12/1/2015

Network Adequacy for Mental Health Patients

How North Carolina Measures Up

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Mental Health in the United States

Mental health is an undoubtedly major component of a person's holistic health that has far-reaching effects on the individual as well as society. Mental illness is not a rare condition or a small issue. A person has a mental illness if they currently, or at any time in the past year, have been diagnosed with a mental, behavioral, or emotional disorder (excluding developmental and substance use disorders) of sufficient duration to meet diagnostic criteria specified within the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). Serious mental illness is a subgroup of mental illness defined a mental disorder with serious functional impairment that substantially limits at least one major life activity for affected individuals (U.S. Department of Health and Human Services (HHS), 2014). In 2012 alone, approximately 43.8 million American adults aged 18 years or older had a mental illness, which corresponds to 18.5 percent of the country's adult population (HHS, 2014). In the same age cohort, ten million American adults had a serious mental illness (4.2% of our population).

A sizeable portion of our population can be labeled as having mental illness or serious mental illness. Why should our society and governments be concerned about this? The devastating effects of

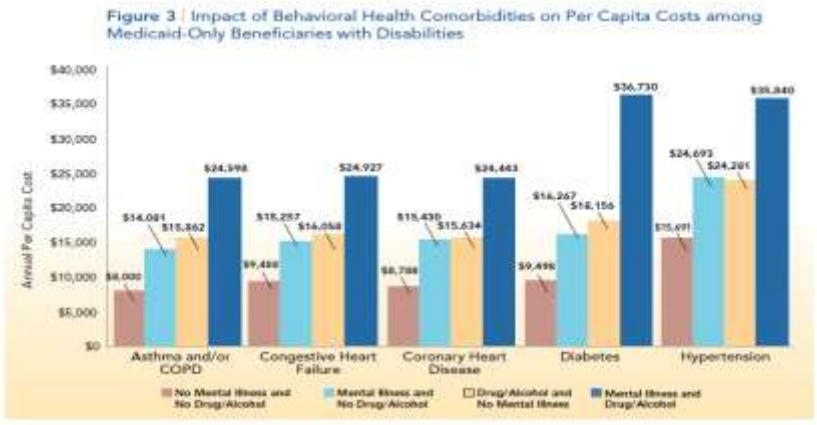

Figure 1: Presentation by Schwartz to NCIOM Rural Health Task Force. June 25, 2013.

serious mental illness are not experienced by the individual in a vacuum. The medical expenditures for the treatment of patients with chronic medical and comorbid mental health/substance use disorder (MH/SUD) conditions can be two or three times as costly when compared with patients who do not present with comorbid MH/SUD conditions. This translates to additional medical costs across Medicaid, Medicare, and private insurers; in 2012, the extra costs associated with comorbid MH/SUD treatments were estimated to be $293 billion (Milliman American Psychiatric Association, 2014).

Furthermore, much of these costs could be avoided if the mental illness was recognized and addressed in a timely fashion, which is unfortunately not the typical case. Mentally ill persons increasingly receive care through correctional facilities due to the “deinstitutionalization” policy of the 1970s. In 1959, nearly 559,000 mentally ill patients were housed in state mental hospitals (Lamb, 1998). By the late 1990s, dropped the number of persons housed in public psychiatric hospitals to approximately 70,000 (CorrectCare, 1999). As a result, mentally ill persons are more likely to live in local communities, but some came into contact with the criminal justice system. In a 2006 Special Report, the Bureau of Justice Statistics estimated that 705,600 mentally ill adults were incarcerated in state prisons, 78,800 in federal prisons and 479,900 in local jails. In addition, research suggests that "people with mental illnesses are overrepresented in probation and parole populations at estimated rates ranging from two to four times the general population" (Prins and Draper, 2009). Growing numbers of mentally ill offenders have strained correctional systems and, by extension, the non-Medicaid aspects in many state budgets.

