Impact of Narrow Networks on Access to Urologic Care and Quality within Medicare Advantage Plans

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INTRODUCTION

The increasing prevalence of narrow networks in health insurance, particularly within Medicare Advantage (MA) plans, reflects a broad health policy trend geared towards balancing cost containment with access to care. Narrow networks, a feature of MA plans characterized by limited access to a panel of in-network providers and hospitals, operate as a cost-control mechanism. Specialty care access, including urology, is particularly vulnerable to these narrow network limitations as urologic care often involves complex, long-term management of conditions that may require frequent and timely access. However, rural and underserved areas face an increasingly difficult access challenge due to the particularly selective inclusion and exclusion of providers and hospitals within narrow networks. We aim to highlight the impact of narrow networks on access to specialty care and quality within these plans as well as provide actionable health policy recommendations geared towards addressing MA narrow networks.

MATERIALS and METHODS

A narrative review was conducted using PubMed, legislative analysis, and reports from credible organizations with a particular focus on articles addressing narrow network effects on specialty care, disparities, or outcomes. PubMed MeSH search terms included terms like "Medicare Advantage narrow networks," "urology access," etc. The literature was analyzed for key themes and summarized.

RESULTS

Table 1. Comparison of Medicare Advantage and Traditional Medicare Networks

Feature	Traditional Medicare	Medicare Advantage (MA)
Provider Access / Geographic Flexibility	Can visit any provider accepting Medicare nationwide; coverage valid anywhere in the United States	Restricted to network providers for non-emergency care; out-of-network costs are higher; limited to plan's service area (except for emergencies)
Specialist Referrals	Not required	Often required
Cost Sharing	Typically 20% coinsurance after deductible for Part B services	Varies by plan; typically includes copays and coinsurance
Out-of-Pocket Limits	No cap on out-of-pocket costs without supplemental insurance (e.g., Medigap)	Annual cap on out-of-pocket costs for covered Part A and Part B services
Supplemental Coverage / Benefits	Medigap available for additional cost; covers deductibles and coinsurance	Supplemental benefits (e.g., dental, vision) often included
Drug Coverage	Requires separate Part D drug plan	Most plans include Part D drug coverage
Prior Authorization	Rarely required	Common for many services and drugs
Foreign Travel Coverage	Generally not covered unless with Medigap	Limited emergency coverage in some plans
Appeals for Denied Claims	Standard appeals process; less frequent claims denials	Higher likelihood of initial denials; appeals often result in overturned decisions

Table 2. Policy Recommendations to Address Narrow Network Challenges

Policy Recommendations	Description
Strengthen Network Adequacy Standards	Enhance time-distance and provider-to-patient ratio requirements Include more rural-friendly criteria
Expand Telehealth Integration	Include urology and other specialties in telehealth exceptions Incentivize hybrid telehealth and in-person care solutions
Increase Transparency and Oversight	Require more stringent public reporting of network breadth, quality, and satisfaction metrics
Address Geographic Disparities	Introduce travel cost subsidies for rural patients accessing specialized care Incentivize and expand provider availability in underserved regions
Improve Consumer Protections	Penalize inappropriate or delayed prior authorization denials Implement expedited appeals processes for urgent cases

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KEY CONTEXT

- MA plans have become increasingly popular, with more than half of Medicare beneficiaries (54% or approximately 33 million people) having enrolled in an MA plan as of 2024.[1]
- MA enrollment is highly concentrated among a small number of health plans, with Humana and UnitedHealthcare being responsible for almost half (47%) of all MA enrollees across the United States, followed closely by Blue Cross Blue Shield, Aetna CVS Health, and Kaiser Permanente rounding out the top five largest firms.[1]
- According to the 2023 AUA census, 1,930 counties (61.4%) in the US have no practicing urologists in them.[2]
- Only 10.1% of practicing urologists operate their primary practice locations in non-metropolitan areas (pop. <50,000) with 8% in micropolitan (pop. 10,000-49,999), 1.6% in small town (pop. 2,500-9,999), and 0.5% in rural (pop. <2,500) areas.[3]

CONCLUSIONS

Narrow networks within MA plans pose significant challenges to access and equity in specialty care, especially for those in rural and underserved settings.

Proposed policy solutions include:
- Strengthening network adequacy standards
- Enhancing telehealth integration
- Ensuring transparency and oversight of MA plan networks

Although cost containment remains a priority for health plans and the federal government, eschewing the needs for equitable and high-quality care for some of the most vulnerable patients is unacceptable. Proposed policy solutions that address MA plan inadequacies to ensure that high-quality and convenient care is accessible regardless of location or socioeconomic status remains a top priority.

[1] Freed M, Biniek JF, Damico A, Neuman T. Kaiser Family Foundation. Medicare Advantage in 2024: Enrollment Update and Key Trends. August 8, 2024. Accessed January 10, 2025. https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2024-enrollment-update-and-key-trends/
[2] American Urological Association (AUA), "AUA Census 2023," Table 1-3 County of Primary Practice Locations. Accessed January 10, 2025.
[3] American Urological Association (AUA), "AUA Census 2023," Table 1-4 Rurality Level of Primary Practice Locations. Accessed January 10, 2025.