

Research BRIEF

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PEDIATRIC AND ADULT PHYSICIAN NETWORKS IN AFFORDABLE CARE ACT MARKETPLACE PLANS

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KEY FINDINGS

Among ACA plans, the proportion of narrow networks were greater for pediatric specialties than for adult specialties (66% vs. 35%), highlighting the need to monitor access to specialty care for children and families.

THE QUESTION

Insurers offering plans on the ACA's health insurance marketplaces have used a strategy of restricting provider networks to limit costs. [Previous work](#) used data from all 'silver' plans offered on the marketplaces in 2014 to quantify physician networks and categorize them into sizes, with the smallest category being networks having less than 10% of available doctors in the rating area.

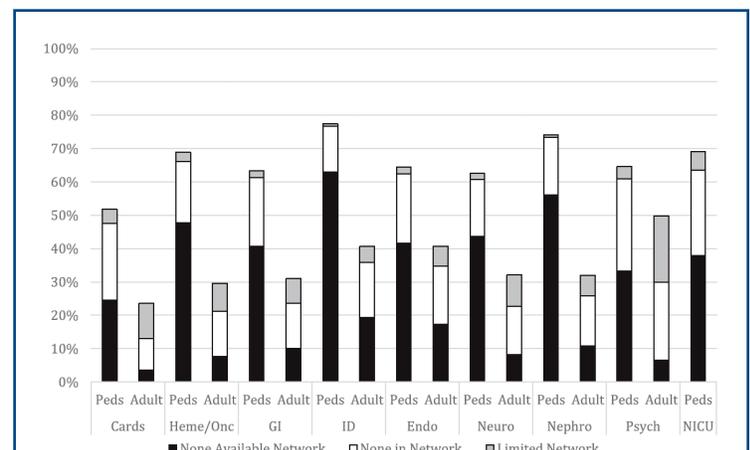
Network size varies across plans, but it also varies within plans by specialty. Because some pediatric subspecialties have fewer providers across the country, plan networks for these specialties might be more narrow than for adult specialties. In this study, the authors compare the network sizes for pediatric and adult specialties in more than 1,000 silver-level plans sold on the ACA marketplaces in 2014 and explore reasons for differences in network breadth.

THE FINDINGS

Among silver plan networks, the proportions of narrow networks were greater in pediatric (66%) than adult (35%) specialist networks. Narrow networks included those that had no specialists who worked in the rating area, no specialists in the network, or were of limited size (i.e., included less than 10% of specialists in the area).

The pediatric specialties with the highest proportion of narrow networks were infectious disease (77%), nephrology (74%), and neonatology (69%). In contrast, adult specialties with the highest proportion of narrow networks were psychiatry (50%), endocrinology (40%), and infectious disease (41%).

The figure below displays the distributions of narrow networks for pediatric and adult specialists. Overall, 44% of pediatric networks had no specialists who practiced in the underlying area (i.e., none available network) compared to 10% of adult networks. The proportions of networks with no coverage of the specialists who practiced in underlying area (i.e., none in network) were significantly higher for all pediatric than adult specialties, except nephrology and infectious disease. Narrow networks were more common in low-population or rural areas compared with higher populated areas.



Types of narrow networks for pediatric versus adult specialists (N=1836). Cards, cardiology; Endo, endocrinology; GI, gastroenterology; Heme/Onc, hematology/oncology; ID, infectious disease; Nephro, nephrology; Neuro, neurology; NICU, neonatology; Peds, pediatrics; Psych, psychiatry. Source: Wong et al., *Pediatrics*, 2017.

THE QUESTION THIS STUDY RAISES, BUT CANNOT ANSWER, IS WHETHER THESE NETWORKS ARE ADEQUATE TO MEET THE NEEDS OF CHILDREN AND FAMILIES. THIS IS A PARTICULAR CONCERN FOR CHILDREN WITH SPECIAL HEALTH CARE NEEDS, WHO ARE MORE LIKELY TO USE SPECIALTY PEDIATRIC CARE.

THE IMPLICATIONS

This is the first study to document the prevalence of narrow networks for pediatric and adult specialists in ACA plans in 2014. The difference was largely due to fewer pediatric specialists across the country. But even where pediatric specialists were available, they were not found in networks more often than their adult counterparts.

Lack of specialists practicing in some areas (both adult and pediatric) is an ongoing workforce issue, especially in low-population, rural areas. Creating and maintaining adequate networks within the constraints of the rural health delivery system will continue to pose a challenge for all health plans, not just the ACA plans on the marketplace.

When specialists are not scarce, limited networks reflect a trade-off between premiums and consumer choice. Restricting provider networks is one way plans can contain costs. Providers may be out-of-network because they choose not to participate in networks (due to low reimbursement), or because insurers exclude them to direct patients to lower-cost providers. Higher cost seems to be the rationale for excluding [children's hospitals](#) from some networks.

The question this study raises, but cannot answer, is whether these networks are adequate to meet the needs of children and families. This is a particular concern for children with special health care needs, who are more likely to use specialty pediatric care. Inadequate networks may create geographic or financial barriers to care, if families must travel long distances or pay substantial out-of-pocket costs for out-of-network care. This study underscores the need for network adequacy standards that assure adequate depth and breadth of pediatric specialist coverage, and for monitoring the effects of narrow networks on children's access to care. Provider network size and access to pediatric specialists in different plans also need to be more transparent for families as they are [shopping for insurance plans](#), with tools like flags for narrow networks and integrated provider look-ups.

THE STUDY

The authors used publicly available provider directories to identify 1,836 unique physician networks at the rating area level for all 2014 individual marketplace silver plans. The data included physician specialty and address, and the authors standardized specialties into 47 specialty groups for analysis. They quantified networks by the fraction of physicians in the underlying rating area within a state that participated in the network. Narrow networks represented an umbrella category for networks with no specialists in the geographic rating area, no specialists in the network (despite availability of specialists in the area), or limited numbers of specialists (less than 10% of those available in the area). The authors compared the proportions of narrow networks between pediatric and adult specialty providers, and for each adult specialty and pediatric subspecialty.

Wong CA, Kan K, Cidav Z, Nathenson R, Polsky D. [Pediatric and Adult Physician Networks in Affordable Care Act Marketplace Plans](#). DOI: 10.1542/peds.2016-3117. Pediatrics, March 2017, e20163117.

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