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Marketplace Plans' Provider Networks Are Just Not Adequate Without Family Planning Centers

By Kinsey Hasstedt and Andrea Rowan

HIGHLIGHTS

- *To translate coverage into accessible care under the Affordable Care Act, all plans offered on the health insurance marketplaces are required to have provider networks capable of meeting the health care needs of all enrollees.*
- *Many factors go into determining whether a plan's provider network is indeed adequate to meet enrollees' needs; exactly how that adequacy is assessed varies from state to state, but all marketplace plans should be held to robust standards that meaningfully advance access to care.*
- *Ensuring marketplace plan enrollees nationwide can obtain sexual and reproductive health care in a timely manner requires plans' provider networks to include safety-net health centers that provide family planning services.*

As of March 2015, nearly 12 million individuals were enrolled in coverage through health insurance marketplaces created by the Affordable Care Act (ACA).[1] Although obtaining coverage is a critical step toward health care, it means nothing if enrollees are not able to actually access care. One way to ensure such access is to require marketplace plans to establish networks of participating providers capable of delivering timely, quality care to all enrollees. The ability of health plans to connect their enrollees to the providers and covered services they need is commonly referred to as "network adequacy," and is measured in many different ways.

The concept of network adequacy predates the ACA, but the law establishes standards specific to marketplace plans. In broad terms, the law requires all marketplace plans to provide their enrollees with reasonable access to quality care. Toward this end, these plans must include so-called essential community providers (ECPs) in their provider networks. ECPs are safety-net providers, such as publicly supported family planning centers, that serve predominantly low-income, medically underserved communities. This provision is intended to ensure that the ACA does not leave behind these providers or their clients—the very individuals the law most aims to help. Indeed, nearly nine in 10 people signed up for marketplace coverage have incomes low enough to qualify for federal subsidies to make their coverage affordable.[1]

Although broad federal network adequacy standards have been established, state marketplaces and insurance regulators have intentionally been left a great deal of flexibility in creating more specific, quantifiable measures of determining whether a marketplace plan's provider network is fit to meet enrollees' needs. Yet, across every state, regardless of those specific standards, safety-net health centers that provide family planning services are well-situated to help fulfill many network adequacy requirements, ultimately advancing enrollees' access to providers they trust for the sexual and reproductive health services they need.

Network Adequacy and Family Planning

Just what makes a plan's provider network adequate is both a long-standing and continually evolving concept. Nearly 20 years ago, the National Association of Insurance Commissioners (NAIC) released a model act on managed care plan network adequacy, which provides language that states can use in legislation or regulations to help

ensure enrollees' access to all kinds of care within all kinds of managed care plans.[2] It also suggests some particular criteria on which the sufficiency of a plan's network can be judged, including the ratio of enrollees to primary and specialty care providers, geographic accessibility, waiting time for appointments with providers and flexible hours of operation. The NAIC is currently reviewing its model act, particularly in light of the ACA, and is expected to release updated recommendations this year.

Based on language from the NAIC model act, the federal government established a very broad standard of "reasonable access" for plans offered on the ACA's health insurance marketplaces. According to final regulations, marketplace plans must maintain "a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay."[3]

In implementing the ACA, the administration has the authority to establish more robust standards of network adequacy for marketplace plans, which could advance access to care for enrollees nationwide. Federal officials have announced their intent to articulate more detailed network adequacy standards based on lessons learned from the early years of the ACA's implementation and with consideration of the NAIC's forthcoming new recommendations.[4] In the meantime, bolstering the standards has largely fallen to state policymakers. Insurance has long been regulated at the state level, and as a type of private coverage, marketplace plans are also subject to any standards that apply to a state's overall private insurance market.

The majority of states have adopted some explicit network adequacy standards addressing the accessibility of various types of health services such as emergency, cancer and other specialty care. States are also considering enrollees' satisfaction with the quality of their care, by establishing systems for complaints and actively seeking feedback from enrollees about their experiences.[5] Within these standards, some are of particular relevance to safety-net family planning centers and the people they serve.

