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## **Policy Recommendations for Addressing Health Insurance Network Adequacy and Provider Network Standards in the Georgia Insurance Market**

Oluwatoyin Adedapo-Jimoh

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## ABSTRACT

### **POLICY RECOMMENDATIONS FOR ADDRESSING HEALTH INSURANCE NETWORK ADEQUACY AND PROVIDER NETWORK STANDARDS IN THE GEORGIA INSURANCE MARKET**

By

Oluwatoyin Adedapo-Jimoh

December 12, 2016

#### **ABSTRACT**

Network adequacy is a key indicator of a health insurance plan's ability to provide access to appropriate, timely, and geographically accessible care. This capstone project focuses on developing policy recommendations to address the issue of insurance network adequacy standards and provider directories in the state of Georgia. These recommendations focus on the state of Georgia due to its lower ranking on health of the population and policy actions of the Georgia legislature during the most recent legislative session. A synthesis of current policy and research articles was conducted, with a particular focus on comparing policies and initiatives in the state of Georgia with those in other states. The effect that certain policy changes on insurance networks have had in these other locations can provide valuable insights about the impact of such policies, should they be implemented in the state of Georgia.

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AND PROVIDER NETWORK STANDARDS IN THE GEORGIA INSURANCE MARKET**

by

OLUWATOYIN ADEDAPO-JIMOH

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APPROVAL PAGE

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## Author's Statement Page

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Oluwatoyin Adedapo-Jimoh  
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## **CHAPTER 1: What is Network Adequacy?**

The Affordable Care Act (ACA) is responsible for setting the first national standard for network adequacy in commercial health insurance. Network adequacy is a key indicator on a health insurance plan's ability to provide access to appropriate, timely, and geographically accessible care. In order to be adequate, a network must (1) provide adequate numbers, types, and geographical distribution of providers, (2) ensure that access to care is timely, (3) include essential community providers that serve predominately low-income, medically underserved individuals, and (4) provide accurate information to consumers about providers.

In health insurance marketplaces, the ACA-mandated changes such as removing annual benefit limits led health insurers to implement strategies to offer lower-cost plans. Most insurers used network design changes such as narrow networks to lower premiums in various ways. A network plan is a "health benefit plan that either requires a covered person to use, or creates incentives, including financial incentives, for a covered person to use health care providers managed, owned, under contract with or employed by the health carrier" (NAIC, 2015). The narrowness of a network is determined by the composition of a network plan and the extent to which its providers are in-network. The term 'in-network' refers to hospitals, physicians, and other healthcare providers who are considered contracted participants in an insurance plan and 'out-of-network' refers to those that are not. For example, a plan would be considered 'narrow' if less than 50% of area hospitals and providers are in-network and would be considered 'ultra-narrow' if less than 20% are in-network. Herein this concept lies the topic of network adequacy. A health insurance network must be adequate to ensure that consumers

enrolled in the plans have reasonable access to all covered benefits included in the terms of the contract (Haeder, Weimer, & Mukamel, 2015).

Network adequacy has been a topic of interest for the past few years especially after the implementation of the ACA and subsequent studies on its efficacy. When the link between health insurance and access to care is inadequate, consumers are forced to choose between forgoing health care and seeking care out-of-network, which can put the potential risk of large medical bills on consumers. Network provider listings are important to achieving network adequacy, but are often found to be inadequate due to narrow networks and inaccuracies. These inaccuracies, caused by improper maintenance of up-to-date information, can lead to limited access to care for consumers and financial strains due to surprise or balance billing. These inaccuracies also make it difficult for regulators to assess network adequacy. The financial impact is important because it can place an additional barrier on the consumer's access to usual source of care. Lack of access to usual source of care is an important aspect of health disparities. Disparities in accessing care can develop as a result of, for example, insufficient distribution of providers, transportation barriers, language barriers, and lack of flexible hours (McAndrew & Hernandez-Cancio, 2014).

### *1.1 Principles of Network Adequacy*

The principles of network adequacy have implications in four healthcare/health insurance domains: availability of providers, timely access to care, financial protection and affordability, and transparency.

- Availability of providers: access to covered services is dependent on the availability of sufficient numbers and types of providers; therefore, health plans should maintain



networks that have the right mix and choices of providers to ensure access to appropriate in-network health services (Gonsahn & Zeldin, 2016)

- Timely access to care: access to health care can be disrupted by long wait times, long travel distances, or shortened hours of operation; therefore, health plans should maintain provider networks with adequate numbers and geographic dispersion to ensure enrollee have access to care in an appropriate timeframe (Gonsahn & Zeldin, 2016)
- Financial protection & affordability: health insurance should have features to protect against the financial burden of high medical costs; and, enrollees should not have to pay out-of-network rates for medical services due to inadequate provider networks (Gonsahn & Zeldin, 2016)
- Transparency: due to the fact that provider directories are the primary tool consumers use to access health care services, consumers should be able to receive accurate information to determine, for example, which providers are in-network (Gonsahn & Zeldin, 2016)

There has been much controversy recently concerning the role of narrow networks in health insurance plans—that is the extent that provider networks restrict patient choice, primarily in terms of which and how many hospitals and physician participate in a network within a geographical area. In particular, following the implementation of the ACA, there is reported evidence of more narrow plans in the Marketplace compared to those not in the Marketplace. The Marketplace is a provision of the ACA and functions as a service to aid consumers with health plan shopping and enrollment. Proponents of narrow networks claim

that health insurance premiums are generally lower in plans with narrow networks, which can offer value to the consumers. This is thought to occur because negotiations/competition over network participation between providers and insurers can encourage a more efficient care delivery system by being comprised of those providers that meet the standards of the insuring company.

