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Affordable Care Act

Network Adequacy and Health Equity: Improving Private Health Insurance Provider Networks for Communities of Color

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The Affordable Care Act's principal goal is to increase access to affordable, high-quality health care.

The law's main strategy for reaching this objective is through expanding health coverage to consumers who have been priced out of or otherwise excluded from the insurance market in the past. Expanding access to health insurance is particularly important for communities of color, who have much lower insurance rates than non-Hispanic whites.[1] Under the Affordable Care Act, uninsured rates for people of color, as well as for whites, have already decreased significantly.[2]

Unequal access to health coverage contributes to the many well-documented health disparities that affect racial and ethnic minorities.[3] But while having health insurance is vital to obtaining health care, evidence shows that communities of color confront additional obstacles to care even when they have health coverage.[4] Among these obstacles is the ability to get access to providers and facilities that can meet their needs.[5]

This brief describes the barriers that people of color face disproportionately in gaining access to necessary health care providers. It then describes the components of an adequate provider network for communities of color that can help alleviate some of these barriers, along with policies to help achieve such networks in private insurance plans. Finally, it outlines strategies to put these policies in place.

What are health disparities?

Variations in health outcomes, known as health disparities, have been documented for decades, particularly between racial and ethnic minorities and non-Hispanic whites. People of color are more likely to have serious chronic diseases like diabetes, certain cancers,[6] asthma,[7] and HIV/AIDS,[8] and are more likely to suffer complications from these conditions that lead to worse outcomes and even premature death.

Communities of Color Face Disproportionate Barriers to Accessing Health Care Providers

While having insurance is a critical first step to meeting people's health care needs, health coverage alone does not guarantee access to timely, affordable, high-quality care. Even when racial and ethnic minorities have insurance, they may continue to face barriers to accessing providers. These include, but are not limited to:

» **Insufficient distribution of providers**: In certain areas of the country, physical access to health care providers and facilities presents an obstacle to care. There are more than 3,500 areas in the country that have been designated by the federal government as medically underserved, meaning that access to health care is limited even for those with health coverage because there is an insufficient number of providers and/or facilities in the area.[9]

Even with health coverage, communities of color still face barriers to care. To help address these obstacles, health insurers' provider networks should be adequate—offering consumers the right care, at the right time, in a language they can understand, without having to travel unreasonably far. By working toward such "network adequacy," we may help reduce some of the health disparities that racial and ethnic minorities experience.

» **Transportation barriers**: Even in places that are not considered medically underserved, transportation challenges that are exacerbated by inadequate public transportation, the distance to medical facilities, and continued racial segregation can make it difficult for underserved populations to get the care they need.

» **Language barriers**: Some consumers may face challenges finding a provider who speaks their language, or a provider that at least has high-quality, certified professional translators available.

» **Lack of flexible hours**: Because many people of color work in low-paying jobs with limited benefits, including sick leave,[10] they may need providers that offer extended hours but struggle to find such providers in their communities.

Although insurance plans alone cannot eliminate all of these barriers, the size, composition, and quality of insurers' provider networks can have a significant impact on their enrollees' ability to obtain timely, high-quality, language-accessible, culturally-competent care.

## Health Plans Create Networks of Providers to Help Control Costs

Most types of health insurance plans, such as preferred provider organizations (PPOs) and health maintenance organizations (HMOs), create "networks" of providers (and hospitals and other facilities) as a way to control costs for the plan and its enrollees. Such insurance plans, often referred to as "managed care" plans, usually charge consumers extra if they receive care from out-of-network providers and facilities.

As part of their formal contracts, health plans and their network providers negotiate the reimbursement rates for the health care services that providers deliver to the health plan's enrollees. Through these contracts, a health plan can control the costs it will pay for its enrollees' medical care, and thereby control health insurance premiums for consumers.

If consumers receive care from health care providers who are not in their plan's network, they will most likely face costs beyond the deductible, copayments, or other cost-sharing they would have to pay if they received care from in-network providers. These extra costs could include a higher deductible, other additional cost-sharing, or the entire bill for the services that the out-of-network provider delivers.