To better understand the national landscape of marketplace plans' network adequacy requirements and how they affect family planning centers and clients, Guttmacher staff reviewed standards specific to marketplace plans and more general private insurance requirements that apply to marketplace plans across all 50 states and the District of Columbia. We searched state laws and regulations, state marketplace administration websites, applications for issuers seeking to offer plans on marketplaces, bulletins and letters from state insurance departments, and other publicly available documents and presentations pertaining to states' marketplace implementation and administration. The analysis presented here represents a compilation of the most recent, reliable information we could obtain for each state for the 2015 plan year (see map and table, page 50). Guttmacher's search identified a handful of common measures of network adequacy on which publicly supported family planning centers are well positioned to help marketplace plans succeed. (These findings largely align with a report recently published by the Commonwealth Fund that looks at network adequacy in a broader context.[6])

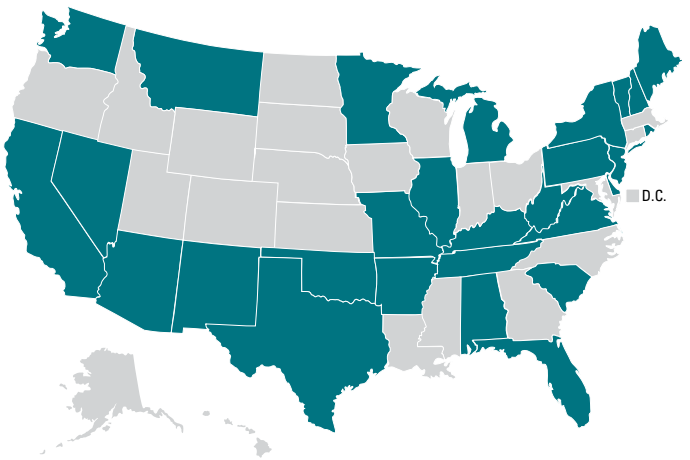
Notably, states with explicit network adequacy standards commonly allow plans to apply for exceptions from those standards; when a plan can do so differs from state to state. In some, plans only have access to an exception in specific situations and when they can justify why they cannot meet a standard—for instance, if there are not enough providers in rural areas to meet minimum provider ratios. Other states offer plans more flexibility in being exempt from requirements, which renders these standards less binding and effective. Overall, these exceptions provide plans with some degree of leeway in adhering to states' minimum network adequacy standards.

Provider Accessibility

One of the most common principles of network adequacy is that providers must be physically accessible to all enrollees, which means having both a sufficient number and geographic distribution of providers. In states that have detailed measures of provider accessibility that marketplace plans must meet, these measures often differ between urban and rural areas. Also, such measures often vary by

FACILITATING FAMILY PLANNING ACCESS

Many states' marketplace plans are subject to explicit network adequacy standards that safety-net family planning providers can help them meet.



	Time and/or distance to provider	Provider to enrollee ratio	Waiting time for appointments	Flexible hours of operation
Alabama	✔			
Arizona	✔		✔	
Arkansas	✔			
California	✔	✔	✔	✔
Delaware	✔	✔	✔	
Florida	✔		✔	
Illinois	✔	✔		
Kentucky	✔			
Maine		✔		
Michigan	✔			
Minnesota	✔			
Missouri	✔		✔	
Montana	✔	✔	✔	
Nevada	✔	✔		
New Hampshire	✔		✔	
New Jersey	✔	✔	✔	
New Mexico	✔	✔	✔	
New York	✔	✔		
Oklahoma	✔			
Pennsylvania	✔			
Rhode Island				✔
South Carolina	✔	✔		
Tennessee	✔			
Texas	✔		✔	
Vermont	✔		✔	
Virginia			✔	
Washington	✔	✔	✔	
West Virginia	✔	✔		

Notes: In some states, standards only apply to certain types of marketplace plans, such as HMOs. This table does not include network adequacy standards that are irrelevant for safety-net family planning providers.

provider type; typically, enrollees are expected to be able to get to primary and urgent care providers more quickly than specialists.

Many states suggest a plan use the ratio of providers to enrollees as a measure of whether its network has enough providers. However, these states do not explicitly set specific benchmarks that plans must meet, instead leaving detailed assessment and approval to the state's insurance department. Other states, however, require marketplace plans to meet particular ratios for particular provider types. For example, marketplace plans in Nevada must have at least one primary care provider per 2,500 enrollees and one obstetrician-gynecologist per 2,500 female enrollees of reproductive age, whereas in Illinois, the required ratio of primary care providers to enrollees is one per 1,000. Such differences may reflect differences between a state's overall rural and urban populations or the number of providers practicing in the state.

Of course, enrollees must also be able to get to these providers. Access to providers is typically measured by distance or travel time from where enrollees live or work. Although some states only recommend that issuers consider access when setting up a provider network, others have established quantifiable measures. For instance, Arkansas requires that marketplace plans ensure each enrollee has at least one primary care provider within 30 miles or a 30-minute drive from her home or workplace, whereas at least one of various types of specialty care providers (including obstetricians) must be within 60 miles or a 60-minute drive. And in Kentucky, primary and urgent care must be accessible within 30 miles or 30 minutes of all enrollees throughout the state; other providers (largely specialists) can be located further from enrollees in rural areas than in urban ones.