Critics of narrow networks oppose them because they argue that this restricts choice of providers. By being too narrow, narrow networks can jeopardize the ability of consumers to obtain needed services in a timely manner, especially if the network consists of an inadequate mix of provider types. There might be too few providers who accept new patients, who have appointments times available within in a reasonable timeframe, and who speak other languages. Narrow networks can result in a skewed risk pool that discourages the enrollment of sicker individuals. Risk pools are programs created by legislatures as a way to provide a safety net for the ‘medically uninsurable’—those who can only access private insurance with restricted coverage or high rates usually as a result of a pre-existing condition. They can become skewed as insurers want lower risk pools to maintain costs so if a network is already narrow, those with more serious conditions are likely to have higher rates and higher rates can discourage enrollment. Also, there is the risk of patients going out-of network to seek care due to an inadequate supply of in-network providers. Out-of-network services can lead to a financial burden on the consumer as a result of surprise/balance billing, in which, the consumer gets billed for the difference between provider’s charge and the payment the insurance plan makes.

There are two ways of measuring network adequacy standards: qualitatively and quantitatively. The qualitative standard states that plans must maintain a ‘sufficient choice of

in-network providers' so consumers can access care without unreasonable delay by any reasonable criteria and include 'essential community providers' who serve low income, medically-underserved communities (Giovannelli, Lucia, & Corlette, 2016). Quantitative standards are defined by addressing the maximum time and distance a consumer must travel to receive care, the amount of time that consumers have to wait for an appointment, provider-enrollee ratios, and availability of extended hours of operation (Giovannelli, Lucia, & Corlette, 2016). These standards link back to the four principles of network adequacy. However, it is difficult to standardize these requirements nationwide or even statewide due to the regional differences in varying market dynamics. This is due to the fact that although healthcare is governed at the national level, state legislatures have authority to set regulations particular to their states and this lack of cohesion makes large-scale standards difficult to achieve. Also, meeting requirements of network adequacy will require addressing the differences in rural and urban communities and identifying their standards accordingly. For example, past insurer attempts to lower premiums through a narrow network strategy was more achievable in large urban settings as opposed to rural areas where there is already less provider density meaning the networks are already inherently limited.

### *1.2 National Association of Insurance Commissioners Model Act*

The adoption of the Health Benefit Plan Network Access and Network Adequacy Model Act by the National Association of Insurance Commissioners (NAIC) set an important framework for states to use in addressing issues with network adequacy and provider directory problems. The NAIC is the U.S standard-setting and regulatory support organization created and governed by the chief insurance regulators from the 50 states (Gonsahn & Zeldin, 2016). The

Act was crafted from intensive input from stakeholders thus state legislators find it useful in their provider access reforms. These reforms are aided by this model Act by developing principles for regulating and implementing policies related to network adequacy. The purpose of the Act is to ‘establish standards for the creation and maintenance of network by health carriers and assure the adequacy, accessibility, transparency, and quality of health care services offered under a network plan’ (NAIC, 2015). It expands the definition of network adequacy as consisting of a health carrier providing and maintaining a network sufficient in number and types of providers. It categorizes sufficiency as including provider-covered person ratios by specialty, primary care professional-covered person ratio, geographic accessibility of providers, geographic variation and population dispersion, waiting times for an appointment, hours of operation, and ability to meet health needs of a community (NAIC, 2015).

In order to meet these criteria, provider directories have to be accurate since these directories are the first opportunity a consumer has to assess providers of health care. To ensure these directories function properly, the Act requires that the general public should be able to view all current providers through an identifiable link and without creating an account. The directory should be updated at least monthly and the health insurer should periodically perform audits for accuracy. A print copy of the directory should be available upon request and all copies should accommodate the communication needs of those with disability, such as hearing or visual impairment, and limited English proficiency.

## **CHAPTER 2: How Does Georgia Measure Up?**

### *2.1 Georgia State of Health Affairs*

Health disparities are a common area of research in public health. Disparities in health may be preventable and identification of these opportunities to achieve optimal health are a nation-wide concern. The main focus of this section will be on the state of Georgia and how existing policies regarding health insurance networks affect disparities in consumer access to care.

