

# Regulating Network Adequacy for Rural Populations: Perspectives of Five States

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## Purpose

The purpose of this study was to examine how five geographically-diverse states with significant rural populations define network adequacy and the degree to which they consider rural issues when regulating networks.

## Introduction

For the vast majority of health plans offered in the private market, the provider network – including the set of hospitals, physicians, and other providers who deliver care under the terms of the insurance contract – is a key coverage feature. The size and composition of the provider network can influence an enrollee’s ability to access primary and specialty care in a timely fashion. There may also be financial implications related to the provider network since expenses associated with care received from a provider outside of the network may or may not be covered, depending on the plan type. Additionally, the set of providers within a plan’s network can vary in quality, which can affect patient outcomes.<sup>1</sup>

Ensuring access to care is an ongoing challenge in rural America, where the healthcare workforce supply is smaller and the healthcare needs are greater. This causes challenges for insurers, consumers, and state regulatory agencies alike. One strategy that is used to help ensure access to care within insurance plans is network adequacy regulation, in which states define and enforce certain requirements for insurers’ provider networks. Often these come in the form of standards around maximum allowable travel times and distances to reach primary and specialty care. However, those standards do not always account for differences by rurality in provider supply, population healthcare needs, and geographic complexities.

Network adequacy is particularly important for rural populations and providers because of concerns related to travel time/distance to non-local providers, the limited availability of transportation options, and the limited supply of health professionals in many rural communities. Despite this, defining what actually constitutes “network adequacy” varies considerably across states and insurance market segments.

## Key Findings

- Three of the five states that we examined, California, Kentucky, and Texas, distinguish between rural and urban areas in their network adequacy standards.
- All state insurance department representatives interviewed described challenges for insurers in meeting network adequacy regulations in rural areas because of limited supplies of providers.
- All state insurance department representatives also acknowledged the need for some flexibility in regulating network adequacy, such as allowing waivers of time and distance standards, especially as it relates to access to care in rural areas.

Health plans have increasingly adopted narrow provider networks as a cost-saving mechanism, and several studies have examined the implications of narrow networks for premiums and enrollees' ability to access care.<sup>1-4</sup> However, limited attention has been focused on rural-specific network adequacy issues.<sup>5,6</sup>

## Approach

For this study, we reviewed the literature on network adequacy, analyzed state and federal network adequacy standards, and conducted structured interviews with representatives of state insurance departments in five states: California, Kentucky, Montana, Texas, and Wisconsin. In addition to their geographic diversity and the presence of significant rural populations (by percentage and/or by size of rural population), these five states were also selected to represent ranges of regulatory approaches to defining and enforcing network adequacy standards, as well as the number of marketplace networks and the percent of narrow networks in the state (Table 1).

## Results

In our discussions with insurance department representatives from the five states, we identified issues related to state-level network adequacy across three rural-relevant themes: 1) rural-urban distinctions in network adequacy standards; 2) provider supply and shortages; and 3) flexibility in enforcing network standards. A detailed description of each theme is presented below.

### *Rural-urban distinctions in network adequacy standards*

Three of the five states distinguish between rural and urban areas in their network adequacy standards (Table 2). In Kentucky, the same time and

**Table 1. Characteristics of states in study**

State	Rural Population <sup>a</sup>	Rural Percent of Total Population <sup>a</sup>	Rural Area (square miles) <sup>a</sup>	Number of Marketplace Networks <sup>b</sup>	Percent that are Narrow Networks <sup>b</sup>
California	1,880,350	5.1	147,560	16	75%
Kentucky	1,806,024	41.6	38,076	4	25%
Montana	436,401	44.1	145,249	5	20%
Texas	3,847,522	15.3	252,486	11	73%
Wisconsin	1,697,348	29.9	52,279	14	57%

<sup>a</sup>U.S. Bureau of the Census, 2010 Census of Population

<sup>b</sup>Polsky and Weiner, 2015.

**Table 2. Examples of rural-specific network adequacy standards**

### Kentucky Revised Statutes §304.17A-515 (1)(e)

1. For urban areas, a provider network that is available to all persons enrolled in the plan within thirty (30) miles or thirty (30) minutes of each person's place of residence or work, to the extent that services are available; or 2. For areas other than urban areas, a provider network that makes available primary care physician services, hospital services, and pharmacy services within thirty (30) minutes or thirty (30) miles of each enrollee's place of residence or work, to the extent those services are available. All other providers shall be available to all persons enrolled in the plan within fifty (50) minutes or fifty (50) miles of each enrollee's place of residence or work, to the extent those services are available.

### Texas Administrative Code 28 TAC §11.1607

#### **Health Maintenance Organization Network**

(h) An HMO is required to provide an adequate network for its entire service area. All covered services must be accessible and available so that travel distances from any point in its service area to a point of service are no greater than (1) 30 miles for primary care and general hospital care; and (2) 75 miles for specialty care, specialty hospitals, and single health care service plan physicians or providers. For portions of the service area in which the network identifies noncompliance with this subsection, the network must file an access plan with the department.

### Texas Administrative Code 28 TAC §3.3704

#### **Preferred Provider Benefit Plan and Exclusive Provider Benefit Network**

(f) Network requirements. Each preferred provider benefit plan must ... provide for preferred benefit services sufficiently accessible and available as necessary to ensure that the distance from any point in the insurer's designated service area to a point of service is not greater than: (A) 30 miles in nonrural areas and 60 miles in rural areas for primary care and general hospital care; and (B) 75 miles for specialty care and specialty hospitals. For portions of the service area in which the network identifies noncompliance with this subsection, the network must file an access plan with the department.

