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

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Executive Summary

For persons living with cancer, access to specialty practitioners is paramount. Millions of Americans are now choosing health coverage through the new insurance Marketplaces and these enrollees need to be able to easily determine whether specific physicians are in a plan's network. This paper explores from a cancer patient's perspective the adequacy of provider networks, the transparency of provider network information for the new qualified health plans (QHPs) offered in the Marketplace and the availability of out-of-network coverage.[1]

For information about the adequacy of provider networks, we accessed information on the inclusion of oncology specialists in four selected silver plan QHP networks offered through the federally facilitated Marketplaces (FFMs) and four selected silver plan networks offered through specific state-based Marketplaces (SBMs). These QHPs were selected, in part, because of the high incidence of cancer in their areas. We compared coverage of oncologists in these QHPs to coverage in commercial products offered outside the Marketplace in the same area by the same issuer, as well as to coverage of oncologists in the same area offered by the most popular health plan offered to federal employees (Blue Cross and Blue Shield Standard Option). We did not include hospitals and other types of health care facilities in our search. Ideally, we would have liked to conduct a systematic analysis of the availability of oncology specialists in the provider networks of QHPs. The data sets that permit such an inquiry are not yet publicly available,[2] however, so we adopted a more modest objective of looking at a small sample of QHPs in a few areas, supplemented by broader information about out-of-network coverage.[3] As data become available we will continue to examine the availability of oncology specialists in QHPs.

[1] While this paper focuses on QHPs, many of the issues discussed (e.g., transparency of information, access to provider directories) are not unique to the QHPs but to health insurance sold more generally.

[2] CMS has not yet collected and made available a list of in-network providers for each QHP. Such a data set would make it more practical to do a more systematic analysis, at least of the FFEs. For calendar year 2014, CMS requires issuers to submit a link to their provider network. CMS Letter to Issuers on Federally-Facilitated and State Partnership Exchanges (April 5, 2013), available at http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2014_letter_to_issuers_04052013.pdf.

[3] Our analysis was conducted in January and February 2014 and should be considered preliminary. We note that our study did not investigate large metropolitan areas, such as Los Angeles and New York City, where narrow networks may be more prevalent. This study is intended as a first look and, because of data constraints, our scope of provider networks was limited to eight silver plans in four states. Our analysis of out-of-network coverage was conducted in April 2014.

For the availability of out-of-network coverage, we broadened our analysis to include 721 unique silver QHPs offered in California, New York, and the 34 states using the FFM.[4] We used publicly available summaries of their benefits and coverage (SBCs) to determine the availability of out-of-network coverage, network type (i.e., preferred provider organization or health maintenance organization), and out-of-network deductibles and out-of-pocket limits. Out-of-network coverage is an important consideration for cancer patients, many of whom may need to seek highly specialized care that may not be available in-network. In addition, the availability of out-of-network coverage differs among the type of plans; traditional broader-network preferred provider organizations (PPOs) typically provide out-of-network coverage, although at higher enrollee cost-sharing amounts, whereas many health maintenance organizations (HMOs) do not.

Key Findings

Consistency in the number of participating oncologists: For the small number of QHPs that we looked at in the selected FFMs and SBMs, we found that the number of oncology-related physicians listed as participating in a silver QHP's network is generally similar to the number participating in the issuer's other commercial plans.[5]

Lack of information: We found it relatively easy to determine if a specific physician or hospital was included in a plan's network, although that information was not always accessible from the Marketplace or issuer's website or it was not clear whether the available information was applicable to a specific plan of an issuer. We consistently found that the information on the number and range of oncology-related providers available in a plan's network, in or outside of the Marketplace, was difficult to determine.

Significant lack of out-of-network coverage: Among the 681 unique silver FFM qualified health plans available on healthcare.gov, 15 unique silver plans available on Covered California, and 25 unique silver plans for which information was available on NY State of Health, 43 percent provide no out-of-network coverage.[6] This result tracks closely with network type—36 percent of the silver plans on healthcare.gov, Covered California, and NY State of Health use an HMO network structure and 8 percent use an Exclusive Provider Organization (EPO) network structure.[7] However, these figures vary significantly by state. In 10 states, all silver plans offer

[4] For the purposes of this analysis, we identified unique silver plans by removing any duplicate plans that differed only in terms of rating area, pediatric dental coverage, or adult dental or vision coverage.

[5] For purposes of this paper, we are using the term "commercial plans" to mean any non-marketplace commercial plans, including those only offered to large employers, and to Federal Employees Health Benefit plans. We did not limit our comparison only to other silver-level plans offered to individuals.

[6] Information based on ACS CAN analysis of healthcare.gov data files, as well as analysis of health plan websites for carriers offering plans on Covered California and New York State of Health. See methodology section for additional details.

[7] The four types of networks available in QHPs on healthcare.gov are Preferred Provider Organization (PPO), Point-of-Service plan (POS), HMO, and EPO. An EPO is a blend of the traditional HMO and PPO models. EPOs typically have limited networks and no out-of-network coverage like HMOs, but do not require referrals from a primary care doctor for specialty care.

out-of-network coverage, while in 8 states fewer than 20 percent of plans offer out-of-network coverage.