Despite the substantial burden of mental health in the United States, the impact of mental health on individuals and society is often understated. Additionally, many obstacles hamper the delivery of mental health care. One obstacle is the dearth of mental health providers. Per the Health Resources and Services Administration (HRSA), a Health Provider Shortage Area (HPSA) is defined as an area with more than 30,000 people in the population, per psychiatrist. Based on their data, approximately 2,800 additional psychiatrists are required to eliminate the current mental health HPSA designations (Health Resources and Services Administration, 2015). The number of mental health providers is low in general, and even lower in rural areas where the need is often be greater.

Another obstacle for mental health care delivery stems from the perception of mental illness. Mental health carries a significant stigma that hampers both the recognition and the delivery of care. For example, people with mental health conditions or possible mental health conditions risk being labeled with a number of pejorative colloquialisms such as “crazy” or “psycho”. These stigmas paint the individuals who have mental health issues as undesirable and/or damaged. It also makes mental illness seem like something which people can simply “snap out of.” A 1994 study has shown that mentally ill patients report a lower quality of life due to the stigma of mental illness (Mechanic, 1994). However, they report a higher quality of life by not only denying their underlying mental condition, but in some cases by redefining it as a physical or biological condition (an illness with no stigma).

The United States has made strides in its recognition of mental health as an issue, though there is still much to be done. The Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 serves as an example of this growing recognition. The act prohibits group health plans and health insurance issuers that provide mental health or substance use disorder (MH/SUD) benefits from imposing less favorable benefit limitations on those benefits than on medical/surgical benefits (Pub. L. 110-343). For example, caps on the number of visits or hospitalizations per year for MH/SUD cannot be more stringent than the rules for the medical/surgical services. The mental health resource usage by patients seen has increased since the introduction of the MHPAEA of 2008. This indicates a long unmet need for mental health services, which existed due to a lack of recognition of mental health (Health Care Cost Institute, 2013).

For the aforementioned reasons, the U.S. should aim to decrease the cost, and increase both the quality and the access, of mental health services. One way to achieve these goals is to examine and set standards of network adequacy for insurance organizations regarding the coverage of mental health services in a given area. Without these kinds of standards, there is no way to ensure that the distribution of mental health services is adequate for a given community. Furthermore, without enforced network adequacy, people may not realize that certain plans lack the mental health coverage they expect until it is too late. As such, we will address the current state of network adequacy for mental health patients in this paper.

Network Adequacy: An Overview

A provider network is a group of providers that includes hospitals, primary care providers, and specialists who have contracts with insurers to deliver care to enrollees

at lower rates in exchange for increased patient volume. This coordination of care and delivery allows for lower costs in plans that results in lower costs for premiums. Traditionally, network adequacy standards have been used to determine sufficient providers in health managed organization (HMO) at the state level. HMOs provide managed care for health insurance by creating exclusive provider networks that lead to lower premiums and lower cost-sharing in-network for enrollees but no coverage for out-of-network costs unless for emergency services. The Affordable Care Act (ACA) launched the first national standard for network adequacy in commercial health insurance by requiring plans in the marketplaces to maintain certain criteria enforced by states (Corlette, Volk, & Berenson, 2014). Most plans found in the marketplace are HMOs.

The ACA charged the HHS with enforcing this criteria when it certified qualified health plans (QHPs) sold in the marketplace, and in 2012 HHS issued the final rules for issuers (Community Catalyst, 2014). To maintain an insurance plan on the marketplace, the ACA developed a broad criteria that included the following standards: 1) providers must be sufficient in number and type of provider to ensure accessibility to services without unreasonable delay; 2) insurance plans must include a certain percentage of essential community providers (ECPs) in-network to serve predominately low-income and medically underserved individuals; and 3) states must create a provider directory to inform consumers about the availability of providers taking new patients (Patient Protection and Affordable Care Act, 2010).

These rules allow states to further identify details about network adequacy standards and methods involved in analyzing plans across states. Network adequacy

standards are needed because it protects enrollees' access to providers that are essential for their health care needs. Typically, network adequacy is monitored retrospectively through beneficiary complaints about inadequate availability of or accessibility to providers or through insurers' access reports (National Committee for Quality Assurance, 2013). In the following sections of the paper, we will identify the current network adequacy standards, the climate surrounding revisions and approaches to those standards, and examine reasons that make a consensus on network adequacy difficult.

