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Updated

Network Adequacy Laws in Covered California Plans*

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Introduction to Managed Care Structure in California

Millions of low-income Californians are enrolled in managed care plans in Covered California.[1] In 2014 nearly 1.4 million Californians enrolled in new coverage through private qualified health plans (QHPs) sold through and regulated by Covered California.[2] Eighty-eight percent of the new enrollees have income below 400 percent FPL and are receiving subsidies to help pay for their premiums.[3]

Covered California QHPs include different managed care models including Health Maintenance Organizations (HMOs), Exclusive Provider Organizations (EPOs), and Preferred Provider Organizations (PPOs).[4] Generally speaking, HMOs have lower cost-sharing, won't pay for care out-of-network except in emergencies, and may require a referral from a primary care provider to obtain specialty care.[5] EPOs also won't pay for most out-of-network care, but they usually don't require a referral to seek specialty care within their networks.[6] PPOs usually charge less cost-sharing if enrollees access services through their preferred network, but will cover for out-of-network care (the enrollee will pay higher cost-sharing to access services out-of-network).[7]

Covered California QHPs are governed by both state and federal law, and are regulated by various federal and state agencies. Covered California plans are regulated by the federal Center for Consumer

* For information about network adequacy in Covered California plans, see our companion piece: NAT'L HEALTH LAW PROG., MANAGED CARE IN CALIFORNIA SERIES #1: NETWORK ADEQUACY LAWS IN MEDI-CAL PLANS. (2014).

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Information and Insurance Oversight (CCIIO) and by the California Health Benefit Exchange Board. Most—but not all—Covered California plans are also licensed by the California Department of Managed Health Care (DMHC) and therefore subject to California's Knox-Keene Act.[8] All HMOs, a few PPOs and most dental and vison plans are regulated by the DMHC. Most PPO plans and indemnity plans are regulated by the California Department of Insurance (CDI), and subject to the California Insurance Code rather than the Knox-Keene Act.[9]

Overview of Network Adequacy

Covered California QHPs receive a set premium payment ("capitation") per enrollee in exchange for providing services.[10] The plans accept the risk of incurring a loss if they spend more on services than they receive through the premium payments, but they will make a profit if providing services costs less than the payments.[11] These arrangements give plans an incentive to limit coverage of services for their enrollees in order to maximize profits.[12] Thus, strong legal protections are necessary to ensure that enrollees have access to high quality, medically necessary services. Federal and state laws both require Covered California plans to have adequate provider networks. But the rules are slightly different depending on whether the plan is regulated by DMHC or CDI. This issue brief reflects the network adequacy standards in place as of June 30, 2018.

The Affordable Care Act broadly directed the Secretary of Health & Human Services to establish criteria for QHPs that would "ensure a sufficient choice of providers (in a manner consistent with applicable network adequacy provisions under section 2702(c) of the Public Health Service Act)."[13] Those incorporated provisions of the Public Health Service Act allow plans to limit enrollment to individuals who live in their coverage area, and to deny enrollment if they lack the ability to deliver services to new enrollees.[14] Building on those existing rules, and following the ACA's direction to establish criteria for QHPs, the Secretary issued regulations in March 2012 that require QHPs to ensure that their provider networks are "sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, so that all services will be accessible without unreasonable delay."[15] Pursuant to the regulations, the Exchange must "ensure that the provider network of each QHP meets the standards specified above."[16]

Since 2012, the Secretary has issued new requirements regarding provider directories, provider transitions, and out-of-network cost sharing. For plans beginning on or after January 1, 2016, the directories must specifically include "information on which providers are accepting new patients, provider's location, contact information, specialty, medical group and any institutional affiliations . . ."[17] This information must be available on the plan's website.[18] In addition, federally-facilitated exchanges must "[m]ake a good faith effort to provide written notice of discontinuation of a provider 30 days prior to the effective date of the change or otherwise as soon as practicable[.]"[19] If a provider is terminated without cause, an enrollee may complete their course of treatment or continue in treatment with the terminated provider for 90 days, whichever is shorter.[20] Finally, beginning in 2018, QHPs are required to "count the cost sharing paid by an enrollee for an essential health benefit provided by an out-of-

network ancillary provider in an in-network setting towards the enrollee's annual limitation on cost-sharing" or provide written to the enrollee that they may incur additional costs.[21]