Findings about the inclusion of providers in specific QHP networks as of the first few months in 2014 should be considered preliminary. Because this is a first look, much remains in flux. For example, QHP provider network information available to consumers is changing. Some provider directories, which are supposed to be available to consumers through links from the Marketplace web sites, had to be removed because they contained errors, listing providers who are not in the plan's network and omitting others who have agreed to the plan's network terms and thus think that they are participating.[8] While some of these errors were addressed following the initial launch of the Marketplace enrollment, consumers continue to encounter inaccurate provider directories. In addition, as of yet we do not know which plans consumers have selected in the Marketplaces, so information about network types and out-of-network coverage is a simple average across silver level plans. If consumers choose PPO-type plans with out-of-network coverage in large numbers despite higher premiums, the Marketplace may shift to include more of these plan types.

Recommendations

- **Based on these preliminary findings, we recommend that HHS and State-based Marketplaces greatly improve the clarity, completeness, comparability and transparency of provider information for consumers, particularly as it relates to access to in-network and out-of-network specialists.**
- **We also recommend that HHS and state-based Marketplaces develop standardized procedures to allow consumers to access out-of-network care when no qualified provider is available in network within a reasonable distance and timeframe. We recommend that HHS and states limit cost-sharing to in-network levels if an exception is granted and adopt rules to protect consumers from balance billing.**
- **Finally, we recommend HHS adopt a series of network adequacy standards to ensure consumers have in-network access to providers and affordable access to out-of-network providers.**

[8] Covered California, the state-based Marketplace, which was unusual in providing for a practitioner directory including the networks for each of the participating plans, announced in early February 2014 that it was removing its directory from the website because of errors. Covered California, News Release, February 6, 2014. However, it continued to include links though to each health insurance plan's provider directory. Consumers are now able to access providers offered for each of the plans on the *Plan Names, ID Card and Provider Directory Reference Guide,* available at www.coveredca.com/PDFs/PlanNamesIDCardProviderDirectoryReferenceGuide.pdf.

Background

The Affordable Care Act (ACA) expanded access to health insurance through reforms of the private health insurance market, Medicaid expansion, income-related premium support and cost-sharing subsidies and establishment of state-based 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.[9] Because the ACA has eliminated discriminatory practices such as the ability of issuers to deny coverage to an applicant for a preexisting medical condition or charge that person a higher premium based on their health status, some issuers are attempting to limit premiums and manage costs by contracting with physicians, hospitals and other health care providers willing to accept lower rates of reimbursement than they may have previously been willing to accept.[10] In the case of some issuers, they are limiting their networks to include only those providers that meet certain quality and performance criteria; consequently, consumers may find that some or even many of the QHPs offered through their Marketplace have relatively narrow provider networks.[11]

For consumers actively in treatment for a serious condition such as cancer, the premium amount is important but the adequacy of an issuer's provider network should be another key consideration in their choice of plan. If enrolled in a plan with a narrow network, a patient may only have access to a limited number of health care providers at in-network cost sharing.[12] If a plan provides no out-of-network coverage, the patient bears full responsibility for the entire cost for any services received from a non-network provider or facility.[13] For persons with cancer this cost can easily be in the tens of thousands of dollars. In addition, individuals may

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[9] Additional background information on narrow networks can be found in recent work published by Georgetown University and the Urban Institute. Corlette S, Volk J, Berenson R and Feder J. *Narrow Provider Networks in New Health Plans: Balancing Affordability with Access to Quality Care*. Georgetown University Health Policy Instit. Center on Health Ins. Reforms and Urban Institute, May 2014, available at http://www.urban.org/UploadedPDF/413135-New-Provider-Networks-in-New-Health-Plans.pdf.

[10] Appleby, Julie, HMO-Like Plans May Be Poised To Make Comeback In Online Insurance Markets, *Kaiser Health News,* January 22, 2013, www.kaiserhealthnews.org/Stories/2013/January/23/HMO-limited-networks-comeback-in-exchanges.aspx; Cusano, David and Amy Thomas, *Narrow Networks Under The ACA: Financial Drivers And Implementation Strategies*, *Health Affairs Blog,* February 17, 2014. http://healthaffairs.org/blog/2014/02/17/narrow-networks-under-the-aca-financial-drivers-and-implementation-strategies/.

[11] McKinsey & Company, *Hospital Networks: Configurations on the Exchanges and their Impact on Premiums,* December 2013. In addition, more anecdotal information has been reported such as: Landa, Amy Snow and Carol M. Ostrom, Many Wash. Health-Exchange Plans Exclude Top Hospitals from Coverage, *Kaiser Health News,* December 3, 2013 and Sabriya Rice, Denying Access to Big Cancer Centers May Undermine Narrow Networks, *Modern Healthcare,* April 7, 2014; Tracy Jan, With Health Law, Less-Easy Access in N.H., *Boston Globe,* January 20, 2014, http://www.bostonglobe.com/news/nation/2014/01/20/narrow-hospital-networks-new-hampshire-spark-outrage-political-attacks/j2ufuNSf9J2sdEQBpgIVqL/story.html?wpisrc=nl_hrw.

[12] The term "cost-sharing" includes health plan deductibles (if any) as well as coinsurance and/or copayments the consumer is responsible for paying.

[13] Health insurance issuers may choose to cover out-of-network services on a case-by-case basis even if the patient's plan offers no out-of-network coverage, particularly if the patient requires specialized care not available in the network.

face difficulties scheduling appointments with the limited number of specialists in a narrow network plan and may face long wait times before appointments become available.

The narrower a plan's network, the higher the probability that patients, like those with cancer who often require highly specialized care, may need to seek care outside of the plan's network. Consumers may not appreciate their financial exposure for the cost of obtaining covered services from non-network providers until they receive their bills.

