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Narrow Provider Networks in New Health Plans: Balancing Affordability with Access to Quality Care

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Introduction

Many health insurance plans offered in the individual market—both inside and outside the new marketplaces (also referred to as “Exchanges”)—have narrowed their provider networks relative to what they have offered in the past.¹ Although it is not yet known how widespread this practice is, anecdotal reports of narrower networks have garnered notice from the media as well as federal and state policy-makers.² As one state official put it, “I don’t know that many of us a year ago anticipated that qualified health plans inside the exchange were going to be changing their networks as dramatically as we experienced them.”³

New network configurations offer trade-offs for consumers. Many insurers were able to lower their overall costs by reducing the prices they pay participating providers, which in turn allowed them to lower their premiums to attract price-conscious shoppers. However, in many cases, consumers have been surprised to discover that their new plan offers a more limited choice of providers. Some others willing to pay more to purchase a plan with broader access to providers have found that only limited-network plans are available in their area.⁴

It is not yet clear whether these new, narrower network plans can effectively deliver on the benefits promised under the plan. If policyholders opt to seek medically necessary care out-of-network, it could expose them to significant financial liabilities. If policyholders delay or forgo care because in-network providers can’t meet their needs, it could put their health at risk.

Consequently, state and federal policy-makers are taking another look at the Affordable Care Act (ACA) requirement that plans participating on the new health insurance marketplaces maintain an adequate provider network. In doing so, they must strike a delicate balance. If they overly constrain insurers’ ability to negotiate with providers, consumers could face significant premium increases. On the other hand, consumers must be able to choose among plans with confidence that they have a sufficient network to deliver the benefits promised and that they will not be exposed to unanticipated health and financial risks because of an inadequate network. Insurers also need incentives to take provider quality into account (in addition to prices).

In this paper we assess the benefits and risks of a range of policy and regulatory options available to federal and state policy-makers. We acknowledge that the development, review and oversight of health plan networks involves trade-offs between premium costs and consumers’ access to and choice of providers. We know of no current regulatory approach that can satisfy all objectives or all stakeholders. However, we conclude that an appropriate balance between consumer choice and cost containment can be struck with a mix of strategies that include regulatory standards, better consumer information and more robust oversight. Specifically, we recommend the following:

- **Regulatory standards should establish a floor of consumer protection:**
 - > Insurers should be required to meet a minimum standard for adequate access to primary care, but allowed greater flexibility with the provision of non-emergency specialty care, particularly when local providers can’t meet quality expectations or demand unreasonably high payment levels.
 - > Insurers who do not have a skilled and experienced in-network hospital or clinician to perform a needed service should be required to provide coverage for that service out-of-network, at no additional cost to the policyholder. This requirement helps ensure that consumers are held harmless if the care they need is only available out-of-network.
- **A regulatory floor will be both challenging to implement and by itself insufficient; consumer protection will also require transparency and oversight.**
 - > Insurers, insurance regulators, and the marketplaces should dramatically improve and expand the information available to consumers about plans’ network design and participating providers so that they have the tools to make informed choices.
 - > State and federal regulators need to expand their capacity to monitor plans’ provider networks and the extent to which consumers are using in- versus out-of-network care.

Background

In preparation for the ACA's 2014 market reforms, insurers used network design to lower costs in different ways. Some decided to exclude certain high-price providers from their networks; others offered all providers lower payment rates (leading some providers to decline to participate). Still others implemented tiered networks so that consumers face lower cost-sharing when they obtain care from an inner tier of preferred providers and higher cost-sharing for care obtained from another tier of less-preferred (but still in-network) providers. Tiered networks can become the functional equivalent of narrow networks when high cost-sharing deters use in less-preferred tiers or use of out-of-network providers. For the purposes of this paper, all of these approaches are labeled “narrow” network strategies, and they stem from insurers’ belief that to gain market share on the new marketplaces, they must offer price-sensitive consumers a competitive premium. One national poll suggests this belief is well-founded—a majority of individuals likely to purchase coverage through the new marketplaces reported that they prefer less-costly narrow network plans over more-expensive plans with broader networks.⁵

Federal and state regulators generally gave insurers a significant amount of flexibility to narrow their networks for the 2014 plan year, even though marketplace plans are required to meet a minimum standard for network adequacy. Although some states adopted more detailed network adequacy standards than the federal one, many state officials tended to place a greater value on encouraging insurer participation than on robust network adequacy standards.⁶

As marketplace consumers enroll in plans and begin to use their new benefits, different parties are reacting to narrow network plans. Consumer groups, along with excluded providers, have expressed concerns about the networks’ ability to provide access to quality care.⁷ Some states—and the federal government—have responded with proposals for 2015 that would strengthen regulatory oversight, restrict insurers’ plan design flexibility, and expand provider networks.

