

September 2017

A Better Approach to Regulating Provider Network Adequacy

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This report is available online at: <https://www.brookings.edu/research/a-better-approach-to-regulating-provider-network-adequacy>

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EDITOR’S NOTE

This white paper is part of the USC-Brookings Schaeffer Initiative for Health Policy, which is a partnership between the Center for Health Policy at Brookings and the USC Schaeffer Center for Health Policy & Economics. The Initiative aims to inform the national health care debate with rigorous, evidence-based analysis leading to practical recommendations using the collaborative strengths of USC and Brookings.

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The author(s) did not receive any financial support from any firm or person for this article or from any firm or person with a financial or political interest in this article. They are currently not an officer, director, or board member of any organization with an interest in this article.

ACKNOWLEDGEMENTS

This White Paper benefitted from thorough research assistance by Caitlin Brandt, and from thoughtful comments from these reviewers, who, naturally, do not necessarily endorse the positions taken here: Jolie H. Matthews, National Association of Insurance Commissioners, Justin Giovannelli, Georgetown University Center on Health Insurance Reforms, and Loren Adler and Matthew Fielder at The Brookings Institution.

EXECUTIVE SUMMARY

As health insurers become more price-competitive, they more often are selling health plans that cover fewer hospitals, and many fewer physicians, in an effort to provide greater consumer value. This narrowing of provider networks is an indication that recent reforms are making insurance markets more competitive, but narrowing networks also raise concern about consumer protection. State and federal regulators are revisiting network adequacy rules that have been in place for several decades, to assess whether they are well suited to modern conditions. The federal government currently defers to states to regulate provider networks, but no clearly-preferred model has yet emerged among states. Although there is a need for thoughtful regulation, there is also a risk of excessive regulation that increases consumer protection at the cost of much higher payment rates for providers and thus higher premiums for coverage.

Accordingly, this White Paper reviews approaches that regulators have taken in the past, and that advocates have proposed, with an aim of devising a regulatory approach to network adequacy that is effective but not constrictive. We conclude that neither general qualitative standards (“sufficient to avoid unreasonable delay”) nor quantitative standards (specified capacity, provider distribution, or wait times) are sufficient, either alone or in combination, to ensure the adequacy of provider networks without being unduly constraining. Qualitative standards are too general to be self-enforcing, and quantitative standards can be too complex or inflexible. Both kinds of standards are designed more for threshold entry into the market as a whole than for resolving patients’ rights in particular cases.

What is required to complement these substantive standards is a more layered regulatory approach that includes a suitable form of dispute resolution. The existing process of independent medical experts reviewing insurers’ medical necessity decisions should also be used to determine when patients need to go out of network to receive necessary medical care. Having a back-stop dispute process in place would resolve a good bit of the regulatory burden of ensuring at the outset that a given network can meet all likely medical needs. And, in turn, looser regulatory reigns would give health plans more flexibility to adapt to market conditions and to adopt promising innovations in care delivery.

I. Introduction and Background

The narrowing of provider networks is one of the most notable developments in health care markets over the past decade. Conventionally, health insurers contract with the majority of hospitals and physicians in a market, in order to best compete for the large employer groups that compose the bulk of the market. Large employers tend to require broad networks to satisfy the preferences of diverse work forces with a single or small number of insurance plans. Having formed broad networks to serve large employers, insurers typically also offer the same networks to individuals and small groups. Health maintenance organizations (HMOs) have been the exception to this rule, typically offering more selective networks, but, since the 1990s, HMOs' share of the market has steadily diminished, to now account for only 15 percent of group market enrollment.¹ Plus, in the last two decades, HMOs themselves have broadened their networks or made them less restrictive, in response to the managed care “backlash” in the late 1990s, and in order to better compete with broader-network Preferred Provider Organizations (PPOs).²

Under competitive pressure to lower health care costs, we are now seeing the rapid emergence of much narrower networks, both within and beyond the HMO sphere.³ Most notably, under the Affordable Care Act (ACA), health plans sold in the individual market are substantially narrower than insurers previously had offered,⁴ with many including fewer than a third of area physicians.⁵ Once such networks take shape for the individual market, they are also likely to be sold in the employer group market.⁶

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¹Kaiser/HRET, 2016 Employer Health Benefits Survey (Sept. 2016), <http://kff.org/report-section/ehbs-2016-section-five-market-shares-of-health-plans/>.

² California Public Employees' Retirement System, Health Maintenance Organization Broad and Narrow Networks (March 2015), <https://www.calpers.ca.gov/docs/board-agendas/201503/pension/item-9.pdf>.