Even in plans that offer out-of-network coverage, patients who seek care outside of their plan's network also may be at risk for incurring significant out-of-pocket costs due to "balance billing." Balance billing occurs when the patient must pay the difference between the out-of-network provider's charge and the amount allowed by the health plan. While the ACA requires plans to cover out-of-network emergency services at in-network cost-sharing and count that cost-sharing toward the deductible and out-of-pocket maximum, there are no such requirements for non-emergency services. In addition, the ACA is silent regarding balance billing for out-of-network claims, thus leaving patients who seek out-of-network care exposed to significantly high out-of-pocket costs, particularly for specialty care services as well as for high-priced prescription drugs. This is a major concern for cancer patients, particularly those who may be enrolled in narrow network plans.

We chose to research patients' access to oncologists, given that they are often the first-line providers for patients with cancer, to determine the general availability of out-of-network coverage. Other studies have examined whether QHPs cover cancer centers and transplant centers designated by the National Cancer Institute and found, on balance, relatively poor coverage of cancer centers in seven states.[14]

[14] Pyenson B, Suh J, 2014 Individual Exchange Policies in Washington: An Early Look for Patients with Blood Cancer, Milliman (Feb. 18, 2014), available at http://www.lls.org/content/nationalcontent/pdf/ways/Individual_Exchange_Policies_Washington2014.pdf.

Methodology

Under the ACA, states were given the option to create their own SBMs; in states that chose not to operate their own, the federal government operates a FFM. For plan year 2014, 16 states and the District of Columbia chose to operate a state-based marketplace and 34 states use the FFM.[15]

We examined the availability of provider network information in four FFM states (specifically selecting four silver QHPs in Tallahassee, FL; Erie, PA; Corpus Christi, TX; and, Richmond, VA) and two silver QHPs each in the SBMs of California and New York). Our research aimed to find out:

- Is provider directory information available, transparent, comparable, and easy for consumers to access and use when making enrollment decisions?[16]
- How many oncologists are covered in QHP networks as compared to non-Marketplace commercial plans[17] and the most popular federal employee plan (in terms of enrollment)?

To address the question of availability of out-of-network coverage for plans participating in the FFM, we also examined the availability of out-of-network coverage for all unique silver QHPs in the FFM, as well as all unique silver QHPs sold through Covered California and NY State of Health for which information was available. We identified silver plans from available datasets[18] and health insurance company websites based on Plan ID number and plan names, and we removed any plans that differed only in terms of rating area, coverage of pediatric dental services, or coverage of adult dental and vision services to arrive at unique silver plans. We had to drop three QHPs from the FFM and 11 QHPs from NY State of Health because we were unable to find a Summary of Benefits and Coverage (SBC) for them, leaving a total of 721 unique silver plans. For each of these plans, we used the link to the SBC provided by HHS or

[15] Two state-based Marketplaces, Idaho and New Mexico, ended up using healthcare.gov for purposes of plan display, application for enrollment, etc., because they could not get their own web sites up in time. www.healthcare.gov.

[16] For example, Avalere conducted a study on transparency of provider network and formulary information. It found that on a scale of 1 to 10, with 10 being the most accessible to consumers, Florida scored 5.8, Texas scored 2.6, Pennsylvania and California scored 4.0, and New York scored 2.0. The Avalere analysis did not include data on Virginia. In the same analysis, Avalere determined that of 85 selected plans, 41 percent had very accessible provider directories and only 46 percent of 13 plan websites visited contained provider lookup tools. Avalere, Exchange and Consumer Experience Analysis, April 2014, available at http://avalerehealth.net/expertise/managed-care/insights/avalere-analysis-exchange-consumer-experience.

[17] In addition to selecting areas within states where there is a high rate of various forms of cancer, we also looked to moderate size localities where the number of providers would not be so large as to make the searches unworkable. We also selected the second lowest price silver plan in those communities. In effect, our sample areas are only illustrative and not generalizable.

[18] Our findings are based on data available from https://www.healthcare.gov/health-plan-information/. For Covered California and NY State of Health, we identified plans through data available from the Robert Wood Johnson Foundation and Breakaway Policy Strategies at http://www.rwjf.org/en/research-publications/find-rwjf-research/2014/03/breakaway-policy-dataset.html. We verified the out-of-network coverage through publicly available summaries of benefits and coverage on insurance company websites.

found on the health plan website to determine whether out-of-network coverage is available, and the deductible and out-of-pocket maximum for out-of-network coverage, when included.

FFM States

To access provider directory information for FFM plans, we used plan and provider information available through healthcare.gov.[19] We organized the data set by state, by county, by metal level, and by premium price.[20] We then identified:

- Communities that had a population of about 100,000 to 300,000 in order to provide sufficient scale for plan networks but without the difficulties of making network comparisons for the largest metropolitan areas;[21] and,
- Communities in which the second lowest price silver plan was a Blue Cross Blue Shield (BCBS) affiliate, in order to be able to compare the Marketplace plan network with the network available under the BCBS Federal Employees Health Benefits (FEHB) program, which is a widely available product with network information available nationwide at http://provider.fepblue.org/.

We looked at the second lowest-priced silver plan (plans with an actuarial value of 70 percent) because the Marketplace enrollment is largely composed of individuals who qualify for premium tax credits.[22] In addition, silver plans are among the more popular option, with 65 percent of those selecting a marketplace plan opting for a silver plan.[23]

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[19] Health plan information was researched in January 2014 and February 2014 with selected verification of some information in May 2014. Health plan information was derived from the healthcare.gov data set (available at https://www.healthcare.gov/health-plan-information/). For Covered California and NY State of Health, we identified plans through data available from the Robert Wood Johnson Foundation and Breakaway Policy Strategies at http://www.rwjf.org/en/research-publications/find-rwjf-research/2014/03/breakaway-policy-dataset.html. We de-duplicated the data as described for the FFM and verified the out-of-network coverage through insurance company websites.