Figuring out how family planning centers fit into these particular standards can be complicated. Some plan issuers categorize these providers as delivering primary care, whereas others consider them to be delivering specialty care. Additionally, unlike other health care settings that primarily rely on physicians, family planning centers often rely on registered nurses or advance practice clinicians to provide services: Two-thirds of counseling vis-

its and seven in 10 exams are performed by such staff.[7] These clinicians commonly experience more difficulty being credentialed by health plans compared to physicians.[8]

Some states encourage health plans to improve access to care by classifying advance practice clinicians as primary care practitioners. This increases the number of eligible practitioners in a plan's service area and helps family planning centers obtain contracts, given their reliance on advance practice clinicians. For instance, network adequacy regulations in New Jersey allow nurse practitioners, physician assistants and certified nurse midwives to qualify as primary care practitioners in meeting the state's provider-to-enrollee requirements.

Because of their extensive geographic distribution, and given that millions of women have long relied on them for care, family planning centers can be pivotal to plans' ability to assemble a network that adequately meets enrollees' needs. There are more than 8,400 publicly supported family planning centers in the United States—with locations in every state and the District of Columbia.[9] In fact, in 2010, 84% of U.S. counties had at least one safety-net family planning center.[10] Furthermore, publicly supported family planning providers serve 44% of poor women nationwide who obtain contraceptive care and 34% of women with incomes between 100% and 250% of poverty[11]—populations that the ACA is particularly designed to help connect to coverage and care.

Accepting New Patients

Having a sufficient number of nearby providers in a network means nothing if those providers are not able or willing to see new patients. To address this, regulations implementing the ACA not only require that all marketplaces make provider directories available to enrollees and those shopping for coverage, but also that those directories indicate providers who are not accepting new patients. Although no states were found to have established specific numeric thresholds, Michigan and New Hampshire do use the number of contracted providers (particularly primary care) accepting new patients as a component in assessing marketplace plans' network adequacy.

Including safety-net family planning centers in marketplace plan networks will undeniably advance enrollees' consistent access to care, because health centers providing family planning services will almost always see new patients. In fact, those receiving funding support from the Title X national family planning program are legally prohibited from turning anyone away. The same holds true for all federally qualified health centers, on which women and couples are increasingly reliant for sexual and reproductive health care. Combined, this amounts to eight in 10 safety-net family planning centers.[9]

Wait Time for an Appointment

Once a woman obtains coverage and finds an accessible provider who will see her and accept her coverage, her next consideration is how long she must wait for an available appointment. Many states only suggest that plans use participating providers' appointment waiting times as a measure of their network adequacy. Yet, once again, some states have articulated specific standards. Vermont requires marketplace plans to work to ensure that enrollees' wait times do not exceed a certain number of days for certain types of care—for instance, two weeks for nonemergency, nonurgent care and 90 days for preventive care. And California requires that marketplace plans generally must provide for nonurgent primary care appointments within 10 business days.

Guttmacher did not find any wait time considerations specific to family planning. It is critical, however, that enrollees are able to obtain contraceptive care and counseling, STI screening and treatment, and other time-sensitive sexual and reproductive health care without having to wait an extended period of time—preferably with same-day appointments, if needed. Enrollees' quick access to contraceptive care is particularly imperative, because women must be able to start using their chosen method of contraception quickly to most effectively prevent unintended pregnancies. Family planning centers work hard to provide timely access to services, and would undoubtedly help plans do so for their enrollees. The average wait time for an initial visit among family planning centers is just over five days.[7] Plus, four in 10 report offering an initial visit appointment on

the same day a patient calls or walks in without an appointment.

Hours of Operation

Whether enrollees can make appointments for times that work in their schedules is another important consideration in assessing a plan's provider network. The availability of evening or weekend appointments is a metric with particular salience for low-income women, whose employers often do not allow flexibility for health care visits during typical weekday, daytime hours.

Although most states do not set particular time requirements regarding hours of operation, a few have taken steps to solidify this measure. For instance, Rhode Island requires that a quarter of a plan's contracted primary care practices in each county offer appointments for at least three hours after normal operating hours one day per week. Alternatively, they can have an agreement with another primary care provider with after-hours appointments.