Narrowing Networks Part of Broader Health System Trends

The use of narrower networks as a mechanism to reduce premiums is not new, and it is not limited to plans in the new marketplaces. In the recent past, commercial

health insurers have offered both narrow and broad network products, largely in response to demand from their employer-based customers. For example, in response to complaints about rising health costs from employer-based health care purchasers, insurers in the late 1980s and early 1990s increasingly offered tightly managed Health Maintenance Organizations (HMOs) or other products that constrained choice of provider in exchange for lower premiums. But these and other access restrictions contributed to a backlash from providers and consumers and led federal and state policy-makers to propose minimum standards for the adequacy of provider networks. While attempts at a federal standard for commercial health insurance foundered, many state legislatures filled the gap.⁸ In 1996, the National Association of Insurance Commissioners (NAIC) adopted a model state law requiring managed-care plans to maintain networks that ensure access to services “without unreasonable delay;” this standard later became the template for federal standards under the ACA.⁹

Whether in response to tougher rules from regulators or employer demand, insurers in the late 1990s and early 2000s shifted to broader networks. While consumers had greater access to and choice of providers, health care premiums for employer-sponsored plans also accelerated, averaging 11 percent per year.¹⁰

These premium increases were not entirely due to expanded networks, but employers increasingly sought ways to constrain their costs, and the pendulum on network design began to swing again. Narrowing networks have again become more common in employer-based insurance, making up 23 percent of the plans offered by employers in 2012, up from 15 percent in 2007.¹¹ As one benefits expert noted, “It’s definitely a growing trend.... there are only so many levers health plans and plan sponsors can pull if they want.... greater efficiency.”¹²

In the individual market, insurers have long had many levers to constrain costs, such as the use of health status underwriting to avoid covering people with health care needs, benefit exclusions (such as declining to cover maternity care or prescription drugs), annual or lifetime dollar limits on benefits, and high cost-sharing (deductibles of \$10,000 or more were not uncommon).¹³ Therefore, they have not historically had the same incentives to narrow the provider networks for their individual market products. With the ACA’s insurance

reforms removing those options for insurers, and in the face of concerns that an influx of sicker enrollees would require higher premiums, narrowing networks became the lever of choice for many individual market plans seeking to reduce costs and appeal to price sensitive consumers.

The Narrow Network Strategy

Current Impetus

The primary current impetus for health insurers to adopt narrow network benefit designs is to gain greater leverage to negotiate lower prices with providers, especially hospitals and large medical groups. In contrast to the situation with public payers, which are able to set nonnegotiable provider rates, commercial carriers negotiate payment rates with providers. Over the past 10–15 years, primarily due to provider consolidation, providers in many markets have been able to achieve greater power to raise prices for their services.¹⁴ Consolidation has been particularly rampant among hospitals and hospital systems as well as single specialty medical groups merging into larger entities. Hospitals are also buying physician practices and employing physicians for various reasons, one of which is to enhance the hospital's and physicians' negotiating leverage with insurers. Wide disparities of hospital prices, mostly reflecting variations in pricing power, have been documented in recent years.¹⁵ For example, commercial insurers on average pay hospitals about 40 percent more than Medicare pays,¹⁶ but variations in payment rates range from near Medicare rates to as much as 600 percent more than Medicare.¹⁷

If an insurer cannot make a bona fide threat to either exclude a provider from its provider network or place it in a disadvantageous cost-sharing tier, it gives up an important source of leverage in payment negotiations. The threat of excluding or limiting a provider's network participation helps price negotiations in two ways. First, the threat itself might moderate a provider's price demands so it can be included in the network. Second, by actually limiting the network, the insurer can obtain a discount in exchange for the additional volume that the selected provider will receive.