[20] The price for a 40-year-old single person was used, but since there is a standardized age rating curve used by all plans in the FFE, the relative price among plans should not be age-specific, and this would be the second lowest price plan for any age individual in that market.

[21] Most narrow network plans are in large urban areas where issuer competition is fierce. Smaller communities and rural areas tend to be dominated by one or two plans, which results in less of an incentive for plans to lower costs. For example, BCBS is the only issuer offering in Tallahassee. Erie has 3 issuers (Highmark, UPMC, and HealthAmericaOne), Corpus Christie has 2 (BCBS and Humana); and Richmond has 4 (Anthem, Coventry, Aetna, and Optima).

[22] As of mid-April March 1, 2014, 85.3 percent of those selecting a plan through the FFM and State Marketplaces qualified for a premium tax credit. While such individuals can use their tax credit for any health plan, they only qualify for income-related cost-sharing subsidies if they choose a silver plan, and the competitive bidding model in the ACA sets the level of the tax credit in each community based on the price of that second lowest-priced silver plan. It is a price point that is presumed to be important to carriers competing for enrollment, and likely a plan that will see some initial enrollment. U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. "Health Insurance Marketplace: Summary Enrollment Report for the Initial Annual Open Enrollment Period." May 1, 2014.

[23] Id.

For the second lowest-priced silver plan in each of the selected communities, we then used the links to the provider network and SBC provided in the FFM data set noted above. We then used the provider network link to identify, where possible:

- Oncology specialists participating in the network of that second lowest price plan, with a search criteria of 15 to 25 miles (depending on the search criteria available for that plan), and in one case a specific county (Leon County, FL);
- Oncology specialists participating in any product offered by that carrier in that community; and,
- Oncology specialists participating in the BCBS Federal Employees Health Benefits (FEHB) Program in that community.

SBMs

To look at provider networks of QHPs in California and New York, we first checked each state's Marketplace website. However, these websites did not allow consumers to browse the details of QHPs without creating individual accounts.[24] We thus turned to the websites of the issuers sponsoring QHPs in those states,[25] with the hope that they would provide for easier and more consistent access to plan provider directories.

For California, we selected the zip code 93033 in Ventura, a city of about 108,000 and the zip code 94901 in San Rafael, a smaller city of about 57,000 in Marin County. For San Rafael, the second lowest cost plan is an Anthem plan but the provider directory for that specific plan was not accessible.[26] We turned next to the lowest cost silver plan, which is offered by Blue Shield of California, where we did find a directory. For a point of comparison, we looked at the FEHBP plan offered in that zip code by Blue Cross Blue Shield's FEHB plan. For Ventura, the second lowest cost silver plan is an Anthem Blue Cross plan, which is a Multi-State Program plan.[27] Again, for comparison, we looked at the BCBS FEHB plan for that area.

For New York, we selected Syracuse, a mid-size city of about 145,000 (the search function permitted selecting the city as a whole) and Forestburgh (zip code 12777), which is a relatively rural community in Sullivan County. For both Syracuse and Forestburgh, the second lowest

[24] The Covered California website now permits a user to browse plans without creating an account. The provider directory is linked to each available plan in the zip code.

[25] To identify the location of the provider directories and plan premium data by metal level on the Internet, we used a website designed to simplify plan searches http://stevemorse.org/obamacare/obamacare.html) and then also checked using Google searches.

[26] The search function for the provider directory sent the user to Anthem's national provider search page but there was no link to the specific products offered through Covered California, in this case Silver Direct Access PPO.

[27] Under the ACA, two Multi-State Program (MSP) plans are supposed to be available in every Marketplace. For 2014, only the Blue Cross Blue Shield Association contracted with the Office of Personnel Management (OPM) to offer Multi-State Program plans. Congress intended MSP plans to increase competition in the individual insurance market, especially in areas that have historically lacked much competition.

price plans were offered by Health Republic Insurance New York, which is a CO-OP plan.[28] In both cases, the plans are EPOs. Since Health Republic does not appear to have a non-QHP or commercial product, we compared it to the BCBS FEHB plan.

Results

Availability, Transparency, and Usability of Provider Directories

The considerable time and effort that it took for health researchers to access the information and identify participating oncology specialists in one QHP network, and to compare those results with other networks, suggests that it would be very difficult for current and future oncology patients, their caregivers, family members, and others to compare plans based on the availability of oncologists. Some provider directories were not easily accessible to consumers; some were difficult to understand; and provider directories might be inaccurate or out of date.

Provider directories are not always readily accessible to the consumer, and some directories are difficult to understand

The provider directory links included in the FFM plan finder for the BCBS-affiliated plans in the four communities we investigated, in general, allow consumers to search for specific providers by name.[29] Most provider directory search tools posted by BCBS-affiliated issuers in Florida, Pennsylvania, Texas and Virginia identify if a given physician is in the plan's network, and what other plan networks operated by the issuer might include that physician might. Some of the websites also allow an individual to identify whether a physician is taking new patients, which is a requirement of the ACA and is of great interest to patients seeking a new provider.[30] In addition, some issuer-provided search tools display additional specialists and allow consumers to determine whether the nearest hospital is in the network. We note that a broader study by Avalere found more significant limitations in the availability of provider directories and search tools, which may be related to our focus on BCBS-affiliated companies.[31]

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[28] CO-OPs (Consumer Operated and Oriented Plans) are private, member-governed health insurance companies forming across the country as part of the Affordable Care Act. Health Republic Insurance of New York is one of 23 CO-OPs nationally.