While the ACA intends to improve commercial insurance plans in the marketplace, its criteria possess several gaps that do not address issues for important for enrollees. The current standards overemphasize the number of providers in a network plan without addressing if the providers within the network are high quality (National Committee for Quality Assurance, 2013). As a consequence, insurers will face increased difficulty creating smaller networks that promote high-quality, low-cost providers, if they must create networks large enough to reach the robust standards required (National Committee for Quality Assurance, 2013). While the ACA requires insurers to submit a provider directory and identify which of those providers are taking new patients, providers may change their mind on whether they will admit new patients and are not obligated to notify the insurer (Patient Protection and Affordable Care Act, 2010; National Committee for Quality Assurance, 2013). Without notification from providers, the insurers do not update the directory. As a result, an outdated directory creates barriers for consumers wishing to become new patients. The current standards

fail to ensure an accurate directory that depicts the influx and efflux of providers within a given network (National Committee for Quality Assurance, 2013).

Each state takes different approaches to evaluating network adequacy. The two most common strategies are the quantitative and the subjective approach. In the quantitative approach, states set maximum travel times, maximum provider-to-enrollee ratios, a minimum number of providers accepting new patients, and a minimum percentage of available providers within an area (Corlette, 2014). For example, California set at least one full-time provider per 1,200 covered persons and primary care network providers within 30 minutes or 50 miles of the enrollee's residence or workplace (California Department of Insurance, 2014). Similarly, Texas caps an HMO beneficiary's travel time to 30 miles in non-rural and 60 miles in rural areas for primary care (Corlette, 2014). Others states enforce more subjective standards that allow commercial plans more flexibility to define standards. For example, Colorado states that issuers develop plans that show that their network is sufficient to provide access without timely delay (Corlette, Lucia, & Ahn, 2014). Based on National Association of Insurance Commissioners (NAIC) state model law, North Carolina Department of Insurance allows the issuers to develop their own network adequacy standards and their own methods to provide necessary care and accessibility to members (Technical Advisory Group, 2012).

No matter how states decide to approach creating network adequacy, it can be difficult to effectively implement standards because a state must balance consumers' access protection with flexibility in an unpredictable market. Consumers have the right to know that the insurance plan they paid for will deliver the adequate benefits no matter how narrow the provider network (Corlette, 2014). By placing the provider directory on

the website, enrollees gain information about providers accepting new patients. When implemented correctly, network adequacy increases transparency between insurers and consumers. Since the ACA's out-of-pocket cost-sharing limits do not apply to out-of-network expenses, a consumer forced to go out-of-network because their QHP is too narrow may incur high healthcare costs. Without the protection of out-of-pocket limits provided through the ACA, a vulnerable, ill consumers have no safety net against high financial costs. Still, protecting access does not ensure quality. The current standards overemphasize number of providers in network, and leave insurers crippled in their ability to have provider networks that deliver low cost, high quality care (Corlette, 2014). Contrary to what consumers perceive, narrow networks may actually provide better integration of services, more information sharing, and subsequent better quality care (Community Catalyst, 2014).

While network adequacy standards must ensure access for consumers, standards that are too stringent will prevent states from creating a viable marketplace that attracts issuers. Each state possesses varying geographic and market characteristics within its borders that make it challenging to impose specific rules across the entire state. While states may be able to account for geographic influence on network adequacy by applying one standard to urban versus rural population as seen in Texas, it is still difficult to anticipate how market variables will influence the countless local markets across the state. To do this, states would need to standardize network adequacy after adjusting for variables such as population density, varying level of provider concentration, referral patterns, and performance metrics (Corlette, 2014). It's unclear if adjusting for these characteristics will undermine a state's ability to create

viable marketplaces with insurers who also want to create healthy, low-cost networks, Therefore, states use more flexible standards because a blanket network adequacy standard may not adequately all the variables needed for a viable market.