While gaining leverage over negotiated prices is the primary reason insurers are returning to limited networks, some insurers report the desire to develop "high-performance" or "value" networks, at least for some markets. In this approach, the providers favored for inclusion in the narrow network not only are willing

to provide comparatively favorable prices but also are potentially able to meet insurer objectives for improving quality and limiting unnecessary care. For example, some insurers are designating Centers of Excellence to which an enrollee is encouraged to go for certain elective specialty services, such as cardiac or other surgeries. While these centers may be outside the plan's service area—and in some cases in a different region or state—they are chosen because they deliver better outcomes at a lower price than local providers, even after the plan has paid for the travel expenses of the patient and a family member.¹⁸

Risks for Consumers

Narrow networks can be advantageous to insurers as a risk-selection mechanism because sicker individuals are likely to be more attracted to broad network plans. Over time, insurers currently offering broader network plans could be tempted to narrow their offerings in order to compete on price and discourage the enrollment of sicker individuals, leading to a race to the bottom. The ACA's risk adjustment mechanism is intended to largely eliminate this incentive, but its effectiveness remains uncertain.

If the network overly limits choice of provider, excluding those with specialized expertise in treating particular conditions, it could not only compromise the quality of care but also expose policyholders to unanticipated and potentially crippling financial liabilities. This can happen when they feel forced to seek care outside the plan network or in a less-preferred provider tier, or unwittingly rely on out-of-network services and face unexpected extra fees.¹⁹ Some consumers may be willing to trade choice of providers for a lower premium, but they may be unaware of the risk they take. Insufficient regulatory oversight and transparency about insurers' network designs may prevent consumers from making informed decisions. In some marketplaces across the country, insurers in the individual market may only be offering narrow network plans, meaning that consumers who want a broad choice of providers do not have that option, even if they are willing to pay more.²⁰

If a network is inadequate, policyholders are also more likely to be charged the difference between the provider's charge and what the insurer has agreed to pay, a phenomenon called "balance billing."²¹ Consumers may know about the potential for balance billing before they obtain a service, but it is not uncommon for patients to receive unexpected charges when treated by out-of-network physicians working at in-network hospitals. The consumer may have specifically selected an in-network hospital

to avoid out-of-network cost-sharing, unaware that the hospital-based physicians (such as anesthesiologists, pathologists and radiologists) at that hospital are out-of-network. These physicians in essence own a monopoly on their specialty's services within the hospital, leaving patients little choice but to use their services and be exposed to out-of-network obligations. Indeed, in states that do not limit balance billing or impose on insurers the obligation to pay out-of-network providers, hospital-based physicians may take advantage of their captive patients by dropping out of plan networks.

In one extreme case, New Jersey physicians were sued for charging what one insurer called “unconscionable” amounts for simple services, including \$59,490 for an ultrasound that would normally cost \$74.²² In most states, if the insurer doesn't pay the full amount demanded by the out-of-network provider, the patient can be billed for the remainder. New York's insurance regulators have logged at least 10,000 reimbursement complaints since 2008, with tens of thousands of dollars attributed to balance billing charges.²³ Some states have attempted to address the problem of balance billing with laws that regulate how much an insurer is expected to pay an out-of-network provider; a few states restrict balance billing by out-of-network providers, at least for some services (i.e., emergency care).²⁴ New York enacted legislation in early 2014 that, in addition to holding consumers harmless from unexpected balance billing also requires greater up-front disclosure of consumers' potential out-of-pocket costs when obtaining care from an out-of-network provider.²⁵

Network Adequacy Under the ACA

The ACA establishes the first national standard for network adequacy in commercial health insurance by requiring plans sold on the health insurance marketplaces to maintain a provider network that is “sufficient in numbers and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay.” Marketplace plans must also include in their networks essential community providers (ECPs) that serve predominantly low-income, medically underserved individuals. A plan's provider directory must be available online and in hard copy upon request.²⁶ In addition, the ACA prohibits insurers from charging consumers out-of-network cost-sharing for emergency services, even if those services are delivered by out-of-network providers.²⁷