[29] It is important to note that the examination of four FFM plans focused on BCBS-affiliated plans. Provider directories for other issuers may not be as easily accessible for consumers. For example, a recent Avalere study noted that some exchange plan websites fail to provide any provider directories or the directories maybe difficult to find on the plan's website. Avalere, Exchange and Consumer Experience Analysis, April 2014, available at http://avalerehealth.net/expertise/managed-care/insights/avalere-analysis-exchange-consumer-experience.

[30] In 2014, CMS encouraged, but did not require, issuers to note whether providers are accepting new patients. For 2015, CMS "expects" that information to be included in the linked provider directory on the Marketplace website.

[31] In their analysis, Avalere determined that of 85 selected plans, 41 percent had very accessible provider directories and only 46 percent of 13 plan websites visited contained provider lookup tools. Avalere, Exchange and Consumer Experience Analysis, April 2014, available at http://avalerehealth.net/expertise/managed-care/insights/avalere-analysis-exchange-consumer-experience.

Another difficulty in finding information is that the specific plan names displayed on the issuer websites we examined do not necessarily match what is displayed on healthcare.gov. Given the large number of plans typically offered by large issuers, the plan name available in the issuer's provider network search tool is sometimes more generic than the specific plan listed on healthcare.gov. This inconsistency may create consumer confusion, possibly leading the consumer to enroll in a QHP that does not cover their preferred physician, despite making efforts to check the provider directory.[32]

Finally, in the case of at least one gatekeeper model HMO[33] in one community we examined, it was challenging to determine the number and types of oncologists as the network listed no subspecialists in many fields, including oncology, because access to such physicians comes through the primary care gatekeeper. That information is not readily understood from the plan's website, and instead the consumer needs to review the network information along with the separately provided Summary of Benefits and Coverage (SBC). Even after this review, the consumer still would not know the status of a particular oncology specialist without further consultation with a primary care physician to learn what oncology specialists the physician typically refers to for care.

It was difficult to determine the adequacy of provider networks from the information available.

Determining the adequacy of a plan's provider network from the publicly-available provider directories is extremely difficult for several reasons. Each issuer specifies the search terms for particular oncology subspecialties differently. Even within the BCBS companies, search terms to identify oncology specialists in the FEHB product were sometimes different than those for a particular BCBS plan in the Marketplace. That difficulty is exacerbated for the consumer attempting to compare networks among different issuers in their community.

A search of a plan's provider network may yield and count sites of care within a specific distance of a zip code or city center. However in many communities, some specialists, such as oncologists, practice at multiple sites, and search results may yield an over count of the number of specialists available to that patient. While disclosing the sites of care for a particular provider can be helpful for consumers, in comparing among different plans offered by different issuers, such data needs to be "unduplicated" in the manner that we did in our reviews.

Accuracy of network directories can be a challenge for providers and patients.

We are able to make no representation as to the accuracy of the information provided, and the provider directories often caution the user to double check with the provider. In some cases, the oncology specialist may be unaware of their participation in a particular Marketplace plan because of the existence of "all products clauses" used by some issuers to lock in the participation of a physician or other provider into all the health insurance plans sold by that

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[32] CMS has indicated that for the 2015 plan year and beyond, "If an issuer has multiple provider directories, it should be clear to consumers which directory applies to which QHP(s)." Centers for Medicare & Medicaid Services, *2015 Letter to Issuers in the Federally Facilitated Marketplace,* http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2015-final-issuer-letter-3-14-2014.pdf.

[33] This community was not included among the final four FFM communities chosen for this paper.

issuer in a state.[34] Physicians are not always aware of these clauses in their participation contracts and so may not know that they are in network providers for the QHP enrollees of a particular issuer in the Marketplace.[35]

Although issuers seeking to participate in the Marketplaces for coverage beginning January 1, 2014, were required to have their provider networks in place for the open enrollment period that began October 1, 2013, some plan networks were still being finalized when we conducted most of our plan website checks in January and February of 2014. In Texas, for example, one of the state's largest private cancer treatment groups at first decided not to participate in any of the health plans being offered through their state's FFM because of concerns about financial exposure. By mid-January, however, the group announced that it had reversed its decision and would be participating in a number of the Marketplace plans. So too did a smaller oncology center based in Austin.[36]

Availability of Out-of-Network Coverage

Overall, 43 percent of the unique silver QHPs available through the FFM on healthcare.gov, Covered California, and NY State of Health do not offer any out-of-network coverage. This percentage varies significantly by state, however. In 10 states (Alaska, Arkansas, Kansas, Missouri, Montana, North Carolina, North Dakota, South Dakota, West Virginia, and Wyoming), all of the unique silver QHPs offer out-of-network coverage. In contrast, none of the silver QHPs in Indiana, New Hampshire, or New York offer out-of-network coverage, and fewer than 20 percent of silver QHPs offer out-of-network coverage in California, Delaware, Georgia, New Jersey, and Utah. Among those plans that do offer out-of-network coverage, the average out-of-network deductible is $6,384.

These results track closely with plan types offered in silver QHPs, with HMO and EPO plans typically not covering out-of-network services. Among all 34 FFM states, California, and New York, 36 percent of silver plans have an HMO network structure and 8 percent of silver plans have an EPO network structure. The use of these plan types also varies significantly by state, as Table 1 illustrates.

