



# Network Adequacy Laws in Covered California Plans\*

Managed Care in California Series

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

Covered California QHPs include different managed care models including Health Maintenance Organizations (HMOs), Exclusive Provider Organizations (EPOs), and Preferred Provider Organizations (PPOs).<sup>4</sup> Generally speaking, HMOs have lower cost-sharing, won't pay for care out-of-network except in emergencies, and may require a primary care provider's referral to obtain specialty care.<sup>5</sup> 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.<sup>6</sup> 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).<sup>7</sup>

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 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.<sup>8</sup> The Health Net PPO

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\* 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).

offered in Covered California is regulated by the California Department of Insurance (CDI), and subject to the California Insurance Code rather than the Knox-Keene Act.<sup>9</sup>

## Overview of Network Adequacy

Covered California QHPs receive a set premium payment (“capitation”) per enrollee in exchange for providing services.<sup>10</sup> 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.<sup>11</sup> These arrangements give plans an incentive to limit coverage of services for their enrollees in order to maximize profits.<sup>12</sup> 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.

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).”<sup>13</sup> 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.<sup>14</sup> 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, to assure that all services will be accessible without unreasonable delay.”<sup>15</sup> Pursuant to the regulations, the Exchange must “ensure that the provider network of each QHP meets the standards specified” above.<sup>16</sup>

Covered California, in turn, requires QHPs to “comply with the network adequacy standards established by [DMHC or CDI, as] applicable.”<sup>17</sup> 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.<sup>18</sup> Similarly, CDI must examine licensed plans at least once every five years.<sup>19</sup> CDI is charged with generally evaluating plans compliance with applicable laws in the examination process.<sup>20</sup> 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.”<sup>21</sup> 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.<sup>22</sup> 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.<sup>23</sup> 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 to low-income populations in each geographic region."<sup>24</sup>

Covered California's contract with its QHPs defines which providers and entities qualify as ECPs in California.<sup>25</sup> 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 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.<sup>26</sup>

Aside from ECP requirements, California law also requires all plans to meet a 1:1200 provider-patient ratio overall, and a 1:2000 ratio for primary care providers.<sup>27</sup> In addition, plans must specifically ensure that enrollees have access to OB/GYNs, mammographers, and ABA Therapists.<sup>28</sup>

## Geographic Access

All Covered California QHPs must provide access to primary care and hospitals available within 15 miles or 30 minutes of an enrollee's home or workplace.<sup>29</sup> 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 facilities.<sup>30</sup> 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.<sup>31</sup> 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.<sup>32</sup>

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.<sup>33</sup> 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.<sup>34</sup>

## Timely Access

DMHC has promulgated detailed standards governing timely access to care pursuant to the Knox-Keene Act.<sup>35</sup> Those standards 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.<sup>36</sup> 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.<sup>37</sup> Plans must also operate a 24/7 triage screening telephone line, and ensure that enrollees do not wait more than 30 minutes for screening.<sup>38</sup> Knox-Keene-licensed plans must report on their compliance with these requirements on an annual basis.<sup>39</sup>

CDI does not yet require its plans to meet particular timeliness standards.<sup>40</sup> Rather, it requires plans to monitor appointment wait times as part of their policies and procedures for ensuring that their network capacity is sufficient.<sup>41</sup>

## Access to Services Out-of-Network

All Covered California plans must provide access to emergency care out-of-network, without requiring prior authorization.<sup>42</sup> 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.<sup>43</sup> Knox-Keene-licensed plans must also provide access to out-of-network providers when needed care is not available in-network.<sup>44</sup> (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, 2013 and March 31, 2014 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.<sup>45</sup> 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.<sup>46</sup>

## 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.<sup>47</sup> 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.<sup>48</sup> 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.<sup>49</sup> Finally, at any point an enrollee may call or email the Covered California Service Center to report a problem with his or her plan’s network.<sup>50</sup>

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

<sup>1</sup> 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://news.coveredca.com/2014/04/covered-californias-historic-first-open.html>.

<sup>2</sup> *Id.*

<sup>3</sup> *Id.*

<sup>4</sup> COVERED CAL., HEALTH INSURANCE COMPANIES FOR 2014 at 11-21 (2013), *available at* <http://www.coveredca.com/coverage-basics/PDFs/CC-health-plans-booklet-rev3.pdf>.

<sup>5</sup> See ELIZABETH DAVIS, HMO, PPO, EPO & POS—WHAT'S THE DIFFERENCE & WHICH IS BEST? (2014), *available at* <http://healthinsurance.about.com/od/healthinsurancebasics/a/Hmo-Ppo-Epo-and-Pos-whats-The-Difference-and-Which-Is-Best.htm>.