### California Code of Regulations 10 CCR § 2240.1

#### **Adequacy and Accessibility of Provider Services**

(j) Networks for mountainous rural areas shall take into consideration typical patterns of winter road closures, so as to comply with access and timeliness standards throughout the calendar year.

distance standards apply for primary care, hospitals, and pharmacists (networks must include at least one within 30 minutes or 30 miles regardless of geographic location), but longer time and distance standards are allowed in rural areas for other specialties (up to 50 minutes/miles). In Texas, networks must include a general doctor and hospital within 30 miles for non-rural areas and 60 miles for rural areas, while their standards for specialty care are the same regardless of location (within 75 miles.) California regulations require that networks in mountainous rural areas take patterns of winter road closures into consideration when complying with network adequacy standards.

The other two states in our study, Montana and Wisconsin, do not have different standards for network adequacy in rural areas, meaning that all insurers must meet the same time and distance standards, regardless of where enrollees live. Notably, Montana has the highest percentage of rural residents, and it requires all participating insurers to offer their marketplace plans in all areas of the state. It also requires insurers' networks to include at least 80% of providers and 90% of hospitals state-wide.

Multiple state representatives stated that there is a need for flexibility and better understanding of the dynamics of particular populations and regions when considering whether or how to differentiate standards by rurality. They emphasized that blunt time and distance standards may neither ensure that rural populations have sufficient access to care nor incentivize insurers to enter rural markets.

The need for flexibility in state regulation of network adequacy aligns with the approach taken by the National Association of State Insurance Commissioners' Health Benefit Access and Network Adequacy Model Act, which specifies that a state commissioner of insurance may determine network sufficiency by reference to "any reasonable criteria," which may include:

- Provider-covered person ratios by specialty;
- Primary care professional-covered person ratios;
- Geographic accessibility of providers;
- Geographic variation and population dispersion;
- Waiting times for an appointment with participating providers;
- Hours of operation;
- Ability of network to meet the needs of covered persons (which may include low-income persons; children and adults with serious, chronic, or complex health conditions or physical or mental disabilities; or persons with limited English proficiency);
- Other health care service delivery system options, such as telemedicine and telehealth, mobile clinics, centers

- of excellence, and other ways of delivering care; and
- The volume of technological and specialty care services available to meet the needs of covered persons requiring technologically-advanced or specialty care services.<sup>7</sup>

#### *Provider supply and shortages*

All five state insurance department interviewees described challenges for insurers in meeting network adequacy regulations in rural areas because of limited supplies of providers. In particular, they described challenges related to specialty care, with four out of five states explicitly mentioning challenges getting enough providers for mental health and psychiatric care. These results are consistent with other studies that have found access to mental health providers to be a significant network adequacy concern in many states.<sup>8</sup>

We also heard about challenges for insurers finding enough providers in the specialty areas of dialysis; ear, nose, and throat (ENT); licensed addiction counseling (mentioned in relation to the current opioid epidemic); surgeons; and oncologists. The interviewees talked about how specialists tend to be located in urban areas, often requiring people from rural areas to travel greater distances to access them. We also heard about specialists located across state borders; the interviewee from Texas noted that although these providers are available to Texans, they cannot be used to meet state network adequacy regulations.

#### *Flexibility in enforcing network adequacy standards*

All five interviewees also acknowledged the need for flexibility in regulating network adequacy, especially as it relates to access to care in rural areas. The representative from California discussed a formal process for this, involving a waiver if exact time and distance standards cannot be met or if there are not enough specialists available to provide care.

Kentucky, Montana, Texas, and Wisconsin had less-formal waiver requirements, but acknowledged the need for flexibility in cases when insurers faced a hardship in meeting adequacy guidelines. For example, the Wisconsin representative discussed cases in which consumers have multiple co-morbidities or need access to highly-specialized care, which may be difficult to find within set time and distance standards in rural areas. The representative from Texas indicated that their department requires insurers to provide an access plan that details how enrollees would be able to access care outside of the defined network regulations, which must be approved by the state regulatory agency before the network can be approved.

The Wisconsin representative also noted that they are considering legislation that would require a similar access plan.

Some of our interviewees discussed challenges for ensuring timely access to care above and beyond regulating time and distance standards. They mentioned geographical and topographical nuances within their states, such as large lakes, winter weather patterns, mountainous roads, and other practical barriers to care. The representative from Wisconsin pointed out that software programs designed to measure time and distance standards are not always adequately equipped to recognize and deal with such nuances, sometimes requiring insurers to find providers in the middle of a lake or a similarly-impractical/impossible situation.

### Discussion

The central message across the three rural-relevant themes that emerged in our study of these five states was that the healthcare environment is different in rural areas and that ensuring access to care for rural populations creates unique challenges. Regulatory agencies face a com-

plex and ongoing challenge to encourage insurers to offer plans in rural areas (perhaps by offering more flexible standards in rural areas) while still guaranteeing that rural residents will have adequate provider networks with any insurer they join.

Telemedicine has been proposed as a potential tool to help insurers meet network adequacy standards in rural areas lacking a sufficient supply of providers.<sup>9</sup> Several of the state representatives discussed the use of telemedicine as a supplement to available care; however, none of them suggested that it could be used as a substitute for meeting in-person network adequacy regulations.

Additional approaches may be needed to ensure timely access to care for rural residents regardless of their insurer. One of these is to continue and expand programs designed to bolster the rural healthcare workforce, including the National Health Service Corps, Area Health Education Centers, the Health Careers Opportunity Program, and the NURSE Corps Scholarship Program. Given that these are all active programs and insurers are still struggling to meet network adequacy guidelines, more may need to be done to train, recruit, and retain the rural health workforce. ■

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