At the same time, the ACA's new insurance rules raise the stakes for consumers who use out-of-network providers. First, out-of-network cost-sharing does not count towards the ACA's limit on policyholders' annual out-of-pocket costs (which for 2014 is set at \$6,350 for an individual and \$12,700 for a family).²⁸ Consumers in plans with a network that cannot meet their health care needs could therefore be at significant financial risk. Second, while the ACA establishes a minimum actuarial value²⁹ for each plan, the cost of out-of-network care is not included in the actuarial value calculation. As a result, consumers cannot rely solely on a plan's precious metal level (bronze, silver, gold, and platinum) to fully assess a plan's relative generosity.³⁰

As implemented, network adequacy standards under federal rules give states and insurers considerable flexibility in interpreting what would constitute “sufficient” numbers and types of providers that can deliver covered benefits without “unreasonable delay.” Some states conducting plan management for the marketplace, either as a state-based marketplace or a state partnership marketplace, have enacted additional standards. For example, Vermont and Delaware set standards for maximum geographic distances and drive time to obtain primary care services. California requires plans to make services in urban areas reasonably accessible by public transportation.³¹ Pre-dating the ACA, several states (including Colorado, Missouri and Montana) also required insurers that did not have an in-network provider to meet a patient's needs to allow the patient to obtain care out-of-network at the in-network cost-sharing level.³²

In federally facilitated marketplaces, where federal regulators have been responsible for health plan certification, states were largely left responsible for reviews of network adequacy—as long as the state had authority to review plan networks and a network adequacy standard at least as stringent as is required under federal rules. In states without sufficient network adequacy reviews, the Centers for Medicare and Medicaid Services (CMS) accepted an insurer's accreditation from two national accrediting bodies, the National Committee for Quality Assurance and URAC to satisfy the requirement.³³

To date, some plans on the marketplaces have gained significant market share because their narrow networks allowed them to offer low premiums. In response to concerns that insurers narrowed their networks too much, federal regulators have said they intend to strengthen their review of insurers' networks for the 2015 plan year. For insurers operating in states with federally facilitated

marketplaces, federal regulators may conduct network reviews themselves, rather than simply accepting state reviews or accreditation status. In doing so, the CMS will “focus most closely on those areas which have historically raised network adequacy concerns,” including hospitals

and mental health, oncology and primary care. Federal officials have further intimated that they may develop new, quantitative limits on the length of time or distance required to access benefits.³⁴

Policy Options: Balancing Consumer Protections With Affordability

States seeking to address concerns about the adequacy of plans’ provider networks while also constraining premium cost growth face a range of legislative and regulatory options. As one state regulator put it, “If the carriers don’t push against provider pricing, who will?”³⁵ One option is to have government address provider payment rates directly. During the 1970s and 1980s, eight states adopted rate-setting systems to set limits on inpatient and outpatient hospital prices.³⁶ However, all but two states—Maryland and West Virginia—abandoned rate setting in the 1990s. Some stakeholders have advocated a “public option” plan that could, like Medicare, offer enrollees access to a broad network while using market power to limit prices. For the foreseeable future, however, the prospects for government rate-setting and a public option in most states are slim.

A pressing need is for the exercise of state authority to review and revise current regulation of the adequacy of insurers’ networks. In doing so, policy-makers must balance the interests of many consumers and provider stakeholders in having a broad choice of in-network providers with consumers’ equally important interest in affordable premiums. To meet the latter interest, insurers will need negotiating flexibility to extract lower prices from providers, particularly hospital systems and large single-specialty and multispecialty group practices. At the same time, states must hold insurers accountable for delivering on promised benefits and consumers must be able to make informed choices from among plan options.

Over the years, states have taken specific steps to address concerns about network adequacy, ranging from laws requiring insurers to contract with “any willing provider,” to quantitative standards of network adequacy, to more laissez-faire approaches. We review the benefits and risks of these approaches and ultimately submit one multipronged approach that could help states strike a better balance between ensuring consumers’ access to covered services, constraining providers’ pricing power,

and encouraging the development of networks based primarily on the value (high quality at a reasonable cost) of the care provided.