PPOs and HMOs both charge more for out-of-network care, but HMO rules are stricter. If consumers go out of network for care in an HMO, they are likely to face higher costs than if they go out of network in a PPO plan. However, to avoid potentially unaffordable costs for care, it is important that consumers in all types of plans receive medical services from providers, hospitals, and other facilities that are considered "in-network."
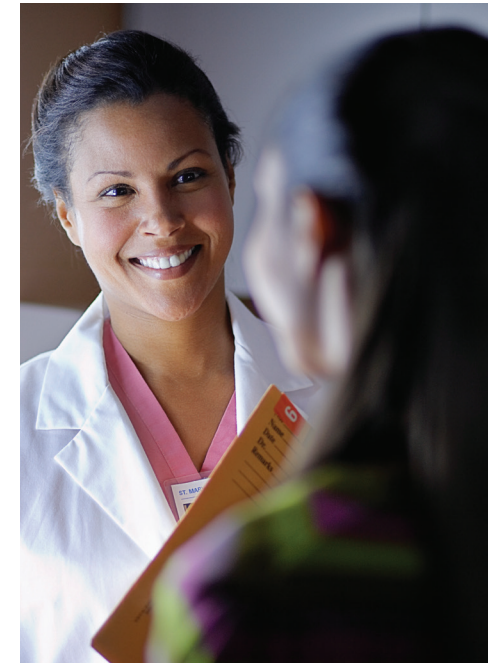
How Insurance Provider Networks Can Better Meet the Needs of Communities of Color

A health plan's network is adequate when it can provide meaningful access to care. This means that through the network, consumers are able to obtain:

» the right care

» at the right time

» in a language they understand

» without having to travel unreasonably far

For a network to be adequate for a diverse population, it must include the following components:

Adequate numbers of providers: Networks should include a sufficient number of providers to ensure that plan enrollees have access to a regular source of primary care, as well as sufficient access to other providers and facilities as necessary. Although health insurers alone cannot increase the number of providers in areas where there simply are too few, they can take the right steps to contract with sufficient numbers of providers, where available.

Adequate types of providers: Networks should include different types of providers to address different health care needs. This variety should allow networks to offer both a wide array of health care services and a variety of providers that fill different roles. Networks must include providers that can deliver all of the services covered under a health plan's benefits package, including primary care, mental health and substance use disorder care, and other specialty services. And not all providers who are needed are physicians: Networks should also include other types of providers who are critical for delivering necessary services or those who can deliver services instead of a physician provider.

For communities of color, it is also particularly important that networks include essential community providers, or ECPs—providers who serve predominantly low-income, medically underserved individuals[11] that are specifically required by the Affordable Care Act[12]. See page 5.

> Networks should include different types of providers to address different health care needs.

What is "network adequacy"?

In most health plans, consumers must receive medical services from providers that are considered "in-network" to avoid extra costs for care. A health plan's network is adequate when it can provide meaningful access to care. This means that through the network, consumers are able to obtain the right care at the right time, in a language they understand, and without having to travel unreasonably far.

👍 **Adequate geographic distribution of providers**: Not only should a network have a sufficient number and array of providers, these providers should also be geographically distributed to allow individuals in diverse areas to reach them without having to travel unreasonably far from their homes or workplaces. This is particularly important for communities of color and other underserved groups, who may depend on public transportation, friends, or family members to travel to medical appointments and thus can only travel a limited distance to obtain care.

👍 **Accessible hours**: For a network to provide care that is truly accessible to diverse populations, it should include providers who are open during nontraditional business hours (in addition to weekdays 9 a.m. to 5 p.m.). Many people with low incomes, many of whom are in communities of color, do not have paid sick leave[13] and cannot afford to take days off from work to receive care. Therefore, networks should include providers who are open late and/or on weekends to accommodate these consumers.

👍 **Timely access to care**: Networks should ensure that consumers do not have to wait unduly long to receive the health care they need, which could prolong identifying an undiagnosed health problem or delay treatment for a medical condition that requires immediate intervention. Therefore, networks should make sure that appointments are available to enrollees within

Essential community providers, who serve predominantly low-income, medically underserved individuals, have been invaluable to communities of color. Many ECPs have a long history of caring for underserved communities and have gained their trust. Many also have experience providing care that is culturally competent and language-accessible (for example, in languages other than English). In fact, some ECPs focus on specific minority or immigrant populations. Many ECPs also provide mental health, substance use disorder, and HIV/AIDS services, which may be difficult to obtain in health plan networks and often subject to stigma.[14] This makes culturally-competent treatment especially important. Therefore, contracting with ECPs is critical to creating health plan networks that meet the needs of communities of color.

a reasonable amount of time. This is particularly important for communities of color, for whom there is already a greater likelihood of delayed diagnosis and treatment compared to whites.[15]

👍 **Language-accessible, culturally-competent care**: Consumers are most likely to seek care from providers who speak their language and understand their culture and medical traditions. And when patients feel comfortable engaging with providers, they will be more likely to comply with providers' recommendations, which increases their likelihood of

having better health outcomes.[16] Networks should therefore include providers who speak the same languages as their patients, or at least make high-quality language assistance services available.