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[34] As of 2009, 11 states prohibited such clauses from being written into provider contracts. American Medical Association, Federation National Managed Care Contract, Issue Brief, 2009, www.chcanys.org/clientuploads/2013%20Policy/All-Products_paper.pdf. Although they are not common in the remaining states, they do exist and have been used by issuers in states like California to expand their networks for purposes of offering QHPs through the Marketplaces.

[35] Dolan, Pamela Lewis, Insurers Invoking All-Product Clauses to Fill Exchange Plan Networks, MultiBriefs, March 3, 2014. Beck, Melinda, Doctors Fault Provider Lists Exchanges Get From Insurers, *Wall Street Journal*, October 30, 2013, http://online.wsj.com/news/articles/SB10001424052702303843104579168030624232874; Rabin, Roni Caryn, Doctors Complain They Will be Paid Less by Exchange Plans, *Kaiser Health News*, November 19, 2013, http://www.kaiserhealthnews.org/stories/2013/november/19/doctor-rates-marketplace-insurance-plans.aspx; Mogul, Fred, So You Found An Exchange Plan, Can You Find A Provider, *National Public Radio,* November 4, 2013, http://www.npr.org/blogs/health/2013/11/02/242355056/so-you-found-an-exchange-plan-but-can-you-find-a-provider.

[36] Texas Oncology Switches Obamacare Stance, *Austin Business Journ*al, January 21, 2014, http://www.bizjournals.com/austin/news/2014/01/21/texas-oncology-switches-obamacare-stance.html.

Table 1: Out-of-Network Coverage and Network Type by State

State	Number of "unique" silver plans	Percent of silver plans with no out-of-network coverage	Average out-of-network deductible	Percent of silver plans that are PPOs	Percent of plans that are HMOs	Percent of plans that are EPOs	Percent of plans that are POS
AK	11	0%	$4,955	100%	0%	0%	0%
AL	3	67%	$9,200	100%	0%	0%	0%
AR	10	0%	$3,100	50%	0%	0%	50%
AZ	37	32%	$5,280	68%	32%	0%	0%
CA	15	87%	$4,500	13%	73%	13%	0%
DE	5	80%	$6,400	20%	20%	60%	0%
FL	50	46%	$8,604	18%	46%	32%	4%
GA	16	81%	$8,833	13%	81%	0%	6%
IA	23	17%	$7,679	35%	9%	9%	48%
IL	30	10%	$8,219	80%	10%	0%	10%
IN	11	100%	N/A	0%	100%	0%	0%
KS	24	0%	$4,358	83%	0%	0%	17%
LA	16	13%	$4,621	50%	13%	0%	38%
ME	9	22%	$5,143	33%	33%	0%	33%
MI	22	59%	$3,733	41%	59%	0%	0%
MO	16	0%	$4,019	100%	0%	0%	0%
MS	5	40%	$8,333	60%	40%	0%	0%
MT	10	0%	$9,450	90%	0%	0%	10%
NC	17	0%	$6,100	41%	0%	0%	59%
ND	7	0%	$6,200	86%	14%	0%	0%
NE	16	31%	$5,400	38%	31%	0%	31%
NH	3	100%	N/A	0%	100%	0%	0%
NJ	11	91%	$5,000	0%	9%	82%	9%
NY	25	100%	N/A	0%	36%	40%	16%
OH	31	42%	$7,033	58%	42%	0%	0%
OK	17	29%	$9,483	65%	29%	0%	6%
PA	47	30%	$6,414	57%	30%	0%	13%
SC	17	71%	$6,400	0%	0%	71%	29%
SD	11	0%	$2,273	36%	64%	0%	0%
TN	30	10%	$6,285	90%	0%	10%	0%
TX	28	61%	$10,773	39%	57%	4%	0%
UT	35	94%	$8,200	3%	94%	0%	3%
VA	28	43%	$7,150	32%	43%	0%	25%
WI	78	65%	$6,074	13%	55%	4%	28%
WV	4	0%	$6,750	100%	0%	0%	0%
WY	3	0%	$7,000	33%	67%	0%	0%
Average		43%	$6,384	42%	36%	8%	14%

Publicly-Available Provider Directories Fail to Adequately Determine the Adequacy of a Plan's Network

While media reports and some studies have found the networks of QHP plans offered by issuers appear to be considerably narrower than the plans offered to employees with respect to covered hospitals and cancer centers,[37] we found it difficult to draw such a generalization for coverage of oncologists for the silver BCBS plans in the eight communities we investigated. However, we did find that 43 percent of silver QHPs offer no out-of-network coverage, which may be an indication of narrower networks or more restrictive network designs (i.e. HMOs and EPOs). For the BCBS plans in Tallahassee, Florida; Erie, Pennsylvania; Corpus, Christi, Texas and Richmond, Virginia, the number of oncology-related specialists available in each plan's network did not widely differ, with the Marketplace QHP sometimes having more and sometimes having fewer oncologists in-network than non-Marketplace plans.

Summary of information about the second-lowest bidding silver plan in 4 communities in States served by the FFE				
		Oncology specialists in network		
Community	**Issuer – Plan – Product Type**	**Network of the QHP plan**	**Any of the issuer's networks**	**FEHB BCBS product**
Tallahassee (Leon County), FL	BCBS Florida – BlueOptions Everyday Health Plus 1410P – EPO	19	19	18
Erie (Erie County), PA	Highmark Health Services – Shared Cost Plus PPO) 2650 a Community Blue Plan – PPO	10	12	12
Corpus Christie (Nueces County), TX	BCBS of Texas - Blue Advantage Silver HMO 004 – HMO	12	19	16
Richmond, VA	Anthem BCBS – Anthem HealthKeepers Silver Direct Access – HMO	38	42	39

In California and New York, the findings were inconsistent. In California, the QHP in Ventura included more oncologists than the FEHB plan, but the QHP in San Rafael included many fewer oncologists than the FEHB plan. In New York, the QHP included more oncologists in the rural area of Sullivan County but many fewer oncologists in urban Syracuse than the FEHB plan.