With the struggle between guaranteeing sufficient patient access to providers and remaining flexible in an unpredictable market, it's no surprise that there has not been a general consensus for network adequacy standards. Insurance commissioners want to balance viable markets to attract insurers with adequate access for patients. Nevertheless, this way of network adequacy maintains the regulatory vacuum, which allows insurers in states like North Carolina to regulate themselves.

Although the ACA was the first to nationalize standards for network adequacy, National Association of Insurance Commissioners (NAIC) created a model state law regulating network adequacy for managed care organizations (MCO) over two decades prior to the ACA (Corlette, 2014). Traditionally, states used NAIC model state law for network adequacy criteria as guidance for their own legislation (Adams, 2014). In fact, the ACA adopted similar recommendations for QHPs offered in the Marketplace based on earlier versions of NAIC's model law. According to Sarbina Corlette, Senior Research Fellow & Project Director at Georgetown University's Center on Health Insurance Reforms, prior to 2014, few states had actually implemented the NAIC's model law and even less had any pre-emptive regulation requiring any adequate network. In this void of regulation, managed care organizations created narrow networks, which substantially lowered health care costs. However, many consumers complained that they were unable to see their preferred provider or hospital because networks were too exclusive (Corlette, 2014)

To fill the regulation cavity, the Center for Consumer Information and Insurance Oversight (CCIIO) sent a letter to issuers attempting to step in for state regulation. In this letter, CCIIO outline a detailed plan to conduct adequacy reviews for issuers' plans, share findings with the states, and enforce monitors for network adequacy (CCIIO, 2014). The federal government sent a clear message to states that if states were unwilling to address the consumer concerns of narrow networks then they would create and enforce regulations (Corlette, 2014).

With their regulatory control threatened, states responded with a letter sent by NAIC leaders to the Interim Director at CCIIO. In this response, these leaders raised the argument that federal oversight would increase duplication of work already performed by states, and suggested instead that a task force be developed and charged with updating the NAIC network adequacy law to reflect the changes made since the ACA's enactment (Hamm, Lindeen, Consedine, & Clark, 2014). Since this time, various state insurance commissioners, insurance companies, and provider groups have met monthly via conference calls to revise the NAIC state model law line by line. With so many stakeholders, difficulties reaching a consensus is common.

Behavioral Health Networks in North Carolina Commercial Health Plans

According to NC General Statute § 58-3-191, each health plan operating in NC must annually file information with the Department of Insurance (DOI) to comply with the managed care reporting and disclosure requirements. These filings, available at the DOI website, are required to report several data points related to the adequacy of provider networks, including:

- Number and types of providers currently participating in each plan's network

- Average actual driving distance to each type of provider
- Expected wait time for appointments with providers from each category

However, even though plans operating in NC have a statutory obligation to disclose these specific network-adequacy related statistics to the DOI, the vast majority of commercial health plans fail to meet their reporting obligations. As of November 2015, commercial health plan disclosure filings were available from six full-service HMO plans and 15 full-service PPO plans, covering a total of 1.3 million lives in NC. However, within these filings, over half of these plans display significant gaps in network-adequacy disclosure. For example:

1. **Sixty-six percent of health plans did not disclose mental health provider ratios:** Three of six HMO plans and 11 of 15 PPO plans did not list the number of mental health providers in their network and their patient to provider ratio across the entire state. Only three HMO plans and two PPO plans provided this information at the county level.
2. **Sixty-six percent of health plans did not disclose average distance to mental health providers:** Three of six HMO plans and 11 of 15 PPO plans did not provide information regarding average driving distance for members to mental health providers.
3. **Sixty-two percent of plans did not disclose wait times for mental health providers:** Four of six HMO plans and nine of 15 PPO plans did not include the average wait time for members to access mental health providers.
4. **Significant disparities exist between disclosure of mental health and non-mental health providers:** Three of six HMO plans and eight of 15 PPO plans did

not provide any information regarding the availability or accessibility of mental health providers. However, all three non-disclosing HMO plans and two non-disclosing PPO plans did provide availability and/or accessibility information for at least one type of non-mental health provider (e.g. PCPs or specialists).