Networks should also include providers who are culturally competent and understand the unique needs of their patient population. This need for culturally-competent providers applies not only to racial and ethnic minorities, but also to the lesbian, gay, bisexual, and transgender (LGBT) community, whose members may be less likely to seek care because they face or fear discrimination from providers.[17]

👍 **Accurate information about providers**:
Consumers need accurate, up-to-date information about which providers are in a plan's network. It is critical that health plans provide this information so that consumers can understand their options for care and avoid unintentionally visiting costly out-of-network providers. Access to accurate information is particularly important for underserved communities, who may have less experience using health insurance and navigating challenges related to determining whether or not providers are in a plan's network. To allow consumers from diverse backgrounds to identify health plans and providers that can best meet their needs, directories should indicate what languages other than English (if any) providers speak. Directory information should also be available in multiple languages.

The Affordable Care Act Gives Consumers Rights to Adequate Provider Access

Under the Affordable Care Act, private insurance consumers in the new health insurance marketplaces have new rights that are designed to ensure that once they are enrolled in coverage, they are able to get the care they need. These include rights to provider network adequacy in general, specific rights to see ECPs, and rights to information about which providers are in a plan's network.

Rights to an Adequate Network

Under the Affordable Care Act, health insurance marketplace plans are required to provide consumers with a "sufficient choice of providers."[18] Regulations to implement this section of the law further require that each marketplace plan "maintains 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."[19]

While consumers now have these important new rights, making these rights meaningful may require further action. Marketplaces or regulators may need to implement more specific standards to ensure that these new rights are carried out for plan enrollees.

> Access to accurate information is particularly important for underserved communities, who may have less experience using health insurance and navigating challenges related to determining whether or not providers are in a plan's network.

⭐ **State-based marketplaces**: In states that operate their own marketplaces,[20] it is up to the state to define the additional specific standards, if any, that a health plan must meet to be considered compliant with the network adequacy requirements described above.

🏛 **Federal marketplaces**: In states with marketplaces that are operated by the federal government ("federally facilitated marketplaces"),[21] the U.S. Department of Health and Human Services (HHS) determines whether marketplace plans are meeting the standards described above, although marketplace plans must also comply with any state laws or rules regarding network adequacy.

For 2014, HHS took a passive approach to compliance for federally facilitated marketplaces. HHS relied mostly on network adequacy reviews conducted by the states or health insurance plan accreditors to verify compliance with the network adequacy requirements described above.

For 2015, HHS intends to more closely review network adequacy compliance for plans in the federally facilitated marketplaces, looking for plans that seem to be outliers based on their inability to provide "reasonable access" before certifying plans as qualified for the marketplace. HHS has also indicated that it is considering implementing more specific standards for network adequacy in the future,[22] which would likely better ensure that marketplace plans meet the requirements in the law and corresponding regulations.

Rights to Essential Community Providers (ECPs)

The Affordable Care Act also requires health plans in the new marketplaces to include in their networks "essential community providers, where available, that serve predominately low-income, medically underserved individuals."[23] Regulations under the law further clarify that 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 for low-income, medically underserved individuals" in the area that the plan serves (the plan's "service area").[24]

The law specifies that ECPs include (but are not limited to) those providers who are eligible for discounted prescription drugs under the federal 340B Drug Pricing Program. Examples of such providers include:

» Federally qualified health centers (FQHCs) and "look-alike" health centers

» Ryan White HIV/AIDS providers

» Hospitals such as Disproportionate Share Hospitals (which serve a significantly disproportionate number of low-income patients and receive payments from the Centers for Medicare and Medicaid Services to cover the costs of providing care to uninsured patients) and Sole Community Hospitals

» Title X family planning clinics

» Hemophilia treatment centers[25]

HHS created a "non-exhaustive database of essential community providers" to help health plans identify ECPs such as those listed above to include in their networks.[26]

⭐ **State-based marketplaces**: In state-based marketplaces, it is up to each state to determine what, if any, specific standards are needed to ensure that plans are meeting these essential community provider requirements.