[37] McKinsey & Company, *Hospital Networks: Configurations on the Exchanges and their Impact on Premiums,* December 2013. In addition, more anecdotal information has been reported such as: Landa, Amy Snow and Carol M. Ostrom, Many Wash. Health-Exchange Plans Exclude Top Hospitals from Coverage, *Kaiser Health News,* December 3, 2013 and Sabriya Rice, Denying Access to Big Cancer Centers May Undermine Narrow Networks, *Modern Healthcare,* April 7, 2014; Tracy Jan, With Health Law, Less-Easy Access in N.H., *Boston Globe,* January 20, 2014, http://www.bostonglobe.com/news/nation/2014/01/20/narrow-hospital-networks-new-hampshire-spark-outrage-political-attacks/j2ufuNSf9J2sdEQBpgIVqL/story.html?wpisrc=nl_hrw.

Summary of information about silver plans in 4 communities in States running their own Marketplaces*			
		Oncology specialists in network	
Community	**Issuer – Plan – Product Type**	**Network of the QHP plan**	**BCBS FEHB Product**
Sullivan County, NY (12777)	Health Republic Insurance New York (CO-OP)-Primary Select Silver EPO	21	8
Syracuse (Onondaga County), NY	Health Republic Insurance New York (CO-OP) Primary Select Silver EPO	29	64
San Rafael, CA (Marin County) (94901)	Blue Shield of CA Enhanced EPO Silver	13	36
Ventura, CA (Ventura County) (93033)	Anthem Blue Cross Silver Direct Access, Multi-State Plan	11	7
Notes: Search options for increments of distance vary for the different plans. We attempted to use as similar a distance criterion as possible.			

Recommendations

The considerable time and effort that it took for health researchers to access the information and identify participating oncology specialists in one QHP network suggests a need to develop a standardized tool accessible from both the Marketplace website and the issuer's website that allows consumers to easily compare plans from different issuers based on networks and enable issuers to make significant improvements in their provider directory search tools. Moreover, consumers need to be clearly informed of the potential financial consequences of selecting providers who are not in a plan's network, including potential balance billing costs. We therefore recommend the following:

Improve Transparency

We strongly recommend that HHS and State-based Marketplaces collect provider directory data from QHPs and develop tools that will allow consumers to easily compare plans based on covered providers. In addition, we urge HHS and states to require QHPs to provide greater transparency related to their provider networks and their provider directories. Regulatory requirements for QHPs should be enhanced to provide for a more comprehensive minimum standard for the accuracy and display of provider directories. CMS has already issued guidance requiring issuers to provide a direct link to provider directories for each QHP and has indicated that plans must submit full provider directories to CMS for review,[38] but this requirement does not go far enough to ensure that information is accurate and consumers can easily compare plans. There are no requirements for consistent design and display of provider directories, or

[38] Centers for Medicare & Medicaid Services, *2015 Letter to Issuers in the Federally Facilitated Marketplace,* http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2015-final-issuer-letter-3-14-2014.pdf.

for timely updating of directories. In addition, states that are administering their own Marketplaces must ensure that these or stronger requirements are in place, implemented and enforced by the Marketplace governing entity or state insurance regulators.

We therefore offer the following recommendations:

- HHS and states should collect provider directory information from all QHPs and develop a tool (ideally an integrated, searchable provider directory) that will allow consumers to directly compare plans based on covered providers and other network features without leaving the Marketplace website.
- We recognize that development of a Marketplace-based provider directory tool may take time, so in the interim we recommend that HHS and the states pursue standardization of issuer-provided provider directories. This standardization should include:
    - Direct links to provider directories with no log-in requirements. A prospective enrollee should have the same access to provider directory information as an enrolled individual. A consumer should not have to be enrolled before complete information is available. In addition, the state Marketplace websites should permit a consumer to compare plans (window shop) including their benefits and provider networks without having to establish accounts.
    - Provider directories posted by issuers should use a standardized template so that the information can be compared across plan options and different issuers. These standardized templates should be required for website display (both on the Marketplace's website as well as the issuer's website) as well as the paper version of the plan's provider directory. As suggested by one expert, "the size of a plan's network should be as transparent as its premium."[39]
        - The provider directory template needs to account for the different types of health plans and their delivery networks in a way that an average consumer can understand so that if, for example, an HMO uses a gatekeeper model for specialty referrals, this information is clearly explained so the consumer is not confused about the absence of specialists listed in the directory.
        - HHS and States must enforce the ACA requirement that provider directories include accurate information on whether or not a physician is accepting patients. To the extent that providers are only accepting new patients in certain locations, that information should be noted as well. HHS and state regulators should also, at a minimum, take steps to verify the accuracy of the directories, even if only on a random sampling basis, at licensing and re-certification.
    - HHS and states should develop standards for the accuracy and timely updating of provider directories.

[39] Emanuel, Ezekiel, In Health Care, Choice is Overrated, *New York Times,* March 5, 2014, http://www.nytimes.com/2014/03/06/opinion/in-health-care-choice-is-overrated.html?emc=eta1.