Because publicly supported family planning centers purposefully take steps to ensure that all patients can easily access their services, marketplace plans would again benefit from including these providers in their networks. Specifically, four in 10 family planning centers report offering some extended hours—during evenings (later than 6 pm), weekends or both.[7]

Essential Community Providers

The most important component of network adequacy for safety-net health centers providing family planning services—and for the people who rely on them—is plans' inclusion of essential community providers (ECPs; see "Vigilance Needed to Make Health Reform Work for 'Essential Community Providers'," Spring 2013). ECPs are providers, like family planning centers, that primarily serve low-income, medically underserved individuals who are likely to be or have been uninsured and to experience difficulty accessing care. According to regulations implementing the ACA, marketplace plans "must have a sufficient number and geographic distribution of essential community providers, where available, to ensure reasonable and timely access to a broad range of such providers."[3] This general requirement applies to all marketplace plans, whether offered through a state-run or federally facilitated marketplace.

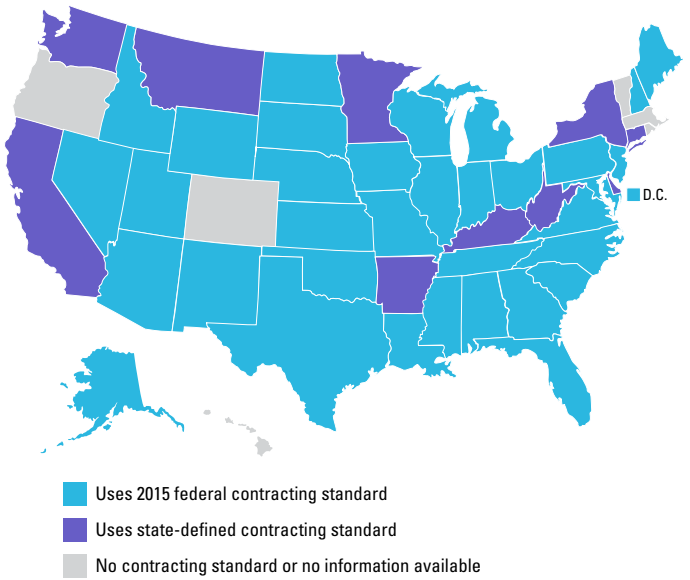
For states that have opted for the federal government to administer their marketplaces, the Department of Health and Human Services (DHHS) annually updates and publishes minimum standards for contracting with ECPs within a broader set of instructions and requirements for issuers on those marketplaces. In 2015 and 2016, a plan offered through a federally facilitated marketplace must contract with at least 30% of the available ECPs in its service area.[4,12] Further, DHHS has established six major categories of ECPs, one of which is "family planning providers." The administration has made clear that this includes both centers that receive Title X funding and those that do not. Plans on federally facilitated marketplaces must offer contracts to at least one provider from each of the six ECP categories, in each of the counties that make up the plan's service area (if such providers are available).

Plans on state-run marketplaces must also include ECPs, but their specific standards may vary. These marketplaces may adopt the federal ECP requirements, and many have, but they may also establish their own standards. Additionally, even states that have opted for the federal government to administer their marketplaces may supplement the federal ECP standards with their own requirements (see map, page 53). (Guttmacher's findings on state-specific ECP standards relevant to family planning are similar to those published by the Kaiser Family Foundation, which looked at ECP standards through a broader lens.[13,14])

For instance, given the far-flung population and provider network in Montana, which has a federally facilitated marketplace, the state's insurance commissioner "determined that the federal network adequacy standard that requires only 30 percent of all ECPs to be 'in network' is not adequate for Montana. [Marketplace plan] issuers should strive to meet a standard that includes at least 80 percent of all ECPs."[15] And Arkansas goes beyond federal law by requiring that marketplace plans denote which providers are ECPs within the provider directories they make accessible to the public.

GETTING FROM COVERAGE TO CARE

Almost every state has adopted standards for marketplace plans to contract with essential community providers (ECPs), most often using the 2015 standards and definitions for federally facilitated marketplace plans.