The ACA's primary goal is to extend health insurance coverage to the millions of nonelderly uninsured individuals nationwide, including 1.8 million uninsured Georgians. The ACA is able to accomplish this through insurance reforms and by establishing new pathways for coverage, "including an expansion of Medicaid to cover nearly all nonelderly adults up to 138% of the Federal Poverty Level (FPL) (\$16,105 for an individual and \$27,310 for a family of three in 2014) and by providing premium subsidies to most individuals with incomes up to 400% FPL to purchase coverage on the Health Insurance Marketplace" (Kaiser Family Foundation, 2014). The FPL refers to the measure of income, as issued by the Department of Health and Human Services, used to determine eligibility for certain programs and benefits. As a result of a Supreme Court decision (*National Federation of Independent Business v. Sebelius*), individual states were allowed to decide whether or not to expand Medicaid for adults. Georgia is not currently implementing the Medicaid expansion, and this decision to not implement expansion has significant implications for the availability of health coverage for poor uninsured adults in Georgia. However, many uninsured Georgians are still eligible for financial assistance to enroll in coverage, particularly through the Marketplace. Although thousands of Georgians have been able to obtain health coverage, as a result of the passage of the ACA and its Marketplace, the population health of the state of Georgia still falls below other states.

Georgia falls below national averages in measures of population health; for example, according to America's Health Rankings, Georgia's ranking on state health priorities fell from 38<sup>th</sup> to 40<sup>th</sup> out of the 50 states. According to the Commonwealth Fund's rankings of state health system performance, Georgia was in the bottom two quartiles between 2009 and 2014 but the actual ranking dropped from 35<sup>th</sup> in 2009 to 45<sup>th</sup> in 2014 (Radley, McCarthy, Lippa, Hayes, & Schoen, 2014). As for health care access disparities, health status measures vary by race/ethnicity. White residents in Georgia are nearly twice as likely as Blacks not to have had a doctor visit in the past 2 years but are more likely than Blacks and Hispanics in the state to report having a usual source of health care (Kaiser Family Foundation, 2014). Over half (56%) of Hispanics in Georgia report that they do not have a usual source of care, compared to less than one-quarter (24%) of Whites (Kaiser Family Foundation, 2014). These trends are mostly consistent with national data on health status and access by race and ethnicity.

## *2.2 Network Adequacy in Georgia*

According to a national report conducted by the Leonard Davis Institute of Health Economics and the Robert Wood Johnson Foundation, the state of Georgia, at 83% (Appendix A), was found to have the highest percentage of narrow networks (Polsky & Weiner, 2015). In 2015, the Georgia Senate created a study committee with a function of exploring provider and consumer protection issues such as network adequacy. The committee produced a final report on concerns about provider directory inaccuracies and recommended a review of the NAIC Model Act. As a result of committee action, Senate Bill 302 was created and passed in April of the 2016 legislative session. The purpose of the bill was "to amend Title 33 of the Official Code of Georgia Annotated, relating to insurance, so as to require certain insurers to maintain

accurate provider directories; to provide for definitions; to provide for electronic and printed provider directories; to require certain information in provider directories; to provide for related matters; to provide for exemptions; to repeal conflicting laws; and for other purposes” (Georgia Senate Bill, 2016, p. 1). Despite the passage of the senate bill, issues concerning network adequacy of provider network standards and the ability of health plans to provide access to all covered benefits require updating and improvement.

A consumer health advocacy organization, Georgians for a Healthy Future, conducted a secret shopper study in order to determine the extent of the provider network error issues. Secret shopper studies serve as an avenue for researchers to anonymously assess the adequacy of network plans. They are conducted through randomly selected number of providers listed in directories and researchers masquerading as potential new patients presenting themselves as seeking doctor’s appointment. Results from one study indicated that the directories were error-ridden and thus put consumers at risk for inadequate access to appropriate health care services (Georgians for a Healthy Future, 2016). A search was done within 30 miles of the Atlanta area zip code of 30312 under four silver-tier HMO plans. This study analyzed four directories under three of the state’s largest insurers and found the following:

- Three in four of the listings had at least one inaccuracy regarding status of being in-network, accepting new patients, practicing at the location listed, inaccurate contact information, or languages spoken
- One in five of the health care providers listed as participating in the network were actually not

- In one particular directory, 40% of the participating providers listed were not actually participating in the plan
- Among providers confirmed as 'in-network', 13% were not accepting new patients
- In one directory, one in four 'in-network' providers were not accepting new patients
- 15% of provider listed phone numbers were not accurate

These studies shed light on the network adequacy problem, specifically with respect to network provider directories (Georgians for a Healthy Future, 2016). These errors limit the usability of the information in a consumer's search for appropriate health providers which may be particularly problematic to the millions of newly-insured individuals who just obtained health care as a result of the ACA and their ability to access needed health care services. The current GA directory standards require plans to provide consumers, those already in the plan and prospective enrollees, with a directory upon request and to update directories at least every 30 days (although this only accounts for information received from a provider). However, there is no defined process for public reporting of errors in provider directories.