Any Willing Provider and Freedom of Choice Laws

In response to the consumer and provider backlash against the tightly managed care networks that proliferated in the 1990s, some states enacted laws intended to restrict the ability of managed care insurers to selectively contract with providers. These state laws vary considerably but come in two general forms. The first is termed an “any willing provider” (AWP) law. AWP laws generally require insurers to accept into their network any provider willing to comply with the insurer’s rates and terms and conditions.³⁷ Other AWP laws simply require health plans to negotiate with providers, without requiring the insurers to contract with providers seeking network inclusion. According to one count, 22 states have an AWP law in place, though the specifics vary considerably from state to state and some are limited to pharmacy providers.³⁸

In the wake of concerns about narrowing plan networks on the new health insurance marketplaces, some states—such as Mississippi and New Hampshire—have considered adopting AWP requirements.³⁹ These laws are controversial, however. Insurers argue that limits on their contracting flexibility increase their costs. While some providers and consumer advocates support these laws, others, even in the provider community, recognize that requiring insurers to include any provider who agrees to contract terms and conditions could adversely affect insurer discretion to develop networks designed to improve quality and reduce costs.⁴⁰

The second type of law is called a “freedom of choice” (FOC) law, which allows a health plan’s policyholders to receive health care services from any qualified provider,

even if the provider has not signed a contract with the health plan. According to one estimate, 23 states have enacted some variation of an FOC law.⁴¹ FOC laws come with their own set of disadvantages, the primary one being that while they permit consumers to obtain care out-of-network, most do not protect them against high out-of-pocket charges.

Network Adequacy Standards: Quantitative and Subjective Approaches

Establishing a standard for network adequacy—or for what it means for an insurer to provide reasonable access to services—is no simple matter. Currently, when states regulate the adequacy of commercial insurers' networks, they have taken two primary approaches. Some set quantitative standards such as time and distance limits, provider-to-enrollee ratios, and appointment waiting time limits.

Examples of Quantitative Standards for Network Adequacy
Provider-to-enrollee ratios
Maximum travel time
Maximum travel distance
Maximum appointment wait times
Minimum number of providers accepting new patients
Minimum percentage of available providers within a service area

For example, California's Department of Managed Care sets out maximum travel times and distances, maximum wait times and minimum provider-to-enrollee ratios. Texas caps an HMO policyholder's travel to no more than 30 miles in nonrural areas and 60 miles in rural areas for primary care, with the maximum distance for specialty care and specialty hospitals set at 75 miles.⁴² The federal government has established quantitative network standards in the Medicare Advantage program, and 29 states have set such standards for their Medicaid managed care organizations.⁴³

Other states impose more subjective or flexible standards for commercial plans, similar to the reasonable access standard defined in the NAIC's model law and now in federal regulations. For example, Colorado requires managed care plans to demonstrate that their network is "sufficient" to provide access "without unreasonable delay," and allows insurers to set provider-enrollee ratios according to "reasonable criteria."⁴⁴

Whether quantitative or subjective, when states have standards for commercial health plans, most are directed toward HMOs and not other network-based plans, such as Preferred Provider Organizations or Exclusive Provider Organizations. Over time, as distinctions between these different types of plans have blurred (i.e., many HMOs offer an out-of-network option and Exclusive Provider Organizations may not), failure to set a common standard among all plans creates an unlevel playing field and leads to consumer confusion. See Table 1.

Setting clear quantitative standards and conducting an upfront review of plans' networks to determine whether they meet those standards has advantages and disadvantages. Among the advantages are the clarity and certainty of numerical standards, and a level playing field among insurers, who, if given flexibility to define adequacy would likely do so differently.

However, this type of regulation is not without problems. First, because networks evolve over time as clinicians and hospitals are added or dropped from the network, the network adequacy review process provides only a temporary snapshot—and may tell a consumer little about the plan at the point in time he or she is purchasing it. Second, it may be difficult to set a standard that sufficiently accounts for geographic and market variables across the state. For example, while a state might impose a different standard in a rural region than in an urban one, it can be challenging to calibrate the standard to all the different conditions that may exist from market to market within a state. In addition to population density, local market conditions can also affect insurers' ability to develop and maintain robust, high quality and efficient networks. Local markets can vary by levels of provider consolidation and concentration, usage and referral patterns, performance on quality metrics, and insurers' use of out-of-area Centers of Excellence for certain services or procedures.