Analysis of Available Filings

Among plans who have reported network adequacy information within their commercial health plan disclosure filings, vast disparities exist between the level of disclosure and actual network performance. This section will examine patient to mental health provider ratios, driving distance to mental health providers, and wait times for behavioral and mental healthcare providers for patients enrolled in NC commercial health plans that have included this information within their DOI disclosure files. Importantly, NC currently does not have any specified standard for any network adequacy metrics, only that the industry self-regulates its own quantifiable standards. As a result, all stated targets have been set by each individual health plan and are listed where available. While not required by the statute, some health plans have disaggregated network information by whether a service area is urban or rural: these distinctions have been noted in the analysis.[1]

Mental Health Patient to Provider Ratios

Seven NC commercial health plans reported both target and actual patient to provider ratios for both psychiatrists and non-MD mental health providers participating in their networks. Among these plans, the most common target ratio was .2 providers to every 1,000 enrolled members for both psychiatrists and non-MD providers. While each

[1] Several plans further disaggregated their information, listing statistics for members in suburban areas. These plans also reported information for both urban and rural areas. Thus, information on suburban areas was not included in this analysis.

plan exceeded its own stated target for patient to provider ratios, actual network performance varied significantly across health plans. For example, FirstCarolinaCare's PPO product reported 215 psychiatrists in network for each 1,000 members; however, Blue Cross and Blue Shield of North Carolina's (BCBSNC) PPO product reported only 1.3 psychiatrists in network for each 1,000 members living in areas of high urbanization.

Table 1: Patient to Provider Ratio: Psychiatry (providers per 1,000 members)		
Carrier	*Target MH/CD Provider Ratio: Psychiatry*	*Actual MH/CD Provider Ratio: Psychiatry*
FirstCarolinaCare PPO	1.0	215.0
Humana	0.1	199.3
FirstCarolinaCare HMO	0.1	33.3
Aetna HMO	0.5	31.0
Aetna PPO	0.5	16.0
BCBSNC HMO (Low Urbanization)	0.2	11.1
BCBSNC HMO (High Urbanization)	0.2	6.5
BCBSNC PPO (High Urbanization)	0.2	1.3
BCBSNC PPO (Low Urbanization)	0.2	0.8
Distribution of Patient to Provider Ratios: Psychiatry		
	Target Ratio: Psychiatry	*Actual Ratio: Psychiatry*
Median Ratio	0.2	16.0
Mean Ratio	0.3	57.1
Mode Ratio	0.2	n/a

Similar discrepancies existed among non-MD mental health provider networks. Again, FirstCarolinaCare's PPO plan significantly exceeded its target goal with 720 non-MD mental health providers in-network for every 1,000 members, whereas BCBSNC's PPO product reported only 9.9 non-MD mental health providers for every 1,000 members.

Table 2: Patient to Provider Ratio: Non-MD Mental Health Providers (providers per 1,000 members)		
Carrier	*Target: MH/CD Provider Ratio: Non-MD*	*Actual MH/CD Provider Ratio: non-MD*
FirstCarolinaCare PPO	0.2	720.0

Humana	0.1	511.4
Aetna HMO	1.0	114.0
BCBSNC HMO (Low Urbanization)	0.2	74.0
Aetna PPO	1.0	62.0
FirstCarolinaCare HMO	0.2	55.6
BCBSNC HMO (High Urbanization)	0.2	49.5
BCBSNC PPO (High Urbanization)	0.2	9.9
BCBSNC PPO (Low Urbanization)	0.2	5.1
Distribution of Patient to Provider Ratios: Non-MD		
	Target Ratio: Non-MD	*Actual Ratio: Non-MD*
Median Ratio	0.2	62.0
Mean Ratio	0.4	177.9
Mode Ratio	0.2	n/a

In general, NC commercial health plans contained significantly more non-MD mental health providers in their networks than psychiatrists; however, this difference varied widely across plans. Notably, BCBSNC, the state's largest managed care organization, consistently displayed the lowest level of providers within its commercial HMO and PPO products compared to other commercial health plans operating in the state.