🏛 **Federal marketplaces**: In states with federally facilitated marketplaces, HHS determines whether plans are in compliance with the essential community provider requirements, but those states can enact laws or rules regarding ECPs that marketplace plans must meet.

In 2014, HHS required plans in the federally facilitated marketplaces to include in their networks at least 20 percent of the ECPs in their service area. In addition, plans were required to offer contracts to all Indian health providers and at least one ECP in each ECP category (such as FQHCs, Ryan White providers, hospitals, etc.) in each county in the plan's service area where such providers are available. Plans that could not meet this standard could still receive certification to participate in the marketplace in certain circumstances that HHS approved.[27]

In 2015, plans must contract with at least 30 percent of the ECPs in their service area, in addition to offering contracts to the entities described above. As was the case for 2014, plans that cannot meet the 2015 standard may still be able to receive certification for the federally facilitated marketplace if they submit a sufficient justification and explanation of how they will serve low-income and medically underserved consumers.[28]

While the 2015 federally facilitated marketplace standards mark an improvement over the 2014 standards, they are still not as strong as what some states have implemented, as described on page 9.

Rights to Provider Network Information

Health plan provider directories are notoriously inaccurate.[29] The Affordable Care Act put in place first-ever federal protections regarding provider directories for private insurance consumers. The law requires marketplace plans to provide information to enrollees and prospective enrollees on which providers are in a plan's network.[30] Corresponding regulations further require plans to make provider directories available to the marketplaces for publication online and to potential enrollees in hard copy upon request. The regulations also require directories to list providers that are not accepting new patients.[31]

⭐ **State-based marketplaces**: States that operate their own marketplaces can set their own standards to ensure that plans comply with the provider directory requirements.

🏛 **Federal marketplaces**: For 2015, HHS has outlined standards to implement these requirements in the federally facilitated marketplaces. The HHS standards require that the links to marketplace plan provider directories on the website of the federally facilitated marketplace (healthcare.gov) go directly to

> The Affordable Care Act put in place first-ever federal protections regarding provider directories for private insurance consumers.

a specific plan's up-to-date provider directory without requiring consumers to log in, enter a policy number, or otherwise navigate an insurance company's website before viewing the directory.

HHS guidance indicates that these directories should include "location, contact information, specialty, and medical group, any institutional affiliations for each provider, and whether the provider is accepting new patients." HHS is also encouraging plans to include in their directories the languages providers speak, provider credentials, and whether providers are Indian health providers. For Indian health providers, HHS further encourages directories to indicate whether providers limit their services to Indian beneficiaries or serve the general public.[32]

States with a federally facilitated marketplace can set additional standards beyond those set by HHS to help ensure accurate and accessible directories.

Making Provider Access Real for Communities of Color: Examples from the States

Taken together, the Affordable Care Act's provisions for access to providers, essential community providers, and provider network information create a new baseline for consumer protections to improve access to care. However, more specific standards in these areas can help ensure that the right to adequate networks as promised under the law is made a reality for private insurance consumers of color.

Below we provide examples of standards to help ensure that private insurance provider networks are adequate for diverse populations as described on page 4. These standards can serve as models for other states—or even the federal government—to implement as they work to ensure that provider networks meet the health care needs of all consumers.

Adequate numbers of providers

The following examples show standards that are designed to ensure that health plan networks have sufficient numbers of providers to meet all enrollees' medical needs:

California: Managed care plans must provide one full-time equivalent physician (generally) per every 1,200 enrollees and approximately one full-time equivalent primary care physician per every 2,000 enrollees.[33]

Delaware: In all plans sold in the marketplace, as well as managed care plans sold outside the marketplace, each primary care network must have at least one full-time equivalent primary care provider for every 2,000 patients. Insurers must receive approval from the insurance commissioner for capacity changes that exceed 2,500 patients.[34]

Adequate types of providers

The following examples show standards that are designed to ensure that health plan networks have a sufficient range of types of providers to meet enrollees' medical needs:

New Hampshire: Managed care plans must have sufficient numbers of specific providers and facilities in their networks that include, but are not limited to:[35]

> Primary care providers

> Obstetricians/gynecologists

> Psychiatrists

> Oncologists

> Allergists

> Neurologists

> Licensed renal dialysis providers

> Inpatient psychiatric providers

> Emergency mental health providers

> Short-term facilities for substance use disorder treatment

> Short-term care facilities for inpatient medical rehabilitation services

New Jersey: Managed care plans must have contracts or arrangements that allow enrollees to obtain covered services from certain types of facilities and providers at in-network costs. These providers and facilities include, but are not limited to:[36]

> Inpatient psychiatric facilities for adults, adolescents, and children

> Outpatient therapy providers for mental health and substance use conditions

> Emergency mental health service providers

> Residential substance abuse treatment centers

> Specialty outpatient centers for HIV/AIDS, sickle cell disease, and hemophilia

> Comprehensive rehabilitation service providers

> Licensed renal dialysis providers

> A hospital offering tertiary (highly specialized) pediatric services

New Jersey has additional standards that apply only to HMOs that require HMO provider networks to include sufficient numbers of specific types of providers including, but not limited to:[37]

> Primary care providers, which can include (among other providers): physician assistants, certified nurse midwives, and nurse practitioners/clinical nurse specialists certified in advanced practice categories comparable to family practice, internal medicine, general practice, obstetrics and gynecology, or pediatrics; and in hospitals or other facilities[38]

> Obstetricians/gynecologists

> Psychiatrists

> Cardiologists

> Neurologists

> Oncologists

Inclusion of essential community providers

The following examples show standards that are designed to ensure that health plan networks provide sufficient access to ECPs (those who serve predominantly low-income, medically underserved populations), as required by the Affordable Care Act:

Connecticut: By January 1, 2015, plans sold in the marketplace must include in their networks 90 percent of the federally qualified health centers (FQHCs) in the state and 75 percent of ECPs on the marketplace's non-FQHC essential community provider list.[39] The marketplace uses its own list of ECPs instead of HHS' database (mentioned on page 8) because it found that the HHS database does not include a sufficient number or sufficient geographic diversity of essential community providers in Connecticut. The marketplace also found that the database does not include sufficient ECPs to deliver all of the essential health benefits that consumers are entitled to receive through their health coverage under the Affordable Care Act.[40]

Washington: In addition to general quantitative standards for the inclusion of ECPs, regulations in Washington include more specific standards for the inclusion of essential community providers in networks that could be particularly important to communities of color:

> *"For essential community provider categories of which only one or two exist in the state, an issuer [insurer] must demonstrate a good faith effort to contract with that provider or providers for inclusion in its network."*

> *"The issuer's provider network must include access to one hundred percent of Indian health care providers in a service area... such that qualified enrollees obtain all covered services at no greater cost than if the service was obtained from network providers or facilities."*

> *"By 2016, at least seventy-five percent of all school-based health centers in the service area must be included in the issuer's network."*[41]

Adequate geographic distribution of providers

The following examples show standards that are designed to ensure that health plan networks provide consumers with access to care in locations that are geographically accessible to where they live or work:

New Jersey: There are geographic accessibility standards for the providers and facilities that all managed care plans must include in their networks, some of which are listed on page 10. For example:

» Outpatient therapy for mental health and substance use conditions, emergency mental health services, and licensed renal dialysis providers must be "available within 20 miles or 30 minutes average driving time, whichever is less, of 90 percent of covered persons within each county or service area."

» The other facilities and providers listed on page 10 that managed care plans must include in their networks (inpatient psychiatric services; residential substance abuse treatment; specialty

outpatient centers for HIV/AIDS, sickle cell disease, and hemophilia; comprehensive rehabilitation services; and a hospital with tertiary pediatric services) must be "available within 45 miles or 60 minutes average driving time, whichever is less, of 90 percent of covered persons within each county or service area."

What is important about these standards, particularly for communities of color, is that they are modified to meet the needs of enrollees who rely on public transportation. Specifically, "in any county or approved service area in which 20 percent or more of a carrier's [insurance plan's] projected or actual number of covered persons must rely upon public transportation to access health care services, as documented by U.S. Census Data, the driving times set forth in the specifications… above shall be based upon average transit time using public transportation, and the carrier shall demonstrate how it will meet the requirements in its application."[42]

In addition to these requirements for all managed care plans, there are geographic access standards that apply specifically to HMOs in New Jersey:

» Primary care providers must be available within "10 miles or 30 minutes average driving time or public transit (if available), whichever is less, of 90 percent of the enrolled population."