Note: Standards are those in effect for 2015. Details about each state's ECP contracting standards and definitions can be found in another version of this map, available at http://www.guttmacher.org/pubs/gpr/18/2/gpr1804815.html

Other states have expanded guidelines for contracting with specific types of ECPs. Multiple states, including Arkansas and Connecticut, emphasize school-based health centers as their own category of ECPs, whereas in the federal standards, such centers would only fall within a broad "other" category. And Washington requires that by 2016, at least 75% of all school-based health centers be included in marketplace plans' networks. These centers are a promising way of addressing unintended pregnancy and STIs among adolescents, and should be part of more plans' networks (see "Meeting the Sexual and Reproductive Health Needs of Adolescents in School-Based Health Centers," Winter 2015). Aside from school-based health centers, Washington guidelines require marketplace plans to contract with at least 90% of all federally qualified health centers in the state. And South Carolina specifies rural health centers as their own type of ECP, while Minnesota includes any nonprofit providers that waive fees or charge on a sliding scale for low-income individuals.

Finally, under the ACA, issuers are required to offer contracts to ECPs in "good faith," which means that the contracts offered to ECPs should not have lower reimbursement rates than those offered to similar providers outside of the safety-net system. Some states are making their own strides toward establishing more explicit protections for ECPs. For instance, in Connecticut, network adequacy regulations require health plans to offer contracts specifically to school-based health centers that are "made on terms and conditions similar to contracts offered to other providers of health care services."[16]

Making It Work

Although the ACA recognizes the importance of providing enrollees reasonable access to care, just what makes a marketplace plan's provider network "adequate" often remains vague. Both federal and state policymakers have a role to play in establishing more robust standards that would ensure timely access to quality family planning services for all enrollees.

DHHS should act on its expressed intent to further define network adequacy standards for marketplace plans. These more detailed standards could then serve as a nationwide floor—applying not only to plans offered on the federally facilitated marketplace, but also to those on state-run marketplaces. At the same time, such minimum standards should allow state policymakers sufficient flexibility to establish and enforce requirements that best serve their unique provider and enrollee demographics.

As low-income individuals increasingly obtain health coverage with the ACA's implementation, the federal requirement that ECPs be part of marketplace plans' provider networks is helping to advance their access to care. And, DHHS has made the requirement that plans on the federally facilitated marketplaces offer a contract to at least one provider per ECP category per county more permanent by including this standard in final regulations starting with the 2016 plan year;[17] previously, it had only been included as part of sub-regulatory guidance. However, the administration can and should take further steps toward stronger standards for contracting with these critical safety-net

providers. First, DHHS should continue to raise the minimum proportion of ECPs with which a plan must contract in its service area. Second, issuers should be required to not just offer "good faith" contracts to but actually establish them with at least one provider per major ECP category in each county, wherever possible. These contracts should include all of the covered services offered by a given ECP, which is of particular concern for family planning centers that also provide abortion care. Third, as with the broader network adequacy standards, minimum ECP contracting requirements should apply to plans on both federally facilitated and state-based marketplaces.

The NAIC could play a role in improving standards as it updates its model act on network adequacy, particularly by emphasizing sufficient inclusion of ECPs and family planning centers specifically. This would likely encourage states to require health plans beyond the marketplaces to contract with ECPs, which would advance continuity of sexual and reproductive health care for individuals who might have to switch forms of coverage. This has particular importance for Medicaid managed care plans, as low-income individuals are at risk of having to move between marketplace and public coverage when their income fluctuates (see "Making Medicaid Managed Care Work for Family Planning Coverage and Services," Winter 2015).

Because much of the responsibility for establishing stronger, more specific requirements for provider networks falls to state policymakers, they can and should go beyond federal minimums to ensure enrollees have access to the most robust provider network possible. Furthermore, state officials should strictly enforce their network adequacy standards. Even in states that have already established more detailed measures of network adequacy, many seem to let issuers off the hook too easily. To truly ensure enrollees' access to care, a plan should only be excused from a given standard in limited circumstances—for instance, if there were a lack of a certain provider type in its service areas. In such a case, the plan should still have to offer an explanation of how it would meet the family planning needs of its enrollees, especially those who are low-income.

State officials also bear responsibility for making their network adequacy standards transparent and easily accessible to the public. This would better enable individuals, advocates and providers to work with policymakers to ensure that enrollees' family planning and other health care needs are being met. Greater transparency would also enable advocates and policymakers to more easily look to other states for specific standards or innovations in network adequacy.

Finally, family planning providers must make the case for plans to contract with them. To do so successfully, they must know the network adequacy requirements—especially regarding ECPs—for marketplace plans in their state and understand what data are available that relate to those standards. The vast majority of women who obtain services from a family planning center do so at least in part because of these providers' accessibility,[18] so their being in network will help enrollees obtain the sexual and reproductive health care they need. It will also diversify providers' revenue streams, so they can keep their doors open to the millions of individuals who rely on their services and counseling every year. ■

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