


## State Standards for Insurance Access to Oncologists

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### Abstract

As the market for health insurance plans expands, each state is responsible for setting standards to ensure that plans contain adequate coverage for cancer care. Little is currently known about what criteria states use for network adequacy of insurance plans. We contacted representatives of the Department of Insurance (or equivalent) for 50 states and the District of Columbia, as well as searched official state websites to compile data on network adequacy standards for cancer care nationwide. The standards of 16 (31.4%) states contained only qualitative elements for access to an oncologist (eg, “reasonable access”), 7 (13.7%) states included only quantitative elements (eg, travel distance and time restrictions), and 24 (47.1%) states included standards with both qualitative and quantitative elements. Standards from 4 states were not available. States should make certain that robust, transparent protections exist to ensure that patients are able to access high-quality cancer care without experiencing the financial toxicity associated with out-of-network billing.

Health insurance plans sold directly to consumers offer varying degrees of access to healthcare providers. Provider networks may be limited to control insurers’ costs or to allow consumers to select plans with lower premiums. Although plans offered through federally facilitated insurance exchanges were initially required to meet detailed standards for provider network adequacy published by the Centers for Medicare and Medicaid Services (CMS) (1), states were allowed to assume primary responsibility for assessing provider network adequacy from 2018 onwards (2). These state standards would generally apply to all insurance products sold within state boundaries, whether or not part of a federally facilitated exchange.

Narrow provider networks have previously been associated with limited access to cancer care (3,4), as well as substantial financial toxicity when enrollees require treatment out of network (5). It is unknown whether decentralization of provider network adequacy may affect access to cancer care and how states have responded to recent CMS guidance. We therefore undertook this investigation to clarify states’ current standards for insurance coverage of cancer care.

Representatives of the departments of insurance and health, or equivalent, for each state and the District of Columbia (51 in total) were contacted electronically and/or by phone through official websites or by using information provided by the National Association of Insurance Commissioners ([www.naic.org](http://www.naic.org)). At least

2 attempts were made to contact official personnel directly. Information was requested regarding the standard used to ensure adequate access to oncologists by insurance plans under their jurisdiction. Official state websites were also searched for law and regulations regarding network adequacy or provider network standards for cancer care.

Existing access standards were classified as including qualitative and/or quantitative elements. Qualitative standards included general language only, such as “reasonable access” to oncologists or cancer care. Quantitative standards include specific travel distance, travel time, or oncologists required per number of plan enrollees. We also documented whether the standard was located in legislation, regulation, or other policy statement or by communication only with the representative of a department. States that explicitly rely on verification of insurance network adequacy by a third party, such as CMS, the National Committee for Quality Assurance, the Accreditation Association for Ambulatory Health Care, or URAC were indicated as such.

We received responses from representatives of 14 of 50 states and from the District of Columbia. Network adequacy standards were identified on 32 of the remaining states’ websites. Publication dates ranged from 2013 to 2019; 46.9% (15 of 32) of standards from state websites were more than 3 years old. Eleven states referenced use of National Committee for Quality

Received: 5 August 2020; Revised: 28 October 2020; Accepted: 20 November 2020

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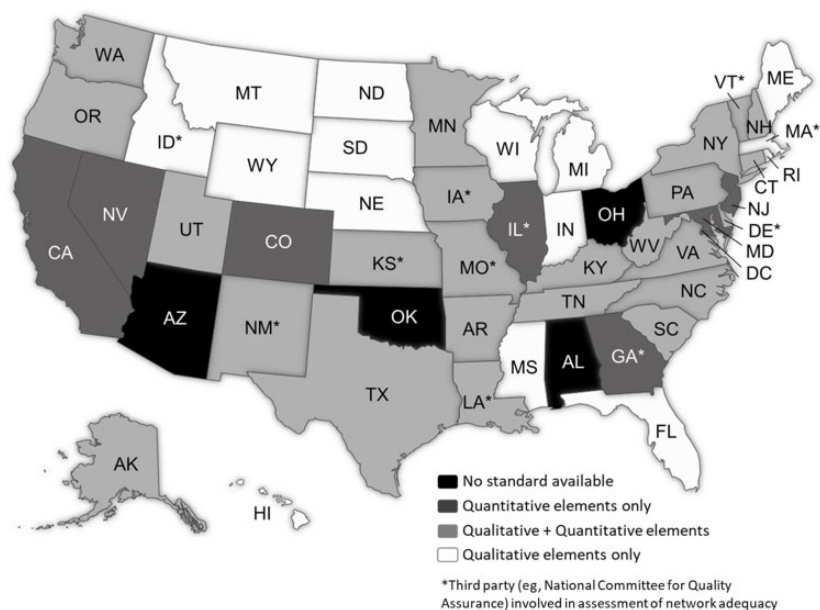


Figure 1. Type of standard for insurance access to oncologists by state.