There is no consumer protection for out-of-network billing due to inaccurate information (Gonsahn & Zeldin, 2016). In order to address the issue of surprise billing, the Senate Surprise Billing Practices Study Committee was created to study the conditions, needs, issues, problems that create health care costs which are greatly exacerbated by surprise bills from out-of-network providers and recommend appropriate action (Georgia State Senate Resolution 974, 2016). There are no available findings to date, and this committee stands to be abolished on December 1, 2016. The report findings of this study committee will be presented during the upcoming legislative session. One of the Georgian governmental departments that is



at the forefront of this issue and serves as an important contact for further recommendation and implementation is the Georgia Department of Insurance. The Georgia Department of Insurance has the authority to assess network adequacy and, under Georgia Code Section 33-20A-5, requires that health insurance plans make benefits available and accessible to each enrollee with appropriate promptness and continuity of care (Gonsahn & Zeldin, 2016).

### **CHAPTER 3: Network Adequacy and Provider Directories in Other States**

The following states were selected because they provide a range of evidence on the network adequacy issue and efforts to make improvements. Given that these states stand at varying levels of narrow networks, they provide examples of key steps that could be taken at achieving various aspects of network adequacy.

#### *3.1 California*

The state of California (CA) was one of the first states to actively research and review the adequacy of statewide insurance plans and their networks. Conducting this research is important because according to a data brief presented by University of Pennsylvania and Robert Wood Johnson Foundation, 75% of networks in CA are considered narrow (Polsky & Weiner, 2015).

The research to review adequacy was conducted primarily through secret shopper studies. Secret shopper studies are conducted, by phone, through researchers selecting a random sample of providers listed in directories and masquerading as potential new patients seeking doctor's appointment. The researchers are assigned to differing insurance groups and seek appointment either for a routine physical or based on presentation of urgent symptoms.

These are conducted as a way to identify when and to what extent directories contain inaccurate information.

One study on provider directories in California found that 18% of providers were not practicing at their listed location (Georgians for a Healthy Future, 2016). Another study reported that obtaining access to providers inside and outside the California Marketplace was challenging. About 30% of cases had consumers unable to schedule an appointment with the first physician of contact, and information within the provider directories were often inaccurate (Haeder, Weimer, & Mukamel, 2016). This study included both rural and urban environments and networks of both Blue Cross of California and Blue Shield of California plans. The study discovered that (1) providers were listed as participating but no longer were about 10% of the time, (2) the provider's specialty was listed incorrectly about 30% of the time, (3) providers were not able to be contacted because of incorrect contact information about 19% of the time, (4) providers were not accepting new patients 10% of the time, and (5) overall, in about 70% of calls, shoppers were unable to set up an appointment with the primary provider contacted (Haeder, Weimer, & Mukamel, 2016).

As a result of the findings from this study, California implemented a requirement for health plan network directories to be updated monthly, more than the current every quarter standard, to ensure that the directories had accurate information about whether a provider was currently in-network and his/her correct contact information. It was also required that regulators perform annual reviews of directory maintenance compliance and post findings online. To promote maintaining the directories, the state set a requirement that any providers failing to respond to information verification within 30 days get a second attempt and after 15

days of unresponsiveness, the provider would be removed from the network (Gonsahn & Zeldin, 2016). In order to address time issues affecting access to care, California was just one of seven states to require certain health plans to include provisions that offer non-emergency services until 10pm at least one day a week or for at least four hours every Saturday (Giovannelli, Lucia, Corlette, 2015). Also, in order to address the issue of adequate number of providers, CA managed care plans were required to provide one full-time physician for every 1,200 enrollees (McAndrew & Hernandez-Cancio, 2014). These findings suggest that these policy changes might be one of the paths forward for improving access and lowering costs; however, future analysis of these administrative policy changes are needed to verify the longevity of these solutions.

### *3.2 New York*

Network adequacy standards in New York were established prior to the ACA. Insurers in NY generally support maintaining narrower networks in order to promote a patient-centered medical home model. According to a data brief presented by University of Pennsylvania and Robert Wood Johnson Foundation, New York (NY)'s proportion of narrow networks is at 39% (Polsky & Weiner, 2015). The NY state criteria for adequacy to meet the needs of its enrollees include the geographic accessibility of providers, the presence of at least three primary care providers within time and distance limits, and the availability of sufficient number and type of specialists (Corlette, Lucia, & Ahn, 2014). Post-ACA, NY maintained that networks must include in each county: a hospital that include core provider types, meet county specific provider-enrollee ratios, a choice of three primary care physicians, at least two required specialists, and

meet time and distance standards of provider availability within 30 minutes by public transportation or car.