Third, for the population of people enrolling in marketplace plans—particularly those who were previously uninsured—it is not yet fully understood how they are likely to seek and receive care. While there is evidence they are more accepting of a narrow network when choosing a plan than those with employer-based coverage, research also shows that many are less familiar with health insurance and benefit concepts, including the concept of a provider network.⁴⁵ Some may enroll in plan networks that prove too limited if and when they develop a health condition; many also have more limited resources and are therefore at greater financial risk if

Table 1. Types of Network Design

Type of plan	Definition
Health Maintenance Organization (HMO)	An HMO integrates health insurance with the provision of health care services. An HMO directly provides (i.e., through their own hospitals and employed physicians) or arranges for health care for their enrollees. The HMO does not generally cover any portion of the cost of care obtained outside the HMO's network of providers.
HMO with Point of Service (POS) option	The POS option allows enrollees of an HMO to obtain covered care outside of the HMO's network of providers, but usually at higher cost-sharing.
Exclusive Provider Organization (EPO)	An EPO is a network of medical care providers who have entered into written agreements with an insurer to provide health care services to enrollees. The insurer will only pay for the health care services of an enrollee if they are obtained within the EPO network.
Preferred Provider Organization (PPO)	A PPO is a network of physicians, hospitals and other providers that agree to provide health care services at discounted rates to the enrollees of a health insurer. Enrollees can generally obtain health care services from providers outside the PPO network, but usually with higher cost-sharing.

Sources: Claxton, G. *How Private Insurance Works: A Primer*, Menlo Park, CA: Kaiser Family Foundation, 2002.; Pan, A. *Exclusive Provider Organizations*, <http://www.healthinsurance.info/plans/EPO.HTM>.

they obtain care out-of-network. Thus, an approach to network adequacy that has worked well for a population with a stable source of employer-based coverage and care may be insufficient for the population of people enrolled in marketplace plans. Fourth, and more pragmatically, many state insurance regulators lack capacity to conduct a comprehensive, pre-market review of insurers' provider lists and contracts across all their plan offerings. An NAIC white paper on network adequacy recommends that state regulators have a "general familiarity" with provider availability in a given area, medical referral patterns, hospital-based providers who might not be in-network when the facility is, and any geographic barriers in an area.⁴⁶ However, many state insurance agencies do not have the staffing to systematically collect, analyze and use this kind of information in their reviews. In a number of states, network adequacy reviews have also historically been done by a separate agency (often the Department of Health) or may in the future be done by the marketplace. This could lead to a lack of coordination and disjointed oversight.⁴⁷ Information technology and network review software may be able to help with this over time, but current tools are limited.

Instead of quantitative standards, many states may prefer to give insurers more flexibility to tailor their networks by taking a subjective approach. However, a subjective standard—such as ensuring policyholders can receive services without "unreasonable delay"—

leaves the determination of reasonableness in the eye of the beholder. For example, Anthem Blue Cross Blue Shield in New Hampshire responded to the new federal network adequacy requirements by excluding over 30 percent of the state's hospitals from its networks. For the insurer and for regulators, this amounted to a reasonable network. But for at least some consumers, and the state hospital association, it is not.⁴⁸ And Washington's insurers found that their definition of "reasonable access" was at odds with that of the state insurance commissioner, who initially rejected the marketplace applications of five insurers on the grounds that they had inadequate networks. The commissioner's interpretation of reasonableness was in turn rejected by an administrative law judge and the state's own marketplace, which urged inclusion of the insurers.⁴⁹ Without a clear standard, it is hard to determine when an insurer's reductions in the provider panel go too far, rendering the plan unable to deliver on promised benefits and reducing policyholders' ability to obtain convenient, needed services within their plan's network. Despite its flaws, a clear, numeric adequacy standard may be preferable to ensure that a network can fully meet policyholders' needs.

Protecting Access While Preserving Flexibility

Whether a state adopts a quantitative or subjective regulatory approach to its evaluation of plan networks, no state should consider its oversight job complete after a plan is approved for sale. In addition to a review of the

overall number and distribution of in-network providers, officials need to consider consumers' ability to understand what kind of plan they are purchasing and once purchased, their ability to obtain in-network care.