Covered California, in turn, requires QHPs to comply with the network adequacy and accessibility standards established by DMHC or CDI and to remain licensed in good standing with the Exchange.[22] Covered California largely defers to existing state law governing network adequacy, as explained in greater detail below, and relies on the state agencies that regulate plans to review and enforce those requirements. Under state law, DMHC is charged with evaluating access and availability of services, and access to emergency services in its licensed plans at least once every three years through its medical survey process.[23] Similarly, CDI must examine licensed plans at least once every five years.[24] CDI is charged with generally evaluating plans compliance with applicable laws in the examination process.[25]

In addition to the role of DMHC and CDI in monitoring network adequacy, Covered California's contract with the plans requires them to "cooperate with the Exchange to implement network changes as necessary to address concerns identified by the Exchange."[26] Thus, Covered California has reserved a limited role to perform its own review of plans' networks to ensure that they meet applicable requirements.

Numbers and Types of Providers

Under federal rules, all QHPs must ensure access to essential community providers (ECPs). An ECP is a provider that serves predominantly low-income, medically underserved individuals.[27] Federal regulations require each QHP to have a sufficient number and geographic distribution of ECPs to ensure reasonable and timely access to a broad range of such providers for low-income, medically underserved individuals in the QHP's service area, in accordance with the Exchange's network adequacy standards.[28] In accordance with these rules, Covered California's QHP contract requires its QHPs to "maintain a network that includes a sufficient geographic distribution of" ECPs to ensure "reasonable and timely access to Covered Services for low-income, vulnerable, or medically underserved populations in [each geographic region]."[29]

Covered California's contract with its QHPs defines which providers and entities qualify as ECPs in California.[30] Those include: entities that participate in the program for limitation on prices of drugs purchased by covered entities under Section 340B of the Public Health Service Act (42 U.S.C. § 256B), Hospitals designated as part of the Disproportional Share Hospital Program under California law, federally-designated tribal health and urban Indian programs, state-licensed or exempt community clinics and free clinics, and providers enrolled in the Medi-Cal Electronic Health Record Incentive Program.[31]

California law also requires all plans to meet a 1:1200 provider-patient ratio overall, and a 1:2000 ratio for primary care providers.[32] In addition, plans must specifically ensure that enrollees have access to OB/GYNs, mammographers, and ABA Therapists.[33]

CDI has further defined what it means for a CDI-licensed plan network to be adequate – "one in which the care provided to an insured person in a network facility is provided by network providers."[34] In other words, networks are rendered *inadequate* when an out-of-network provider provides care to an insured person in a network facility. There are two exceptions, however– either when the insured person initiated a request without being prompted to receive care from an out-of-network provider and when the "coverage is provided on terms no less favorable, and at greater cost, to the insured person than would have applied had the care been provided by an in-network provider."[35]

Geographic Access

All Covered California QHPs must provide access to primary care providers and hospitals within 15 miles or 30 minutes of an enrollee's home or workplace.[36] In addition, DMHC Knox-Keene-licensed plans must provide ancillary services—that is, "laboratory, pharmacy and similar services and goods dispensed by order or prescription on the primary care provider"—within "a reasonable distance" of primary care providers.[37]

CDI-licensed plans must provide access to specialty care within 30 miles or 60 minutes, and access to mental health care within 15 miles or 30 minutes.[38] In addition, CDI-licensed plans must ensure that "[f]acilities used by providers to render basic health care services are located within reasonable proximity to the work places or the principal residences of the primary covered persons, are reasonably accessible by public transportation and are reasonably accessible to" people with disabilities.[39]

CDI-licensed plans are required to provide access to mental health and substance use disorder professionals within 30 minutes or 15 miles of a covered person's primary residence or workplace.[40] Adequate networks must include a variety of mental health and SUD services, such as crisis intervention and stabilization, psychiatric inpatient hospitals services, and detoxification.[41] Plans are also required to have a network hospital within 15 miles or 30 minutes of a covered person's primary residence or workplace.[42] These plans must include an adequate number primary care providers and specialists with admitting and practice privileges at these network hospitals, an adequate number of network outpatient retail pharmacies, and assure access to preventative services, including women's preventatives care and access to contraceptives methods.[43] Finally, CDI-licensed plans are prohibited from discriminating against enrollees based on a number of factors including age, actual or perceived gender identity, sexual orientation, disability, national origin, sex, family structure, and ethnicity. [44]