In order to achieve more accuracy in provider directories, New York passed legislation that includes provisions requiring directories to list addresses, telephone numbers, languages spoken, specialties, and hospital affiliation for all plan providers as a way to guarantee accurate information about providers (McAndrew & Hernandez-Cancio, 2014). These provisions can help improve accuracy because the completeness of the contact information provides a higher chance of reporting of discrepancies. The state decided to hold its insurance plans to a more stringent requirement by imposing that online directories be updated within 15 days of adding or terminating a provider or changing a provider's hospital affiliation (Giovannelli, Lucia, Corlette, 2015). On the financial front, in 2014, NY enacted legislation removing consumers from being accountable for unexpected balance billing and requires greater consumer disclosure of the potential for out-of-pocket costs from out-of-network providers (Corlette, Volk, Berenson, & Feder, 2014)

### *3.3 Washington*

According to a data brief presented by University of Pennsylvania and Robert Wood Johnson Foundation, the distribution of narrow networks in Washington (WA) is at 33% (Polsky & Weiner, 2015). This lower percentage of narrow network has allowed the state to focus more on improving adequacy standards and making provider information as accurate as possible. Washington authorities adapted the state's framework to include more detailed and concrete network standards concerning time and distance requirements, specified ratio of primary care providers to plan enrollees, and maximum wait times for primary care and specialist

appointments (Giovannelli, Lucia, Corlette, 2015). The state established a requirement for plan directories to be updated on monthly basis (Giovannelli, Lucia, Corlette, 2015). In general, consumers in WA can expect to wait ten business days to see a primary care provider and fifteen days to see a specialist for a routine visit (Gonsahn & Zeldin, 2016). For maintaining accurate provider information, WA health plans must update their provider directories monthly and these directories must accommodate those with disabilities and limited English proficiency; the directories must include provider information such as language spoke, affiliations, specialties, and availability of interpreter services.

### *3.4 New Jersey*

According to a data brief presented by University of Pennsylvania and Robert Wood Johnson Foundation, the distribution of narrow networks in New Jersey (NJ) is at 67% (Polsky & Weiner, 2015). Network adequacy in the state of New Jersey has been evaluated using secret shopper studies. These studies found, for example, that one in three psychiatrists listed in health plan directories had incorrect contact information (Georgians for a Healthy Future, 2016). New Jersey is one of the 27 states that requires at least some insurance plans to satisfy one or more quantitative measures of sufficiency. The main measure is specifying the maximum amount of time and/or distance an enrollee travel to access care. New Jersey requires its managed care plans to have at least two primary care physicians within ten miles or 30 minutes of 90% of their consumers, thus satisfying a quantitative standard (Giovannelli, Lucia, & Corlette, 2016). Insurers in New Jersey must also confirm the participation of any providers that have not submitted a claim in twelve months and confirm intent to stay in the network. If the

provider is unresponsive, a follow-up request is mailed and if there is no response in 30 days, the provider is removed from the network (Gonsahn & Zeldin, 2016).

### *3.5 Maryland*

According to a data brief presented by University of Pennsylvania and Robert Wood Johnson Foundation, the distribution of narrow networks in Maryland (MD) is at 25% (Polsky & Weiner, 2015), much lower than many other states. In spite of the low prevalence of narrow networks, the Maryland Women's Coalition for Health Care Reform and the Mental Health Association of Maryland reports a range of issues MD consumers have in obtaining care. Results suggest that (1) of 1,493 OB/GYNs, only 490 (32.8%) were accepting new patients and providing well-woman visits (Maryland Women's Coalition for Health Care Reform, 2015), (2) only 14% of the 1154 psychiatrists listed were accepting new patients and available for an appointment within 45 days, and (3) only 43% of psychiatrists listed could be reached at first try (Mental Health Association of Maryland, 2015).

The Maryland Senate Bill 929/ House Bill 1318, which was passed during the 2016 legislative session in April, specified quantitative metrics to ensure that providers were geographically accessible, appointment wait times were appropriate, and provider-enrollee ratios were sufficient (McAndrew, 2016). Also, insurers must provide a way for consumers to report inaccuracies in directories such as phone number, email address, or another electronic way; and, insurers must investigate and update the errors within 45 days (McAndrew, 2016). Insurers must also periodically review samples of directories for accuracy on a quarterly basis, keep documentation of these reviews, and make them readily accessible to insurance commissioner upon request (McAndrew, 2016).

Maryland also has qualitative standards to assess the adequacy of plans' provider networks. For example, there is a requirement for carriers to maintain a panel of in-network providers that is sufficient in numbers and types of available providers to be able to meet the needs of enrollees (Giovannelli, Lucia, Corlette, 2015).

#### **CHAPTER 4: Policy Recommendations for Georgia**

In an effort to increase access to health care and address the network adequacy and provider network standards, I propose recommendations that involve: 1) setting and enforcing more rigorous standards, 2) improving directory transparency, and 3) utilizing better data collection and oversight methods to maintain adequacy. This is important because improving access to health care does not stop at the passage of legislation but continues with the efficient and effective implementation of evidence-based methods. However, before implementation can occur, a clearly identifiable source of funding to support compliance with regulation is of upmost significance. Beyond support for the Georgia Department of Insurance, it is beneficial for policy-makers to identify other funding sources such as specific legislative mandates for assessment of network adequacy.

##### *4.1 Setting and Enforcing More Rigorous Network Standards*

All insurers should meet and be responsible for upholding network adequacy standards that address each of the following areas:

- Creating and enforcing substantive quantitative standards that ensure access to care in a timely manner. These quantitative standards are the most effective way to hold health insurers accountable in creating a common standard. The standards involve setting

provider-enrollee ratios, maximum travel time and distance for enrollees (for both public and personal transportation), and maximum appointment wait times. It is also crucial to set a minimum limit for the number of providers in a health plan accepting new patients and the percentage of available providers in a service area.

