Cancer Care and the Adequacy of Provider Networks Under the ACA Marketplace Plans

Background

The Affordable Care Act (ACA) expanded access to health insurance through reforms of the private health insurance market, including income-related premium support and cost-sharing subsidies and establishment of Health Insurance Marketplaces. Although the health plans sold through the Marketplaces have to meet federal and state network adequacy standards, these standards, at least as applied for 2014, generally permit issuers significant leeway in the design of their provider networks. For consumers actively in treatment for a serious condition such as cancer, the adequacy of an issuer's provider network is a key consideration in their choice of plan, as is coverage for their particular providers and hospital.

To determine the adequacy of provider networks, the transparency of provider network information, and the availability of out-of-network coverage in the Marketplaces, we examined eight selected silver plan networks in California, Florida, New York, Pennsylvania, Texas, and Virginia to determine the number of oncology specialists included in each network. We compared these results to the number of oncologists available in each issuer's non-Marketplace plans offered in the same area, as well as to coverage of oncologists in the same area offered by the federal employee Blue Cross and Blue Shield Standard Option plan. In addition, we determined the availability of out-of-network coverage for 721 silver plans offered in Covered California, NY State of Health, and the 34 states using healthcare.gov.

Key Findings

Because this is a first look at coverage of oncologists in Marketplace plans, the following results should be considered preliminary. We intend to update our research in the future.

- **Lack of transparency**: Provider directories are not always accessible from the Marketplace or issuer's website, and it is not always clear whether the available information is applicable to a specific Marketplace silver plan. When a provider directory was available, it was difficult to determine the number and range of oncology-related providers available in a plan's network. However, we found it relatively easy to determine if a specific physician or hospital was included in a plan's network.
- **Similar number of oncologists in Marketplace and non-Marketplace plan networks**: For the small number of silver plans that we investigated, we found that the number of oncologists included in a silver plan's network was generally similar to the number participating in the issuer's non-Marketplace plan networks.
- **Significant lack of out-of-network coverage**: Among the 721 silver plans available in California, New York, and the 34 states using healthcare.gov, 43 percent provide no out-of-network coverage. In 10 states, all silver plans offer out-of-network coverage, while in 8 states fewer than 20 percent of plans offer out-of-network coverage.

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Recommendations

Transparency

It would be very difficult for current and future cancer patients to compare Marketplace plans based on the availability of oncologists. Therefore, we recommend that HHS and states:

- Collect provider directory information from all Marketplace plans and develop a tool that will allow consumers to directly compare plans based on covered providers and other network features without leaving the Marketplace website.
- Standardize issuer's provider directories by creating a standardized template to allow comparison across plan options, requiring direct links with no log-in requirements, and introducing standards for the accuracy and timely updating of provider directories.

Network Adequacy Requirements

Nearly one-half of silver plans lack out-of-network coverage, and many Marketplace plans have narrow networks, potentially making it difficult for cancer patients to access appropriate treatment without significant out-of-pocket cost. We recommend that HHS or states adopt network adequacy standards based on the existing Medicare Advantage time and distance requirements. Plans should be required to indicate whether providers are currently accepting new patients.

Exceptions Processes and Second Opinions

Cancer patients often require very specialized care, and it is likely that patients with a rare cancer will not be able to find all of the necessary specialists in every health plan network, even with stronger network adequacy protections. We recommend that HHS and states:

- Require a standardized exceptions process to allow access out-of-network providers if no in-network provider is available, qualified, or within a reasonable distance.
- Limit cost-sharing to in-network levels if an exception is granted, and adopt rules to protect consumers from balance billing by out-of-network providers.
- Require issuers to allow an enrollee who develops a serious condition like cancer to obtain a second opinion from an out-of-network specialist at in-network cost-sharing levels if no alternative in-network specialist is available, qualified, or within a reasonable distance.

Balance Billing

Balance billing can occur when an out-of-network provider charges more for a service than the issuer's out-of-network payment rate, leaving the patient responsible for the difference in addition to any cost-sharing required by the issuer.

- States that have not yet chosen to do so should adopt balance billing restrictions. In addition, many states have balanced billing restrictions related to HMOs, and these restrictions should be expanded to cover all health plans. At the federal level, HHS should adopt requirements to protect consumers from balance billing when they are granted an exception to receive an out-of-network service at in-network rates. Such requirements are already in place for multi-state plans, which are offered on the Marketplaces and overseen by the Office of Personnel Management.

A copy of the full report, "Cancer Care and the Adequacy of Provider Networks Under the ACA Marketplace Plans" is available at http://www.acscan.org/policy-resources/view/private-insurance/.