<sup>6</sup> *See id.*

<sup>7</sup> *See id.*

<sup>8</sup> *See generally* CAL. HEALTH & SAFETY CODE §§ 1340-1399.818.

<sup>9</sup> *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, <http://www.opm.gov/healthcare-insurance/multi-state-plan-program/opm-multi-state-plan-program-fact-sheet/> (last visited May 5, 2014).

<sup>10</sup> 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/coverage-basics/> (last visited May 5, 2014).

<sup>11</sup> *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* <http://kaiserfamilyfoundation.files.wordpress.com/2014/01/8544-explaining-health-care-reform-risk-adjustment-reinsurance-and-risk-corridors.pdf>.

<sup>12</sup> *See generally* Sekhri, *supra* note 11.

<sup>13</sup> 42 U.S.C. § 18031(c)(1)(B).

<sup>14</sup> *Id.* § 300gg-1(c).

<sup>15</sup> 45 C.F.R. § 156.230(a)(2) (established by 77 FR 18469, March 27, 2012).

<sup>16</sup> *Id.* § 155.1050.

<sup>17</sup> COVERED CAL., QUALIFIED HEALTH PLAN CONTRACT FOR 2014 § 3.05 (2013), *available at* <http://www.hbex.ca.gov/solicitations/QHP/library/QHPModelContract-Final.pdf>.

<sup>18</sup> CAL. HEALTH & SAFETY CODE § 1380(c).

<sup>19</sup> CAL. INS. CODE § 730(b).

<sup>20</sup> *Id.* § 733(d).

<sup>21</sup> COVERED CAL., *supra* note 17 § 3.05.

<sup>22</sup> 45 C.F.R. § 156.235.

<sup>23</sup> *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.

<sup>24</sup> COVERED CAL., *supra* note 17 § 3.06.

<sup>25</sup> *Id.* at § 3.06(b).

<sup>26</sup> *Id.*

<sup>27</sup> CAL. CODE REGS., tit. 28, § 1300.67.2(d); CAL. CODE REGS., tit. 10, § 2240.1(c)(1).

- <sup>28</sup> 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).
- <sup>29</sup> 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).
- <sup>30</sup> CAL. CODE REGS., tit. 28, § 1300.51(c)(H)(iv).
- <sup>31</sup> CAL. CODE REGS., tit. 10, § 2240.1(c)(3)-(4).
- <sup>32</sup> *Id.* § 2240.1(b)(3).
- <sup>33</sup> COVERED CAL., *supra* note 17 at § 3.06(a).
- <sup>34</sup> *Id.*
- <sup>35</sup> See CAL. HEALTH & SAFETY CODE § 1367.03.
- <sup>36</sup> CAL. CODE REGS., tit. 28, §§ 1300.67.2.2(c)(5)(A)-(F)
- <sup>37</sup> *Id.* § 1300.67.2.2(c)(5)(G).
- <sup>38</sup> *Id.* § 1300.67.2.2(c)(8).
- <sup>39</sup> *Id.* § 1300.67.2.2(g).
- <sup>40</sup> See CAL. INS. CODE § 10133.5 (requiring the Department of Insurance to develop timeliness regulations by 2004).
- <sup>41</sup> CAL. CODE REGS., tit. 10, § 2240.1(b)(7).
- <sup>42</sup> 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).
- <sup>43</sup> CAL. HEALTH & SAFETY CODE §§ 1383.1, 1383.15; CAL. INS. CODE §§ 10123.67, 10123.68.
- <sup>44</sup> CAL. CODE REGS., tit. 28, § 1300.67.2.2(c)(7)(B).
- <sup>45</sup> CAL. HEALTH & SAFETY CODE § 1373.96(l); CAL. INS. CODE § 10133.56(i).
- <sup>46</sup> 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).
- <sup>47</sup> 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 (forthcoming 2014); see also HEALTH CONSUMER ALLIANCE, WHAT TO DO IF YOU HAVE A PROBLEM WITH YOUR HEALTH PLAN 1-2 (2008) available at <http://healthconsumer.org/fso47Laeng.pdf>.
- <sup>48</sup> CAL. HEALTH & SAFETY CODE § 1368.01; CAL. INS. CODE § 10169.
- <sup>49</sup> 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 (forthcoming 2014); see also HEALTH CONSUMER ALLIANCE, *supra* note 47 at 2-3.
- <sup>50</sup> See Covered Cal., Contact Us, <https://www.coveredca.com/phone-numbers> (last visited Jun. 17, 2014).