- Making consumers aware of the right to access out-of-network care at in-network cost-sharing levels if a carrier does not have an in network provider that is available without unreasonable delay or travel.
- Ensuring protection for consumers from out-of-network cost-sharing, when using out-of-network services that were inaccurately deemed in-network. Insurers who do not have in-network services should be required to provide service at no additional cost to the enrollee. However, having a policy in place to protect consumers is not a replacement for maintaining an adequate network.

#### *4.2 Improving Transparency through Provider Directories*

Consumers should be able to quickly assess and compare standardized network information prior to making a decision on health plans. Provider directories work in two ways: they hold insurers to an obligation to keep the directories current and hold providers accountable for reporting changes to participation in a network and new patient application status. In order to facilitate consumer decision-making, GA should promote the following policies:

- Post accurate directories for each plan in a standardized, downloadable, searchable, and software compatible format that is available to the general public through a clearly identifiable link or tab on the website



- Include information, available in a searchable format, for providers (name, gender, contact information, participating office locations, specialty, board certification, medical group affiliations, facility affiliations, languages spoken, accepting new patients status), hospitals (name, type, telephone number, participating hospital location, accreditation status), and facilities (name, type, telephone number, types of services performed, participating facility locations). A criteria for language spoken, for example, could be determined by looking at census data to identify the population being served by an insurer's coverage range.
- Require updating directories every 30 days. Oversight could be conducted by the GA Department of Insurance. Consequences for not updating could include penalties as determined by the state legislature and Department of Insurance. Having such a penalty could serve as an incentive for insurer cooperation.
- Maintain access to directories possible to the public without having to log in or create an account.
- Make print copies of directories available upon request.
- Include in plain language information on what provider directory applies to which plan and the criteria used by plans to build the provider network.
- Accommodate the needs of individuals with disabilities and people with limited English proficiency. This could be accomplished by creating a resource guide that provides information on interpreter services and/or offering print copies in other languages.
- Provide a dedicated email address, telephone number, and electronic link that consumers can use to report inaccuracies, and a process to address complaints and

correct inaccuracies. By keeping an accurate account of these reports/complaints, the insurer can routinely sample data on contact information to analyze patterns of main complaints and act accordingly to correct inaccurate information.

- Have insurers conduct annual audit of all directories with a protocol in place for health plans to follow-up with providers
- Have dedicated staff within an insurance plan contact providers participating in networks who have not submitted claims within 12 months to determine their network participation status
- Have insurers report annually to the GA Department of Insurance on consumer-reported inaccuracies and resolutions, and all auditing reports
- Hold health plans accountable for correcting errors in provider directory inaccuracies that result in a consumer seeking and utilizing out-of-network care. This would prevent consumers from being accountable for higher cost out-of-network services due to inaccuracy.
- Enforce all standards through the GA Department of Insurance, with funding allocated into the state budget for the Department or through requesting audit contractors
- For rural GA communities, maintain control and oversight on how health plans structure their rural networks and possibly require implementation of telehealth into those standards as well (Talbot, Coburn, Croll, & Ziller, 2013)

By committing to take these steps to improve network adequacy, we can make a meaningful impact on Georgians' healthcare experience, access to providers, and integrity of the information they rely upon.

### *4.3 Better Data Collection & Oversight to Maintain Adequacy*

With the implementation of policy changes, it is important to conduct routine audits of network adequacy. One way of accomplishing this is to specify methods for collection and analysis of data related to different network adequacy measures. It is also beneficial to have review processes in place to maintain adequacy. Policy-makers, insurers, and regulators have a range of available options:

- Determine explicitly what circumstances trigger a regulatory review of plan and what information regulators would use to assess compliance with set standards. State and federal regulators need to actively monitor plans by collecting and analyzing data regarding use of: out-of-network services, scores on consumer satisfaction, and internal/external appeals through consumer complaints. An example of a survey is included as Appendix B.
- Implement routine secret shopper studies. Secret shopper studies or audit studies are valid methods to ensure continued maintenance of accurate information. Funding could be acquired through the Department of Health and Human Services as these audit studies have been attempted previously to study other health policy issues. The organization tasked with executing these studies would be the GA Department of Insurance as part of network adequacy assessments.
- Regulators should also require insurers to report changes in adequacy measures at the mid-year mark to the GA Department of Insurance. As previously stated, insurers that do not clearly inform consumers about plan benefits and costs should be required to not hold consumers accountable for out-of-network costs.

Data should be collected by insurers on aggregated number of out-of-network claims, number of complaints filed with the health plan regarding problems accessing and receiving care, number of complaints filed with the health plan regarding inaccurate provider directories, and number of complaints regarding restriction of provider access due to enrollment in a narrow network. Lastly, these health plan reviews should occur at multiple points in time for each health plan. Review should occur when a new service area is being added or expanded, when complaints signify a potential problem, and when a significant change is being made to the network. These result of these reviews should be publicly reported to assist consumers in making informed choices.