Under the ACA, federal and state regulators have new authority to collect data from insurers on the volume and types of services enrollees are receiving out-of-network.⁵⁰ While capacity to collect and analyze that data may currently be limited, over time regulators will gain the opportunity to identify outliers or trends suggesting a lack of network adequacy. Data could also be made available to health researchers, whose published studies could help supplement analyses from state agencies. State and federal regulators should also be publicizing and closely monitoring plans' consumer satisfaction scores, such as through the Consumer Assessment of Healthcare Provider and Systems survey, as well as any complaints received by insurers, the Department of Insurance, and the health Insurance marketplace. They could be conducting "secret shopper" surveys to assess whether policyholders can actually obtain necessary care within the network on a timely basis and within a reasonable geographic radius of their home or workplace.

In addition, state and federal regulators have not historically included metrics on access that reflect the changing nature of care delivery. Effective regulation needs to be flexible enough to accommodate new and emerging delivery models. A white paper published by

the National Committee for Quality Assurance observes, "Current network adequacy standards put a premium on the number of providers in a plan's network. They rarely address whether those in-network providers are high quality or offer expanded access."⁵¹ For example, regulators could review whether insurers are providing incentives for physicians to offer weekend and evening hours. They could assess whether providers' training, experience, and performance on quality metrics are driving insurers' decisions to include them in networks or whether network inclusion is mostly price-driven. They could ask whether providers in the network are reimbursed when they use information technology such as videoconferencing, email, live chat and electronic health records to communicate with and deliver care to patients. Reviewers could also examine whether the insurer is using reimbursement or cost-sharing incentives to encourage providers and patients to use the most appropriate care setting for the care being delivered.

While it may reduce consumers' premiums when insurers configure their networks to include low-cost hospitals and other providers and exclude the highest-cost, consumers pay a price when cost is the only factor taken into account. Insurers and other payers collect from providers a wide range of data on quality metrics and consumer experience. But current regulatory standards do not require them to take providers' performance on those metrics into account as they build or cull their networks.

Striking the Balance: Improve Transparency and Facilitate Better Consumer Choices

As federal and state officials assess their current network adequacy standards, they need to account for new mechanisms of care delivery and new ways in which consumers are comparing and shopping for health coverage. This also means recognizing the difference between provider access and provider choice. Consumers in all plans, no matter how narrow, deserve to be confident they'll have access to a provider network that can deliver the benefits promised under their policy. But that commitment doesn't require unrestricted choice of providers. Many consumers are willing to forgo an unrestricted choice of providers in exchange for a lower premium, so long as in-network providers deliver high-quality care that can meet their needs.

Reaching a Better Standard

First, to protect consumers from a potential race to the bottom, policy-makers should require all insurers, both inside and outside the marketplaces, to meet a minimum network adequacy standard that limits the amount of time and distance a policyholder must travel in order to access emergency, primary care, and high-volume specialty services. A similar quantitative time and distance standard should also be required for nonemergency specialty care, but regulators should have the flexibility to grant insurers waivers if they can demonstrate that hospitals and specialty providers within the requisite geographic area do not meet or are not willing to meet

the plan's requirements for price and quality. With such flexibility, providers who use telemedicine, meet plan expectations for quality performance, offer evening and weekend office hours, and serve as Centers of Excellence for specialized care could be considered as if they are within the time/distance limits. As they are currently, quantitative time and distance standards would still need to be calibrated within the state to local conditions. A model for this is the Medicare Advantage program, which has time/distance limits that vary based on five different types of geographic areas, ranging from dense urban areas to less populated rural and frontier areas.⁵² As noted above, quantitative network adequacy standards have drawbacks, but they currently offer the most effective way to hold insurers accountable to a common standard, build confidence that marketplace plans are high quality, and help ensure consumers receive needed care within a reasonable proximity to their home or place of work.⁵³ With greater transparency, better consumer information, and robust market oversight, over time these quantitative standards, given their many limitations, may prove to be unnecessary.