» For the specialists for which only HMOs have specific provider inclusion standards (including obstetricians/gynecologists, psychiatrists, cardiologists, neurologists, and oncologists, as listed on page 10), HMOs must have a policy that assures access to these specialists "within 45 miles or one hour driving time, whichever is less, of 90 percent of members within each county or approved sub-county service area."[43]

Vermont: Under state rules for marketplace plans and for managed care plans outside of the marketplace, travel times for enrollees to in-network providers "under normal conditions from their residence or place of business, generally should not exceed the following:

1. 30 minutes to a primary care provider;

2. 30 minutes to routine, office-based mental health and substance abuse services;

3. 60 minutes for outpatient physician specialty care; intensive outpatient, partial hospital, residential or inpatient mental health and substance abuse services; laboratory; pharmacy; general optometry; inpatient; imaging; and inpatient medical rehabilitation services;

4. Ninety (90) minutes for kidney transplantation; major trauma treatment; neonatal intensive care; and tertiary-level cardiac services, including procedures such as cardiac catheterization and cardiac surgery."[44]

Accessible hours

The following example illustrates a standard that is designed to ensure that health plan networks can provide care at times that are convenient to diverse populations who may be unable to obtain care during standard (9 a.m. to 5 p.m. weekday) business hours:

California: In addition to being available during standard business hours, basic health care services through a plan's network "shall be available until at least 10:00 p.m. at least one day per week or for at least four hours each Saturday" under California standards that apply to most PPO plans, as well as to some other managed care plans.[45]

Timely access to care

The following examples show standards that are designed to ensure that health plan networks can provide enrollees with access to care in a timely manner:

California: HMOs, as well as many PPOs,[46] must ensure that enrollees are offered appointments within the following timeframes:

» Within 48 hours of a request for an urgent care appointment for services that *do not* require prior authorization from the HMO in order for the enrollee to have the appointment covered by the HMO

» Within 96 hours of a request for an urgent appointment for services that *do* require prior authorization

» Within 10 business days of a request for non-urgent primary care appointments

» Within 15 business days of a request for an appointment with a specialist

» Within 10 business days of a request for an appointment with a non-physician mental health care provider

» Within 15 business days of a request for a non-urgent appointment for ancillary services for the diagnosis or treatment of an injury, illness, or other health condition

These waiting times may be shortened or extended as clinically appropriate based on the opinion of a qualified health care professional acting within the scope of his or her practice, consistent with professionally recognized standards of practice. If the waiting time is extended, it must be noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the enrollee.[47]

Washington: Health plans must demonstrate that enrollees can get an appointment with a primary care provider for non-preventive services within 10 business days of requesting one. When an enrollee is referred to a specialist, health plans must establish that the enrollee can get an appointment with such a specialist within 15 business days for non-urgent services.[48]

Language-accessible, culturally-competent care

The following states provide examples of protections that are designed to ensure that health plan networks can provide language-accessible, culturally-competent care:

California: All health insurance plans must have language access programs (LAPs) that assess the language needs of their enrollees and provide free interpreter services at all points of contact in the health plan, including with providers in the health plan's network. Health plans must also provide enrollees with notice of their right to receive these language services.[49]

New York: HMOs must be assessed on their "ability to provide culturally- and linguistically-competent care to meet the needs of the enrollee population" during their initial licensure reviews and at least every three years thereafter.[50]

Accurate information about providers

The following states provide examples of protections that are designed to ensure that consumers with diverse needs have access to accurate, up-to-date information about which providers are in a health plan's network:

New York: This year, New York passed legislation with new consumer protections for health plans that use contracted provider networks (PPOs, HMOs, etc.). It includes a provision requiring that each plan's provider directory list providers' addresses, telephone numbers, languages spoken, specialties, and any hospital affiliations. Insurers must update these listings online within 15 days of a provider joining or leaving their network or a change in a provider's hospital affiliation.[51]