Network Adequacy Requirements

The lack of out-of-network coverage in nearly one-half of silver QHPs, combined with the prevalence of narrow networks, may make it difficult for cancer patients to access appropriate treatment without significant out-of-pocket cost. The current federal network adequacy requirements for QHPs are non-specific and leave significant discretion to both issuers and regulators to determine what is adequate.

We recommend that HHS adopt a set of network adequacy standards based on the existing Medicare Advantage (MA) time and distance requirements. MA plans are required to have sufficient numbers of providers in their networks by specialty type, including hospitals and other facilities (e.g., outpatient infusion and chemotherapy). For cancer, the required specialty types include medical oncologists, surgical oncologists, and radiation oncologists. MA plans must also meet maximum distance and travel time limits, which are varied by specialty and county based on the number of beneficiaries and type of region.[40] Both CMS and MA plans have access to software to assess whether an MA plan meets these thresholds, and this software could be modified for QHPs. The CMS process allows flexibility for MA organizations to be granted exceptions if justified by local community patterns of care.[41]

When making the determination to choose a health plan, patients want to ensure they have access to the necessary providers. While making provider directories available is an important tool for consumers, ultimately patients want to know whether they can see a provider within a reasonable timeframe. The adequacy of a plan's network will depend in some part on how many individuals enroll in a given plan. If a plan's actual enrollment exceeds the estimated enrollment, individuals may experience access problems. We recommend that plans be required to note on their provider directories whether providers are currently accepting new patients. In addition, directories also should, to the extent feasible, note whether patient wait times for appointments are expected to exceed 30 days.

[40] The regions are Large Metro, Metro, Micro, Rural, or Counties with Extreme Access Considerations. CMS, MA HSD Provider and Facility Specialties and Network Adequacy Criteria Guidance, www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/Downloads/CY2014-HSD-Provider-and-Facility-Specialties-Criteria-Guidancev2.pdf.

[41] CMS, MA HSD Provider and Facility Specialties and Network Adequacy Criteria Guidance, www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/Downloads/CY2014-HSD-Provider-and-Facility-Specialties-Criteria-Guidancev2.pdf.

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 QHP network, even with stronger network adequacy protections. While cancer patients in mid-treatment may seek to choose a plan based on availability of oncologists or cancer centers, a patient who receives a cancer diagnosis mid-year may not have considered the availability of oncologists when choosing a plan. We therefore recommend that HHS and states require a standardized exceptions process to allow enrollees to access out-of-network providers if no in-network provider is available, qualified, or within a reasonable distance.[42] We also recommend that HHS and states limit cost-sharing to in-network levels if an exception is granted and adopt rules to protect consumers from balance billing. We urge HHS to require that the exceptions process be at least as protective as that used by the Office of Personnel Management for Multi-State Program plans, which are also offered on the Marketplaces.[43]

In addition, CMS and state regulators should require QHPs (or all issuers) to allow any enrollee who develops a serious condition like cancer to be able to obtain a second opinion from an out-of-network oncologist for the price of in-network cost-sharing if no alternative in-network oncologist is available, qualified, or within a reasonable distance. If the first and second opinions are in conflict, the QHP should be required to cover a third opinion.

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. In the event of a balance billing charge for out-of-network services, the consumer has few options: She can challenge the balance billed amount with the provider and/or the health plan, particularly in cases where they did not choose an out-of-network provider. This occurs, for example, when the provider uses a non-network laboratory or a network hospital includes providers (such as anesthesiologists, oncologists or other specialists) who are not included in the plan network. Alternatively, she can seek an external appeal on the grounds that the plan network did not include an in-network provider to provide a medically necessary service.

Balance billing can leave patients who make a good faith effort to select the right plan for their treatment needs with significant out-of-pocket costs. The challenge for federal and state policy makers is that balance billing cannot be solved strictly by regulating issuers but instead requires measures that also address the billing practices of hospitals and providers.

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[42] We note that, for preventive services, CMS clarified that patients must be allowed to access services without cost sharing from an out-of-network provider if no in-network provider can provide the service (see http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs12.html). However, this guidance does not appear to apply to all Essential Health Benefits.

[43] See Office of Personnel Management's Multi-State Plan Program Issuer Letter available at http://www.opm.gov/media/4517978/2014-002_dms_.pdf.

We therefore recommend the following:

- States that have not yet chosen to do so should adopt balance billing restrictions.[44] In addition, many states have balanced billing restrictions related to HMOs, and these restrictions should be expanded to cover all QHPs.[45]
- At the federal level, HHS should adopt requirements for QHPs 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 OPM.

Technical assistance was provided by Health Policy Alternatives, Inc.

[44] Many states have addressed the problem of balance billing by imposing balance billing restrictions on HMOs. As of 2013, 49 states and DC prohibited HMO in-network providers from balance billing HMO enrollees; 9 states restricted out-of-network providers from balance billing HMO enrollees. Connecticut goes further by prohibiting providers from billing any managed care enrollee for services covered under the managed care plan, except for copayments or deductibles. Fewer states limited balance billing for PPO enrollees: 27 states prohibited in-network providers from balance billing PPO patients; 9 states prohibited or restricted balance billing by some or all types of out-of-network providers. Kaiser Family Foundation, State Restriction Against Providers Balance Billing Managed Care Enrollees, 2013, http://kff.org/private-insurance/state-indicator/state-restriction-against-providers-balance-billing-managed-care-enrollees/.

[45] In addition, Medicare Advantage fee-for-service plan rules permit non-contracted providers to balance bill beneficiaries, but may not balance bill more than 15 percent of the Medicare allowed amount. CMS, *MA Payment Guide for Out of Network Payments,* 9/27/2013 Update, www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/downloads/oon-payments.pdf.