Driving Distance to Mental Health Providers

Six plans reported on actual driving distance to in-network behavioral health providers in urban areas, and seven plans reported on driving distance to in-network providers in rural areas (an additional two plans listed distance targets, but did not report actual results for both urban and rural areas). For psychiatrists in rural areas, the most common distance target was for a provider to be within 30 miles of a patient's home, with a median target of 23 miles. Among rural populations, the most common distance target was 60 miles from a patient's home, with a median target of 50 miles. Each reporting plan performed within 99% of its distance goal for in-network

psychiatrists for both rural and urban plans, with the exception of BCBSNC's HMO plan, which only had 83.4% of its members within 60 miles of an in-network psychiatrist.

Table 3: Patient Distance to Providers: Psychiatry		
Carrier	*Target Performance: Psychiatry (% goal)*	*Actual Performance Psychiatry*
Urban / Non-Rural		
BCBSNC PPO	1:30 mi	100.0%
BCBSNC HMO	1:30 mi	100.0%
FirstCarolinaCare PPO	1:35 mi	100.0%
National Union PPO	1:15 mi	100.0%
Aetna HMO	1:10 mi (90%)	99.9%
Aetna PPO	1:10 mi (90%)	99.7%
Humana PPO	85% in 30 mi	n/a
National Foundation PPO	1:15 mi	n/a
Rural / Non-Urban		
National Union PPO	1:50 mi	100.0%
Aetna HMO	1:40 mi (90%)	100.0%
FirstCarolinaCare PPO	1:35 mi	99.9%
BCBSNC PPO	1:60 mi	99.8%
Aetna PPO	1:40 mi (90%)	99.7%
FirstCarolinaCare HMO	1:60 mi	99.3%
BCBSNC HMO	1:60 mi	83.4%
Humana PPO	85% in 90 mi	n/a
National Foundation PPO	1:50 mi	n/a
Distribution of Distance Targets: Psychiatrists		
	Urban	*Rural*
Mean Target	22 miles	54 miles
Median Target	23 miles	50 miles
Mode Target	30 miles	60 miles

Distance targets for non-MD mental health providers were the same as those for psychiatrists in urban areas, most commonly having a provider within 30 miles with a median target distance of 22 miles. However, distance targets were slightly lower for rural areas, with the most common standard being within 40 miles with a median target distance of 50 miles. All plans reported that at least 99% of their members had access to an in-network non-MD mental health provider within the specified distance target.

Table 4: Patient Distance to Providers: Non-MD Mental Health Providers		
Carrier	*Target Performance (non-MD)*	*Actual Performance (non-MD)*
Urban / Non-Rural		
FirstCarolinaCare PPO	1:35 mi	100.0%
National Union PPO	1:15 mi	100.0%
BCBSNC PPO	1:30 mi	100.0%
BCBSNC HMO	1:30 mi	100.0%
Aetna HMO	1:10 mi (90%)	100.0%
Aetna PPO	1:10 mi (90%)	100.0%
Humana PPO	85% in 30 mi	n/a
National Foundation PPO	1:15 mi	n/a
Rural / Non-Urban		
Aetna HMO	1:40 mi (90%)	100.0%
Naitonal Union PPO	1:50 mi	100.0%
FirstCarolinaCare PPO	1:35 mi	100.0%
BCBSNC PPO	1:60 mi	100.0%
BCBSNC HMO	1:60 mi	100.0%
Aetna PPO	1:40 mi (90%)	99.9%
FirstCarolinaCare HMO	1:45 mi	99.2%
Humana PPO	85% in 90 mi	n/a
National Foundation PPO	1:50 mi	n/a
Distribution of Distance Targets: Non-MD Providers		
	Urban	*Rural*
Mean Target	22 miles	52 miles
Median Target	23 miles	50 miles
Mode Target	30 miles	40 miles

Wait Times for Mental Health Appointments

Six plans reported how many patients could access a mental health provider within a target range for both emergency and routine appointments, while only five plans reported on how many patients could access a mental health provider within a target timeframe for urgent appointments. All reporting plans set a target of same-day or better for emergency appointments, and all reporting plans set a target of either same day or within 48 hours for urgent appointments. However, target wait times for routine

appointments varied from 10 days (BCBSNC PPO, Humana PPO and Aetna HMO & PPO) to 45 days (FirstCarolinaCare HMO).