With respect to ECPs, the Covered California QHP contract specifies that whether a plan has a sufficient geographic distribution of ECPs is defined by the Exchange.[45] Covered California will account for several factors in determining whether the geographic distribution of a QHP's ECPs is sufficient, including: the nature, type, and distribution of ECPs in each region; the balance of hospital and non-hospital ECPs in each region; whether the network includes at least 15 percent of entities in each applicable geographic region that participate in the program for limitation on prices of drugs purchased by covered entities under Section 340B of the Public Health Service Act (42 U.S.C. § 256B); whether the network includes at

least one ECP hospital in each region; the extent to which the network includes federally qualified health centers, school-based health centers, and county hospitals; and other factors as mutually agreed upon by the Exchange and issuers regarding the ability to serve low-income populations.[46]

Timely Access

DMHC has promulgated detailed standards governing timely access to care pursuant to the Knox-Keene Act.[47] Those standards, which have also been adopted by CDI, require plans to ensure that enrollees have access to services within the following timeframes: urgent care, where no prior authorization is required, within 48 hours of request; urgent care, where prior authorization is required, within 96 hours of request; non-urgent care and primary care, within 10 business days of request; non-urgent care specialty care, within 15 business days of request; non-urgent non-physician mental health care, within 10 business days of request; and non-urgent ancillary services, within 15 business days of request.[48] These times may be extended if the referring or treating provider determines that a longer wait time will not negatively impact the enrollee's health.[49] Plans must also operate a 24/7 triage screening telephone line, and ensure that enrollees do not wait more than 30 minutes for screening.[50] Knox-Keene-licensed plans must report on their compliance with these requirements on an annual basis.[51]

Access to Services Out-of-Network

All Covered California plans must provide access to emergency care out-of-network, without requiring prior authorization.[52] Plans must also provide for or arrange for enrollees to have access to in-network or out-of-network providers, respectively, to obtain a second opinion.[53] Knox-Keene-licensed plans must also provide access to out-of-network providers when needed care is not available in-network.[54] (Since CDI plans are typically arranged in a PPO-model that provides some coverage for care accessed by non-preferred providers, the issue of out-of-network access tends to arise less frequently in those plans.) For all plans, enrollees who were previously enrolled in an individual market plan that was cancelled between December 1, 2017 and March 31, 2018 may be able to continue receiving services from their previous providers, even if those providers are not in the network of their new Covered California plan, if they have certain qualifying conditions, like a severe chronic illness or a pregnancy.[55] And in all cases, plans must coordinate payment with out-of-network providers to ensure that enrollees do not incur greater costs for seeing an out-of-network provider.[56]

Options for Enrollees When Their Plan's Network Does Not Provide Access to Needed Services

When Covered California enrollees are not able to access a service they need through their QHP, they have three options to seek redress. First, the enrollee may file a grievance with the plan. Each QHP has its own internal grievance process.[57] Plans generally have 30 days to resolve a grievance, but if the grievance concerns potential loss of life or limb, severe pain, or imminent & serious threat to health, the

plan must resolve it within three days.[58] Second, enrollees may—after they have filed a grievance with the plan and have either received an unfavorable decision, or have waited 30 days without a decision (three days in expedited cases)—seek external review through DMHC or CDI as applicable.[59] Finally, at any point an enrollee may call or email the Covered California Service Center or the Health Consumer Alliance to report a problem with his or her plan's network.[60]

As more low-income Californians enroll in private managed care plans for the first time through Covered California, consumer advocates must ensure that the plans' networks are adequate to provide all covered services. Consumer advocates should work with Covered California, DMHC, CDI, and policymakers to monitor and enforce California's strong consumer protections that aim to ensure access to services for managed care plan enrollees.

