

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

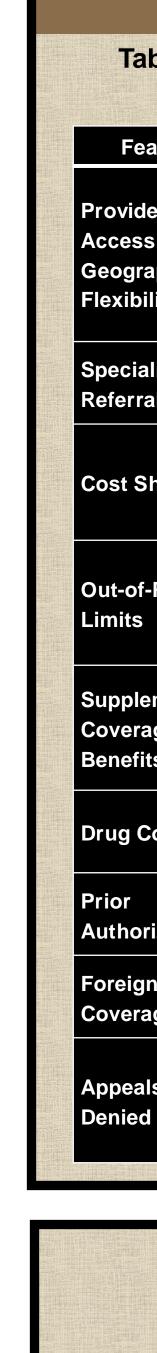
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## INTRODUCTION

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.



[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.

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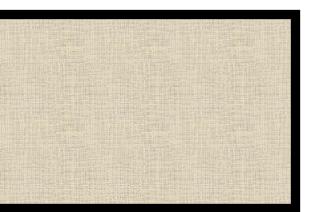
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able 1. Comparison of Medicare Advantage and Traditional Medicare Networks			Table 2. Policy F		Recommendations to Network Challenges	
eature der	Traditional Medicare Can visit any provider accepting Medicare	Medicare Advantage (MA) Restricted to network providers for non-emergency		Policy Recommendations	Descrij	
ss / raphic pility	nationwide; coverage valid anywhere in the United States	care; out-of-network costs are higher; limited to plan's service area (except for emergencies)		Strengthen Network Adequacy Standards	Enhance time-distance and ratio requirements Include more rural-friendly	
ialist rals	Not required	Often required			Include urology and other	
Sharing	Typically 20% coinsurance after deductible for Part B services	Varies by plan; typically includes copays and coinsurance		Expand Telehealth Integration	exceptions Incentivize hybrid telehealt solutions	
of-Pocket s	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		Increase	Require more stringent pu breadth, quality, and satisf	
lemental rage / fits	Medigap available for additional cost; covers deductibles and coinsurance	Supplemental benefits (e.g., dental, vision) often included		Transparency and Oversight	Introduce travel cost subsi	
Coverage	Requires separate Part D drug plan	Most plans include Part D drug coverage		Address Geographic	accessing specialized care Incentivize and expand pro underserved regions	
orization	Rarely required	Common for many services and drugs		Disparities		
gn Travel rage	Generally not covered unless with Medigap	Limited emergency coverage in some plans			Penalize inappropriate or of authorization denials	
als for ed Claims	Standard appeals process; less frequent claims denials	Higher likelihood of initial denials; appeals often result in overturned decisions		Improve Consumer Protections	Implement expedited appe urgent cases	

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## **MEDICAL CENTER**

### **KEY CONTEXT**

o Address Narrow	
ription	
nd provider-to-patient	
ly criteria	
r specialties in telehealth	
alth and in-person care	
ublic reporting of network sfaction metrics	
sidies for rural patients re	
provider availability in	
r delayed prior	
peals processes for	



- 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.



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