Actual network performance for wait times with psychiatrists varied widely among plans. For emergency appointments, the median percentage of members who were able to receive care from a psychiatrist within the target time frame was 96.0%. For urgent appointments, the median percentage was 83.0%, and for routine appointments, the median percentage was 76.5%. Significant variation existed between the plans for emergency appointments; for example, 100% of FirstCarolinaCare PPO members were reported to have access to an in-network psychologist within the target timeframe, but only 64% of Aetna HMO members and 62.3% of National Foundation PPO members had access to a psychologist within the target timeframe.

Table 5: Appointment Wait Times: Psychiatry		
EMERGENCY		
Carrier	*Target Provider Availability: Psychiatry*	*Actual Performance: Psychiatry*
FirstCarolinaCare PPO	Immediately or Triage	100.0%
Golden Rule Insurance Company PPO	n/a	100.0%
Aetna HMO	100% / 24 hours / 7 days	96.0%
FirstCarolinaCare HMO	same day in medically appropriate setting	96.0%
Aetna PPO	100% / 24 hours / 7 days	94.0%
National Foundation PPO	24/7	66.2%
Humana PPO	85% immediately	n/a
All Plans:	**Immediately / Same Day**	**Median: 96.0%**
URGENT		
Carrier	*Target Provider Availability: Psychiatry*	*Actual Performance: Psychiatry*
FirstCarolinaCare PPO	Same Day	100.0%
Aetna PPO	90% / within 48 hours	89.0%
FirstCarolinaCare HMO	48 hours	83.0%

Aetna HMO	90% / within 48 hours	64.0%
National Foundation PPO	Same day	62.3%
Humana PPO	85% within 48 hours	n/a
All Plans:	**Same Day - 48 Hours**	**Median: 83.0%**
ROUTINE		
Carrier	*Target Provider Availability: Psychiatry*	*Actual Performance: Psychiatry*
FirstCarolinaCare PPO	30 days	100.0%
FirstCarolinaCare HMO	45 days	100.0%
Aetna HMO	90% / 10 business days	80.0%
Aetna PPO	90% / 10 business days	73.0%
Golden Rule Insurance Company PPO	n/a	66.6%
National Foundation PPO	30 calendar days	59.2%
BCBSNC PPO	10 days	n/a
Humana PPO	85% within 10 calendar days	n/a
All Plans:	**10-45 Days**	**Median: 76.5%**

Actual network performance for appointment wait times with non-MD mental health providers was generally much better than network performance for psychiatrist appointment wait times. For emergency appointments, the median percentage of members who were able to receive care from a non-MD mental health provider within the target time frame was 97.5%. For urgent appointments, the median percentage was 100%, and for routine appointments, the median percentage was 97.0%. All plans had actual network performance for non-MD provider wait times above 90% for each category, with the exception of National Foundation PPO, which had performance levels of 63.8% for emergency appointments 62.3% for urgent appointments, and 59.2% for routine appointments.

Table 6: Appointment Wait Times: Non-MD Mental Health Providers		
EMERGENCY		
Carrier	*Target Provider Availability: Non-MD*	*Actual Performance: Non-MD*
FirstCarolinaCare PPO	Immediately or Triage	100.0%