ENDNOTES

[1] Press Release, Covered Cal., Covered California's Historic First Open Enrollment Finishes with Projections Exceeded (Apr. 17, 2014) (Covered California enrollment as of April, 2014 nearly 1.4 million), *available at* http://shadac.org/sites/default/files/Old_files/shadac/publications/CoveredCalifornia_4.17.14.pdf.
[2] *Id.*
[3] *Id.*
[4] COVERED CAL., HEALTH INSURANCE COMPANIES FOR 2014 at 11-21 (2013), *available at* https://www.coveredca.com/PDFs/CC-health-plans-booklet-rev4.pdf.
[5] *See* ELIZABETH DAVIS, HMO, PPO, EPO & POS—WHICH PLAN SHOULD YOU CHOOSE? (2014), *available at* http://healthinsurance.about.com/od/healthinsurancebasics/a/Hmo-Ppo-Epo-and-Pos-whats-The-Difference-and-Which-Is-Best.htm.
[6] *See id.*
[7] *See id.*
[8] *See generally* CAL. HEALTH & SAFETY CODE §§ 1340-1399.818. *See* DMHC, http://wpso.dmhc.ca.gov/hpsearch/viewall.aspx, for a full list of plans regulated by DMHC.
[9] *See, e.g.,* Cal. Dept. of Ins., Rate Filing for Health Net Life Insurance Company (2013) (Filing # HNLI-129208669). In four counties, enrollees may choose a "multi-state plan" offered by Anthem Blue Cross. That plan is not regulated by DMHC or CDI, but only by the federal Office of Personnel Management, and thus will not be subject to the rules discussed in this paper. Office of Personnel Management, Multi-State Plan Program and the Health Insurance Marketplace, https://www.opm.gov/healthcare-insurance/multi-state-plan-program/consumer/?page=1#url=Overview (last visited July 2, 2018).
[10] Enrollees pay their premium to the plans directly, and for some lower income enrollees, the federal government also pays a share of the premium to plan through advanced premium tax payments. *See* Covered Cal, Coverage Basics, https://www.coveredca.com/individuals-and-families/getting-covered/coverage-basics/ (last visited July 2, 2018).
[11] *Cf.* Neelam K. Sekhri, *Managed care: the US experience*, 78 BULLETIN WORLD HEALTH ORG. 830 (2000) (discussing the relationship between risk and premium rates in private managed care plans like Covered California plans). This year, Covered California plans may receive some financial relief if premium payments do not cover all of their costs through mechanisms including risk adjustment payments, risk corridors, and reinsurance. *See generally* HENRY J. KAISER FAMILY FOUND, EXPLAINING HEALTH CARE REFORM: RISK ADJUSTMENT, REINSURANCE, AND RISK CORRIDORS (2014), *available at* https://www.kff.org/health-reform/issue-brief/explaining-health-care-reform-risk-adjustment-reinsurance-and-risk-corridors/.
[12] *See generally* Sekhri, *supra* note 11.
[13] 42 U.S.C. § 18031(c)(1)(B).
[14] *Id.* § 300gg-1(c).
[15] 45 C.F.R. § 156.230(a)(2) (established by 77 FR 18469, March 27, 2012).
[16] *Id.* § 155.1050.
[17] 45 C.F.R. §156.230(b)(2) (established by 80 FR 10750, February 27, 2015).
[18] *Id.*
[19] *Id.* §156.230(d) (established by 81 FR 12204, March 8, 2016).
[20] *Id.*
[21] *Id.* at §156.230(e) (established by 81 12204, March 8, 2016).
[22] COVERED CAL., QUALIFIED HEALTH PLAN CONTRACT FOR 2017-2019 § 3.1, *available at* *http://hbex.coveredca.com/insurance-companies/PDFs/2017-2019-Individual-Model-Contract.pdf*.
[23] CAL. HEALTH & SAFETY CODE § 1380(c).
[24] CAL. INS. CODE § 730(b).
[25] *Id.* § 733(d).
[26] COVERED CAL., *supra* note 22 § 3.3.2.
[27] 45 C.F.R. § 156.235.