## **CONCLUSION**

This capstone provided a general overview of network adequacy and the problems/challenges in enforcing health insurance plans to be adequate. An approach was taken at reviewing existing policies and procedures that attempt to characterize network adequacy. In all its parts, network adequacy is a topic of current interest and is one that affects all healthcare consumers. For the state of Georgia, it is important to take network adequacy as an avenue for improving the healthcare of Georgian consumers and the state healthcare system. After policies have been recommended and implemented, the most important next step is to implement review processes to assess the effectiveness of the proposed changes.

Given the outcome of the 2016 Presidential elections and the proposals of the President-elect, health policy stands to go under many changes in the next four years. Primarily, the proposed repeal of the ACA would result in loss of the law's provisions that governs the assessment of network adequacy thus lessening the perceived priority. There is projected to be

an increase in the number of uninsured consumers, which defeats the purpose of having adequate networks (Saltzman & Eibner, 2016); if consumers are unable to obtain health insurance, having adequate networks does not hold much meaning to them. The proposed policy changes are also projected to increase consumer out-of pocket spending, which directly affects the financial protection and affordability principle of network adequacy. Since the current regulation and enforcement of network adequacy is at the state level, promoting the inter-state sale of health insurance interferes with state-specific regulations and coordinating variations. All in all, the way healthcare is governed in this country stands to be heavily impacted and the future of network adequacy depends heavily on future policies changes regarding the ACA and overall healthcare in the United States.

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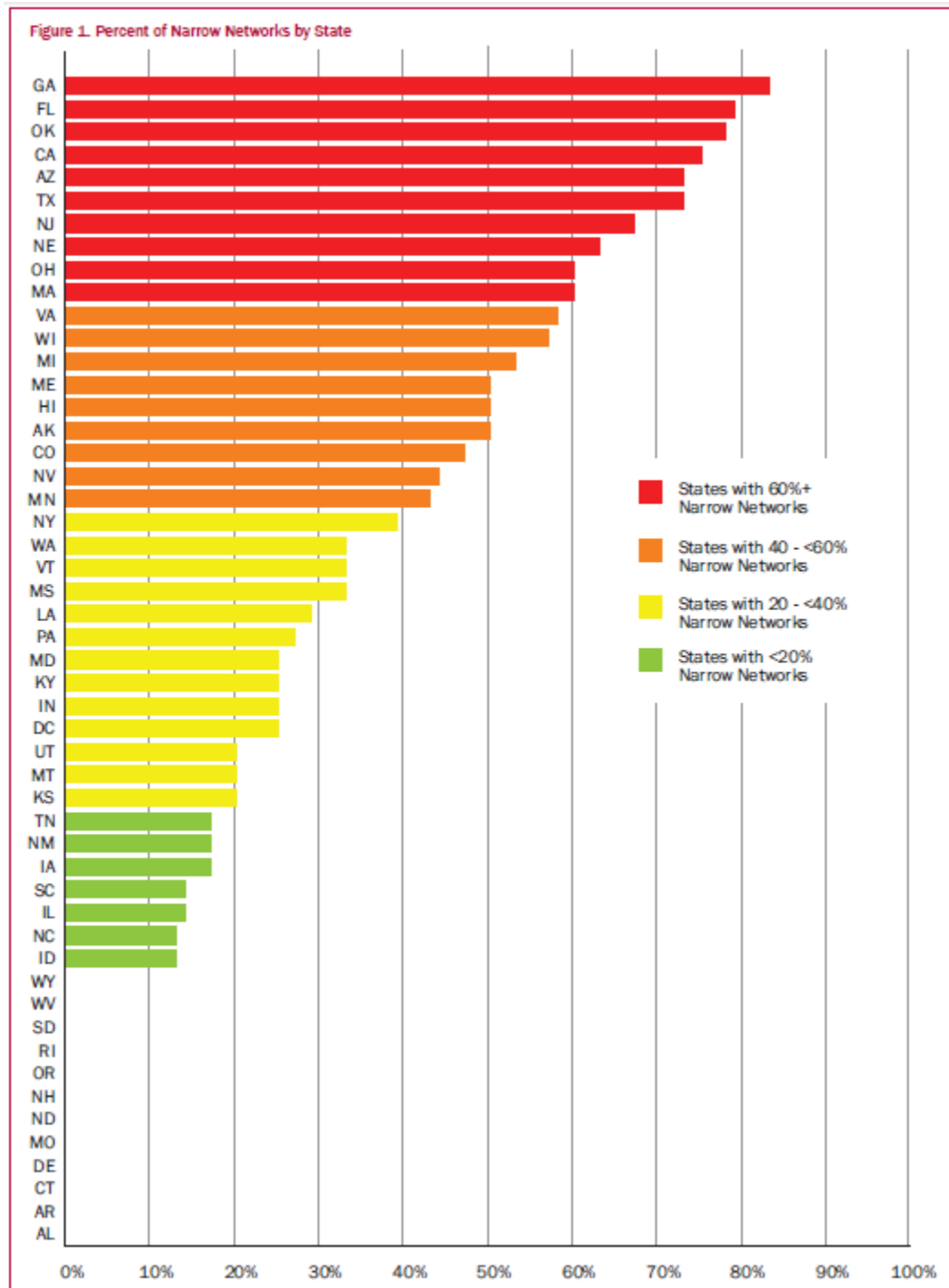
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## APPENDIX