Table 1. Sample language in standards for insurance access to oncologists

Type of standard	Example state	Example language
Qualitative	Hawaii	"A health carrier providing a network plan shall maintain a network that is sufficient in numbers and appropriate types of providers."
Quantitative: distance, travel time	Georgia	"Specialists should be available within thirty (30) minutes or thirty (30) miles for urban locales, forty-five (45) minutes or forty-five (45) miles for rural locales."
Quantitative: ratio of provider to member	Illinois	"1 Oncology/Radiation provider per 15 000 policy members"
Quantitative: wait time	Maryland	"... an individual should be able to get an appointment within 30 calendar days from someone who is in network."

Assurance standards for assessment of network adequacy; these are available for review (6). Many of these states listed other private accreditation organizations as well. We were unable to determine whether these states solely rely on private accreditation agencies or supplement with independent oversight. Of the 47 state standards identified, 17 (36.1%) were found in legislative documents, 22 (46.8%) in regulation, 8 (17.0%) in other policy documents, and 5 (10.6%) in communication with state representatives only.

Twenty-four (47.0%) states had standards with qualitative and quantitative elements for access to an oncologist, 16 (31.3%) states had qualitative elements only, and 7 (13.7%) states had quantitative elements only. Specific quantitative standards varied by state. Standards from 4 states (Alabama, Arizona, Ohio, and Oklahoma) were not available (Figure 1). Eleven states considered medical and surgical oncologists together as 1 provider group.

The most commonly used phrases for qualitative elements were "sufficient" and "reasonable" provider networks. Combined maximum travel time and distance was the most

common quantitative standard (12 states). Eleven states specified travel distance only, and 4 provided travel distance, travel time, and provider-to-member ratios. Finally, 4 states specified 1 of the following factors: travel time only; travel time and provider-member ratios; travel time and maximum allowable wait times; or travel distance, travel time, and wait time (Table 1). Detailed responses from each state are available in Supplementary Table 1 (available online).

States currently have a wide variety of standards in place for insurance coverage of cancer care across the United States. We were not able to assess how many states' standards were updated after the publication of the 2018 CMS guidance. This investigation should be updated in the near term to assess whether states respond to regulatory changes with revised network adequacy standards.

It may be challenging for patients, healthcare professionals, and policy makers to identify the specific criteria used by each state to ensure that insurance plans provide adequate access to oncologists. As the market for insurance products continues to expand, it is essential for network adequacy standards to be

clear and transparent to protect consumers who require care for cancer.

Given substantial geographic and sociodemographic diversity across the United States, a single network adequacy standard may be neither possible nor desirable for all states and insurance markets. States should therefore collaborate with patient advocates and cancer professionals who have knowledge of local markets and patients' needs to develop basic standards for insurance coverage. Transparent standards will also permit study of cancer care delivery outcomes related to network adequacy, improvement in access to high-quality care, and minimization of the sometimes disastrous financial consequences of out-of-network billing. Additional research is also needed to determine how general cancer care standards can be applied to rare or complex cancer patients, to further improve equality in access to care. Finally, it is concerning that some states' current standards appear to conflate access to medical and surgical oncologists; in light of their distinct scopes of practice, updated policies should clearly distinguish between these 2 specialties.

## Funding

None.

## Notes

**Role of the funder:** Not applicable.

**Disclosures:** The authors report no conflicts of interest.

**Prior presentation:** These data were previously presented at the

2020 virtual Annual Meeting of the Society of Gynecologic Oncology (March 2020).

**Author contributions:** C.J.M. and D.I.S. contributed to study design, data collection and analysis, and drafted and critically revised the manuscript.

## Data Availability

The data underlying this article are available in the article and in its online [Supplementary Material](#).

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