FirstCarolinaCare HMO	same day in medically appropriately setting	100.0%
Golden Rule Insurance Company PPO	n/a	100.0%
Aetna PPO	100% / 24 hours / 7 days	95.0%
Aetna HMO	100% / 24 hours / 7 days	94.0%
National Foundation PPO	24/7	63.8%
Humana PPO	85% immediately	n/a
All Plans:	**Immediately / Same Day**	**Median: 97.5%**
URGENT		
Carrier	*Target Provider Availability: Non-MD*	*Actual Performance: Non-MD*
Aetna HMO	90% / within 48 hours	100.0%
FirstCarolinaCare PPO	Same Day	100.0%
FirstCarolinaCare HMO	48 hours	100.0%
Aetna PPO	90% / within 48 hours	96.0%
National Foundation PPO	Same day	62.3%
Humana PPO	85% within 48 hours	n/a
All Plans:	**Same Day - 48 Hours**	**Median: 100.0%**
ROUTINE		
Carrier	*Target Provider Availability: Non-MD*	*Actual Performance: Non-MD*
Golden Rule Insurance Company PPO	n/a	100.0%
FirstCarolinaCare PPO	30 days	100.0%
FirstCarolinaCare HMO	45 days	100.0%
Aetna HMO	90% / 10 business days	94.0%
Aetna PPO	90% / 10 business days	91.0%
National Foundation PPO	30 calendar days	59.2%
BCBSNC PPO	10 days	n/a
Humana PPO	85% within 10 calendar days	n/a
All Plans:	**10-45 days**	**Median: 97.0%**

Conclusion

Mental health and substance abuse patients face more obstacles to care than patients who only have physical health needs. Many patients with mental health or substance abuse issues cost insurance companies (both public and private) billions of

dollars in treated care; indeed, there are many more mental health/substance abuse patients who possibly let their condition go untreated due to stigma or costs (Kessler, 2001). Network adequacy standards could be used, in theory, to increase access to quality mental health providers in North Carolina. Qualified health plans sold in North Carolina, for example, are required by the ACA to have a sufficient number of providers and provider types to ensure a level of access that does not cause "unreasonable delay." However, the DOI in North Carolina relies on the insurance industry to "self-regulate;" that is, the definitions of adequate numbers and types of providers are made by the insurance companies. Therefore, the DOI has to rely on whatever data the insurance companies have submitted on their networks and assume that their data reflect adequate access to a variety of providers and provider types. Not all states allow the industry to fully self-regulate; for example, Texas imposes certain quantitative standards that insurance companies must meet for their plans' networks to be considered "adequate."

We looked at the publicly-available data from the DOI to analyze how insurance companies define adequacy and how well the plans from these companies met the industry's own targets. However, there was a significant lack of data for many preferred provider organization (PPO) plans, which violates state requirements for disclosure (§58-3-191, 2014). Furthermore, some plans only provided data on mental health providers, and neglected to include data for non-mental health providers. Our analysis showed that among the plans that did provide publicly-available data, there were large discrepancies between the quantified targets set by the insurance companies and actual metrics listed by the plan filings. Some plans met their target standard for certain

metrics, while others underperformed, which indicates a possible access barrier to the mental health needs of many patients statewide.

Unfortunately, we cannot recommend any policy ideas with the limited data and information we currently have. However, we do feel comfortable putting forward a couple of ideas. Firstly, the North Carolina DOI should increase enforcement of data reporting in its network adequacy filing requirements. As we mentioned earlier, some plans do not report full information regarding the number of providers, particularly the mental health providers in their networks. If the DOI enforced reporting more strictly, Commissioner Goodwin could get a better idea of what standards may be feasible in North Carolina. A future commissioner would be able to establish quantified standards for network adequacy, moving one step closer to standardizing a concept that is often hard to define.

In addition, there is one federal rule currently proposed by HHS regarding national standards for network adequacy; it is not yet available for comments (to be published for comments on December 2, 2015). This rule aims to increase stringency of network adequacy standards for at both the state and federal levels. First, it requires all states to have minimum quantitative standards not unlike what Texas requires now. The regulation provides two options to achieve this: 1) states must adopt federal minimum standards; or 2) states must write and establish their own standards, but it must be at least as stringent as the federal standards. Furthermore, this rule will add more standards for insurance companies selling on HealthCare.gov. These standards will include detailing “time and distance standards” as well as “minimum provider-covered person ratio,” among other details. Finally, the proposed rule aims to incorporate many

proposals made by the NAIC on how to define and measure network adequacy. We think this rule will provide insight into some next steps on the development of network adequacy as a concept, both for the nation and for other states.

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