn. Stat. § 62D.124

APPENDIX I

Nevada Requirements for Minimum Number of Specialist Providers[14]

Minimum Number of Providers with Specialties	Ratio
Cardiology	1 provider/facility for every 7,500 covered persons.
Dermatology	1 provider for every 17,500 covered persons.
Gastroenterology	1 provider for every 25,000 covered persons.
Hematology/Oncology	1 provider for every 17,500 covered persons.
Nephrology	1 provider for every 10,000 covered persons.
Ophthalmology	1 provider for every 27,500 covered persons.
Orthopedics (General, Hand, and Neurosurgery)	1 provider for every 10,000 covered persons.
Otolaryngology	1 provider for every 25,000 covered persons.
Pulmonology	1 provider for every 20,000 covered persons.
Surgery (General, Cardiovascular, Cardiothoracic, Vascular, and Colorectal)	1 provider for every 12,500 covered persons.
Urology	1 provider for every 25,000 covered persons.

[14] Nevada Department of Insurance Bulletin 15-005, as of May 8, 2015. See http://doi.nv.gov/uploadedFiles/doinvgov/_public-documents/News-Notices/Bulletins/14-005.pdf