At a minimum, however, insurers who do not have an in-network hospital or clinician to perform a needed service, or do not have a provider with the appropriate training and expertise, should be required to provide coverage for that service out-of-network at no additional cost to the policyholder. Such a requirement helps ensure that consumers are held harmless if the care they need is only available out-of-network. This requirement, accompanied by advance disclosure, can also help consumers who might face balance billing when they receive care at an in-network facility from out-of-network physicians, such as anesthesiologists, radiologists and pathologists. New York's 2014 law holding patients harmless for surprise bills when at in-network facilities, while not yet implemented, could become a model for other states.⁵⁴

However, this option is not a replacement for maintaining an adequate network. Because it requires a case-by-case assessment, it places a burden on consumers both to be informed enough to seek out-of-network care with in-network cost-sharing and to have the time and energy to pursue it with their insurer. Unfortunately, some of these issues can only be resolved through an appeals or dispute resolution process, which can place considerable demands on patients' time and resources.

Improving Transparency

Second, all consumers need the ability to make an informed choice—an ability that is inadequate in the

individual insurance market today—both inside and outside the marketplaces. At a minimum, consumers need standardized information about the breadth and restrictiveness of plan networks, before they make a purchasing decision. The ACA requires plans sold on the marketplaces to include a provider directory and to denote when a listed provider is not accepting new patients.⁵⁵ However, provider directories are notoriously inaccurate and unreliable. Some provider directories offered on insurers' websites don't clearly display how the network configuration may change among different plans offered by the same insurer. At least one state-based marketplace has had to pull its own provider directory off its website because of errors.⁵⁶

Consumers, whether shopping for coverage on or off the marketplace, should be able to quickly assess what kind of network a plan has (i.e., broad or restrictive choice) and compare it easily to other plans in their price range. They should also be able to have confidence that the provider directory is accurate and up-to-date. Provider directories are a two-way street: insurers have an obligation to keep them current and avoid errors, but providers must also be held accountable for reporting when a provider leaves the network or is no longer taking new patients. To ensure consumers can make informed decisions, both in selecting a plan and then in using their coverage, insurers should be required to make monthly updates to their on-line provider directories. Consumers cannot be expected to make optimal plan and provider choices if they cannot get easy-to-understand, up-to-date and clear information about the type of plan network they are buying and the names, locations and types of participating providers. The state and federal marketplaces should offer consumers a special enrollment opportunity if they need to switch plans or carriers because they were given inadequate or incorrect network information when making their initial plan selection.

Consumers also benefit from standardized, consumer-friendly information about each health plan's performance on enrollees' ability to obtain needed care quickly and easily, such as through a star rating system and consumer satisfaction scores. However, in this first year of implementation, with many other technology challenges confronting them, the marketplaces did not provide that information to consumers in an actionable way.⁵⁷

Better Data Collection and Oversight

Lastly, state and federal regulators need to actively monitor plans inside and outside the marketplaces by collecting and analyzing data regarding policyholders'

use of out-of-network services, consumer satisfaction scores, complaints filed with the department of insurance or the marketplaces and internal or external appeals. As noted above, such oversight would be enhanced through “secret shopper” calls or spot-check audits to ensure that policyholders are able to access the provider they need in a timely fashion. Regulators should also require insurers to report mid-year changes to their network to departments of insurance and to enrollees. Plans that don’t deliver on promised benefits should be required to not hold

consumers financially accountable if they can only obtain needed care outside the network.

The above recommendations address some but not all of the challenges raised by narrow or restrictive provider networks. Because many of the ACA’s insurance market and delivery system reforms have only just been fully implemented, they will require continued monitoring and adaptation to improve the functioning of insurance markets and protect consumers’ access to affordable, high quality care.

Conclusion

There is no perfect approach to the oversight of health plan networks. In the absence of other government policies to constrain provider prices, insurers’ ability to exclude or threaten to exclude providers from the network is important to their ability to negotiate reimbursement rates and offer more affordable premiums to consumers. On the other hand, if insurers narrow their networks too much, consumers could be harmed if forced to go out-of-network or to a less-preferred provider tier to meet their needs. Policy-makers therefore need to strike a balance between consumer protection and insurer flexibility.

Our proposed approach sets minimum quantitative standards, with waivers for certain providers based on price and quality; improves transparency and consumer information to give consumers better tools to make informed choices; gives insurers the flexibility to develop more value-oriented network designs so long as they maintain a provider network that can meet people’s needs; and—to assure effective consumer protection—calls for continuous monitoring of consumers’ use of out-of-network services, complaints and appeals, and more active oversight of plan behavior.

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