Washington: Health plans must update their provider directories monthly, and directories must be offered to accommodate individuals with limited English proficiency and disabilities. For the providers, the directories must list languages spoken, specialties, and institutional affiliations (such as hospital affiliations or provider groups of which they are a member), among other characteristics. Directories must also include information about any available interpreter services, communication and language assistance services, and accessibility of physical facilities, as well as the mechanism by which an enrollee may access such services. In addition, directories must include specific descriptions of any available telemedicine services.[52]

Other Standards to Consider

In addition to the standards mentioned above, there are other sources for model consumer protection language regarding provider networks. Individuals and governments seeking to strengthen provider network standards for private insurance consumers of color may also want to examine the following:

» network adequacy requirements from Medicaid managed care contracts

» network adequacy standards for private Medicare plans (Medicare Advantage)[53]

» the National Association of Insurance Commissioners' Managed Care Plan Network Adequacy Model Act[54]

> HMOs must be assessed on their "ability to provide culturally and linguistically competent care to meet the needs of the enrollee population…

Rights to Go Out of Network

Protections to ensure that provider networks are adequate to serve all populations are critical. However, it is just as important that consumers have the right to go out of network in instances where health plans are unable to deliver in-network providers who can meet enrollees' medical needs in a timely manner.

In 2014, New York enacted such a right for consumers. Under New York's new "Surprise Medical Bills" law, "if a plan's network does not have a geographically accessible provider with appropriate expertise to treat a patient's medical problem, patients in all plans can seek services from an out-of-network provider without incurring the additional out-of-network expense—the patient's health plan will pay for all expenses other than the usual in-plan copayments and cost-sharing." [55]

Furthermore, if an enrollee and his or her health plan disagree on whether the plan has an appropriate in-network provider available to address the enrollee's medical needs, the enrollee has the right to take the disagreement to an independent arbitrator: the state's independent external review system. That system will order the plan to allow the enrollee to see the out-of-network provider (without facing extra costs) if it finds that:

- The health plan does not have an in-network provider with appropriate training and expertise

- There is an out-of-network provider who has the expertise needed and can treat the patient

- The out-of-network provider's services are likely to lead to a better clinical outcome [56]

It's critical that sufficient protections are in place everywhere to ensure that health plan provider networks are adequate to serve diverse communities. But even with these protections in place, there are times when a plan's network might not meet certain enrollees' medical needs. In these cases, it's important to have a stopgap protection in place that allows enrollees to go out of network without facing extra costs. This example from New York provides a model of such a stopgap that other states could replicate.

Advocating for Provider Network Standards to Protect Diverse Communities

There are many influencers at the state and federal level who have authority over which standards are in place to ensure that all communities have meaningful access to the providers and facilities necessary to meet their health care needs once they enroll in coverage.

Individuals concerned about health plan provider networks for communities of color should talk to the following officials about which standards should be in place to make timely, geographically accessible, culturally competent care more available to diverse populations:

» state insurance regulators, usually called insurance commissioners

» state legislators

» state marketplace board members, directors, and staff (in states that operate their own marketplaces)[57]

» federal officials who work for the U.S. Department of Health and Human Services (HHS), such as the HHS Regional Director for the relevant state, who can be found on the map at this website: http://www.hhs.gov/iea/regional/

» members of Congress

To be most effective in advocating for provider network standards, individuals should share concrete examples of the access problems that consumers in diverse communities face. Concerns from providers, including ECPs, are also powerful and should be shared not only with officials, but also with insurance companies, which may be able to develop better systems to contract with these providers.

Conclusion

The Affordable Care Act extended new health coverage options to millions of Americans in communities of color—a monumental step toward decreasing racial and ethnic disparities in health and health care. To build on this historic accomplishment, we must work to ensure that health plans can meet the needs of diverse populations.

Officials can help achieve this goal by enacting policies to ensure that health plan provider networks:

» include a sufficient breadth of providers and facilities

» include providers that are geographically accessible to communities of color

» offer timely care during convenient hours

» are language accessible and culturally competent

» have meaningful and accurate information available about the in-network providers and facilities

When health plan provider networks meet these criteria, they contribute to better health care, and, ultimately, better health outcomes, for people of color.

Health insurance plans alone certainly cannot eliminate all of the barriers consumers of color face when seeking health care. But the size, composition, and quality of insurers' provider networks can have a significant impact on their enrollees' ability to obtain timely, high-quality, language-accessible, culturally-competent care.

Endnotes

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