**Evaluation of Minnesota Health Insurance Network Adequacy**

The United States spends 17% of the GDP on health care, approximately 3 trillion dollars, more than any developed country, yet many residents have limited access to health providers. Access is limited to persons with health insurance either through an employer or the exchange, is covered under a government-sponsored program, can afford to pay for insurance or care privately, or is covered though a safety-net provider (Shi & Singh, 2017).

In this project, I am investigating the adequacy of provider networks in the health insurance exchange in Minnesota. My research questions are whether there are sufficient providers in health plan networks operating across Minnesota and whether the health plan networks meet state regulations on network adequacy. With private insurance consuming a higher market share in overall coverage, I hypothesize 65% of health insurance networks are insufficient in Minnesota. Information on provider networks was obtained from the Minnesota Department of Human Services to determine breadth & depth and how networks varied across geographic boundaries within the state. There is concern among health policy experts that insurers will limit provider networks to avoid enrolling high-risk consumers.

This research is significant because the goal of the Affordable Care Act (ACA) is to increase access to health insurance and health care services. If insurers offering policies on the state exchanges (online marketplaces where persons may purchase and receive subsidies toward the purchase of health insurance) have limited provider networks with few specialists and hospitals, then the goal of improving access to care may not be accomplished. Nonetheless, limited provider networks are likely to offer lower premiums to consumers. Thus evaluating the tradeoff of limited provider networks and lower premiums is essential.

Narrow networks are a cost containment strategy, defined as limited group of providers who have contracted with an insurance company to provide care (Lee, 1948). These providers have agreed to deliver good quality care for a low payment. The Affordable Care Act has increased standard of benefits, imposed a maximum limit on out-of-pocket spending, eliminated annual or lifetime limits, and created state health insurance exchanges. Narrow network plans are becoming more popular as a means to drive down health care costs. These plans make up about 50% of marketplace offerings using a combination of relatively low premiums and a limited choice of providers (“Regulation of Health Plan Provider Networks”, 2016).

The popularity of these plans allow insurance companies an upper hand to negotiate quality of care and costs with providers, in hopes of providing potentially higher value care. However, these plans have risks of being too narrow to offer care in a timely manner. Some networks lack in-network specialty physicians; many physicians are not open to taking new patients; some are not available within a reasonable time; and several have no interpreters to communicate with patients. This causes the plan enrollees to look for out-of-network providers, resulting in higher out-of-pocket expenses for consumers. Approximately 22% of marketplace plan networks were too narrow, in terms of having 30% to 70% of area hospitals in-network (“Regulation of Health Plan Provider Networks”, 2016). Moreover, findings from previous research hint to a network’s size and care-offered decreasing over time.

The Affordable Care Act requires that provider networks on exchanges offer a sufficient number and type of providers so all services are accessible without unreasonable delay. Also, plans are required to disclose their provider directories to the marketplace for online publication (Minnesota requires quarterly updates). Twenty-seven states have developed quantitative standards for network adequacy, such as the maximum amount of time and/or distance an enrollee must travel to access covered services. In Minnesota network adequacy is defined as the lesser of 30 miles or 30 minutes to the nearest provider for primary care, mental health and hospital services and 60 miles or 60 minutes to the nearest provider of specialty, ancillary, specialized hospital and other services (referred to as the 30/60 rule).

Using Geographic Information Systems (GIS) and public information from the Minnesota Department of Health and the Minnesota Department of Human Services, faculty members and I will analyze data and calculate statistics appropriately. We will be assessing whether health insurance plans meet network adequacy requirements, the number of state waivers obtained by health insurance carriers (to waive the network requirements), and the policy implications of enforcing the network adequacy rules.

Over the span of 15 weeks, I plan to allocate 2 weeks to research setup; 5 weeks for data collection; 4 weeks for data analysis; 3 weeks for assembling the research into a paper and poster; 1 week will be put aside for buffer time. An itemized expense description for the requested stipend and expenses is below.

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| **Source:** | **Requested Amount:** |
| Research Compensation | $1500 |
| Printing/photocopying | $50 |
| Phone | $50 |
| Literature search | $50 |
| Poster | $150 |

The analysis will provide information to Minnesota agencies and state legislators with regard to network adequacy and whether health plans operating in Minnesota comply with state and insurance regulations. This will inform policy makers on the need to strengthen insurance regulations. Furthermore, I intend to do a poster presentation of my research at the UMD Undergraduate Artistic/Research Showcase.