[28] *Id*. Federal regulations include a safe harbor provision that allows certain "integrated" issuers—issuers like Kaiser Permanente that provide a majority of covered services through employed physicians or a single contracted medical group—to meet the ECP requirement through other means.
[29] COVERED CAL., *supra* note 22 § 3.3.3.
[30] *Id*. at § 3.06(b).
[31] *Id.*
[32] CAL. CODE REGS., tit. 28, § 1300.67.2(d); CAL. CODE REGS., tit. 10, § 2240.1(c)(1).
[33] CAL. HEALTH & SAFETY CODE §§ 1367.695 (OB/GYNs), 1367.65 (mammographers), 1374.73 (ABA Therapists); CAL. INS. CODE §§ 10123.84 (OB/GYNs), 10123.81 (mammographers), 10144.51 (ABA Therapists).
[34] Cal.Code Regs., tit. 10, §2240.1(b)(6).
[35] *Id.*
[36] CAL. CODE REGS., tit. 28, §§ 1300.51(c)(H)(i)-(ii) (DMHC plans); CAL. CODE REGS., tit. 10, §§ 2240.1(c)(2), (5) (CDI plans).
[37] CAL. CODE REGS., tit. 28, § 1300.51(c)(H)(iv).
[38] CAL. CODE REGS., tit. 10, § 2240.1(c)(3)-(4).
[39] *Id.* § 2240.1(b)(3).
[40] *Id*.§ 2240.1(c)(6).
[41] *Id*.
[42] *Id*. § 2240.1(c)(7).
[43] *Id*. § 2240.1(c)(8) (adequate number of providers), 2240.1 (c)(10) (outpatient pharmacies), 2240.1(g) (preventative services).
[44] *Id*. § 2240.1(h).
[45] COVERED CAL., *supra* note 22 at § 3.3.3(a).
[46] *Id.*
[47] *See* CAL. HEALTH & SAFETY CODE § 1367.03.
[48] CAL. CODE REGS., tit. 28, §§ 1300.67.2.2(c)(5)(A)-(F); CAL. CODE REGS., tit. 10, §§ 2240.15(b)(5)(A)-(F).
[49] CAL. CODE REGS., tit. 28, § 1300.67.2.2(c)(5)(G); CAL. CODE REGS., tit. 10, § 2240.15(b)(5)(G).
[50] CAL. CODE REGS., tit. 28, § 1300.67.2.2(c)(8); CAL. CODE REGS., tit. 10, § 2240.15(b)(7).
[51] *Id.* § 1300.67.2.2(g).
[52] CAL. HEALTH & SAFETY CODE §§ 1262.8, 1371.4; CAL. CODE REGS., tit. 28, § 1300.67(g); CAL. INS. CODE § 10112.7; CAL. CODE REGS., tit. 10, § 2240.1(b)(5).
[53] CAL. HEALTH & SAFETY CODE §§ 1383.1, 1383.15; CAL. INS. CODE §§ 10123.67, 10123.68.
[54] CAL. CODE REGS., tit. 28, § 1300.67.2.2(c)(7)(B).
[55] CAL. HEALTH & SAFETY CODE § 1373.96(l); CAL. INS. CODE § 10133.56(i).
[56] CAL. HEALTH & SAFETY CODE §§ 1262.8(a), 1383.1(b); CAL. CODE REGS., tit. 28, § 1300.67(g), 1300.67.2.2(c)(7)(B); CAL. INS. CODE §§ 10112.7(a)(3)(B)(ii), 10123.67(b).
[57] For information about filing an internal plan grievance, see our companion piece: NAT'L HEALTH LAW PROG., MANAGED CARE IN CALIFORNIA SERIES #5: INTERNAL GRIEVANCES AND EXTERNAL REVIEW (August 13, 2015).
[58] CAL. HEALTH & SAFETY CODE § 1368.01; CAL. INS. CODE § 10169.
[59] CAL. HEALTH & SAFETY CODE §§ 1368(b)(1)(A), 1374.30; CAL. INS. CODE § 10169(J)(3). Most complaints about network adequacy will be resolved through the agencies' complaint processes, but cases involving disputes over the medical necessity of a service or treatment, payment for an emergency or urgent care service provided out-of-network, or whether a particular service or treatment is experimental or investigational may be sent to a clinical review process known as Independent Medical Review (IMR). *See* CAL. HEALTH & SAFETY CODE § 1374.30; CAL. INS. CODE § 10169. For information about requesting external review, see our companion piece: NAT'L HEALTH LAW PROG., MANAGED CARE IN CALIFORNIA SERIES #5: INTERNAL GRIEVANCES AND EXTERNAL REVIEW (August 13, 2015).
[60] *See* Covered Cal., https://www.coveredca.com/find-help/contact/ (last visited July 2, 2018); visit the HEALTH CONSUMER ALLIANCE, https://healthconsumer.org/.