### A. Percentage of Narrow Networks by State



Source: Polsky, D., Weiner, J. (2015). State Variation in Narrow Networks on the ACA Marketplace. <<http://ldi.upenn.edu/sites/default/files/pdf/state-narrow-networks.pdf>>

B. Insurance Department Survey of Network Adequacy

**Insurance Department Survey of Network Adequacy  
Regulatory Requirements and Oversight**

May 28, 2014

**Please Note That All Survey Responses Are Confidential.**

State: \_\_\_\_\_ Survey Respondent Name: \_\_\_\_\_ Title: \_\_\_\_\_  
Email Address: \_\_\_\_\_

**Section A: Please answer each of the following questions as it applies to your Department's activities related to network adequacy regulatory oversight.**

**1. Has your state adopted the NAIC Managed Care Plan Network Adequacy Model Act (Model #74)?**

- a. \_\_\_\_\_ Yes, we have adopted the NAIC Model Act as written, or with minor revisions.
- b. \_\_\_\_\_ Yes, we have adopted portions of the NAIC Model Act, but with significant revisions.
- c. \_\_\_\_\_ No, we have not adopted the NAIC Model Act.
- d. \_\_\_\_\_ Uncertain of our state's status.

**2. Indicate which of the following complaint codes, or codes with very similar descriptions, are included in your complaint tracking system to enable the identification of complaints related to network adequacy or access to care:**

- a. \_\_\_\_\_ Inadequate Provider Network
- b. \_\_\_\_\_ Network Adequacy
- c. \_\_\_\_\_ Access to Care
- d. \_\_\_\_\_ Timely Access to Care
- e. \_\_\_\_\_ Inaccurate Provider Directory
- f. \_\_\_\_\_ Out-of-Network Claim Dispute/Resolution
- g. \_\_\_\_\_ Out-of-Network Services
- h. \_\_\_\_\_ Formulary Restrictions
- i. \_\_\_\_\_ Balance Billing
- j. \_\_\_\_\_ Other (Please describe) \_\_\_\_\_

**3. On a scale of 1 to 5 (1 is the least significant, 5 is the most significant), how significant are the following challenges in the regulation and oversight of network adequacy?**

- a. \_\_\_\_\_ Maintaining adequate trained staffing levels for network analysis activities
- b. \_\_\_\_\_ Obtaining complete and accurate network adequacy data files from health plans and conducting a thorough review at licensure
- c. \_\_\_\_\_ Monitoring and identifying network adequacy problems on an ongoing basis once the initial plan has been filed and approved
- d. \_\_\_\_\_ Ensuring health plan enrollees have sufficient information to understand the risks and potential costs associated with receiving out-of-network services
- e. \_\_\_\_\_ Lack of authority to exercise increased oversight and impose enforcement actions and penalties
- f. \_\_\_\_\_ Please identify any additional challenges you have encountered: \_\_\_\_\_  
\_\_\_\_\_

**4. Does your state have any required provisions/notifications in health plan member handbooks, disclosure document requirement for enrollment, or other documents distributed by health plans, that are designed to ensure consumers are adequately informed of the circumstances in which a member may see an out-of-network provider, and how to avoid doing so?**

a. \_\_\_\_\_ No

b. \_\_\_\_\_ Yes; Please describe \_\_\_\_\_

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**5. Does your state have any “transparency” requirements or network adequacy provisions designed to prohibit or limit circumstances when no facility-based physician (i.e., anesthesiologist, pathologist, radiologist, ER physician, etc.) is available to a patient, even though the hospital/facility is in the patient’s network? If so, please describe**

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**6. On a scale of 1 to 5 (1 is low, 5 is high), indicate the extent to which you believe your state’s current requirement for regular reporting of the following health plan data is important (or you believe it would assist your Department in the oversight/monitoring of network adequacy, if it were required):**

a. \_\_\_\_\_ Aggregated data on number/percentage of out-of-network claims

b. \_\_\_\_\_ Data on number/percentage of out-of-network claims by service area

c. \_\_\_\_\_ Claims value of out-of-network claims

d. \_\_\_\_\_ Reimbursement rate payments for in-network claims vs. out-of-network claims

e. \_\_\_\_\_ Number of complaints filed with health plan regarding problems accessing care, receipt of care by out-of-network providers, claims payment of out-of-network services

f. \_\_\_\_\_ Number of complaints filed with health plan regarding inaccurate provider directory information

g. \_\_\_\_\_ Number of complaints filed with health plan regarding restriction of provider access due to enrollment in a narrow network

Please identify any additional data or information that would be helpful:

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Source: Health Management Associates. (2014). Ensuring Consumers’ Access to Care: Network Adequacy State Insurance Survey Findings and Recommendations for Regulatory Reforms in a Changing Insurance Market. National Association of Insurance Commissioners.

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