³ This paper focuses on the private insurance market, but narrow networks also typify Medicaid managed care plans, and they have become much more significant in the Medicare Advantage market. Gretchen Jacobson, Ariel Trilling, & Tricia Neuman, Medicare Advantage Hospital Networks: How Much Do They Vary? (Kaiser Family Foundation, June 2016), <http://files.kff.org/attachment/Report-Medicare-Advantage-Hospital-Networks-How-Much-Do-They-Vary>. Principles developed here for the private market could also be applied to these public sector health plans.

⁴ See generally Michael A. Morrissey, et al., Five-State Study of ACA marketplace Competition (Brookings Institution, Feb. 2017), <https://www.brookings.edu/wp-content/uploads/2017/02/summary-report-final.pdf>.

⁵ Daniel Polsky, et al., Trends In Physician Networks in the Marketplace in 2016 (U. Penn., Dec. 2016), <http://ldi.upenn.edu/brief/trends-physician-networks-marketplace-2016>; Erica Coe, Jason Bello, & Jessica Lamb, Hospital Networks: Perspective from Three Years of Exchanges (McKinsey, April 2016), <http://healthcare.mckinsey.com/hospital-networks-perspective-three-years-exchanges>; Adita Sen, et al., Most Marketplace Plans Included at Least 25 Percent of Local-Area Physicians, Health Affairs 36(9): 1615-23 (2017).

⁶ Mark Hall & Paul Fronstin, Narrow Provider Networks for Employer Plans (Robert Wood Johnson Foundation & EBRI, Dec. 2016), <http://hcfo.org/files/hcfo/HCFOReportHall2016.pdf>.

Many analysts view this emergence of alternative networks as a positive market development.⁷ Prior to the ACA, insurers in the individual and small group markets competed to a large extent based on their ability to select or exclude people for health risk. By prohibiting this form of competition, the ACA forces insurers to compete more based on the underlying value their plans offer in health care delivery. Notably, many Republican proposals to replace the ACA would at least partially preserve this core feature of market reforms.

A key feature of these insurance market reforms is to implement a market structure long known as “managed competition,” in which individuals receive a fixed contribution to shop for their own coverage, rather than employers (or the government) choosing what insurance to purchase for them. Under the right set of market rules, health economists, such as Stanford’s Alain Enthoven,⁸ have long predicted that competition between insurers would more effectively drive competition among providers, producing better value both in health insurance and health care delivery.

The ability of insurers to form narrower networks is a key aspect of this improved market dynamic. A narrower network gives insurers greater leverage to negotiate lower payment rates or to select those providers it believes will deliver the best quality at an affordable price. Narrow networks go hand in hand with the emerging emphasis on “accountable care organizations (ACO)” and other structures in which providers coordinate their practices to deliver care more effectively and efficiently.

Although we are still a long way from achieving the full vision of managed competition, we see from the ACA’s reformed market that, when price-sensitive consumers select from more standardized health plan options, many prefer to purchase a lower-priced plan that offers fewer providers, rather than paying more for a conventional broad network.⁹ Reviewing consumer satisfaction with these choices, the Government Accountability Office summarized that “enrollees who obtained their coverage through the exchanges have...generally expressed satisfaction with their choice of providers, according to national surveys we reviewed.”¹⁰ Although some dissatisfaction is expressed, it is not a great deal more than the level of dissatisfaction with employer group plans.

Despite being a generally favorable development, substantially narrower provider networks present a variety of potential patient protection concerns. Most obviously, a narrow network may have insufficient capacity to serve the number of people who enroll, or the providers may be too geographically dispersed to be reasonably accessible. Even when that is not the case across the board, a network might have acute

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⁷ For example, David H. Howard, Adverse Effects of Prohibiting Narrow Provider Networks, *New Engl. J. Med.* 371:591-92 (2014); Simon Haeder, Narrow Networks and the Affordable Care Act, *JAMA* 314:669-670 (2015); Leemore Dafny, et al., Narrow Networks on the Health Insurance Marketplaces, *Health Affairs* 36(9): 1606-14 (2017).

⁸ Alain Enthoven, Consumer-Choice Health Plan, *New Engl. J. Med.* 298:650-8; 709-20 (1978).

⁹ Liz Hammel, et al., Kaiser Health Tracking Poll (Feb. 2014), <http://kff.org/health-reform/poll-finding/kaiser-health-tracking-poll-february-2014/>.

¹⁰ GAO, Most Enrollees Reported Satisfaction with Their Health Plans, Although Some Concerns Exist (Sept. 2016), <http://www.gao.gov/products/GAO-16-761>.

shortages in specific specialties.¹¹ Or, health plans might purposefully understaff certain specialties in order to avoid attracting people with expensive existing conditions, such as cancer or mental illness.¹²

The economic burden of receiving care out-of-network can be substantial, even crippling, for any patient, but especially so for lower-income patients.¹³ Some health plans do not cover out-of-network care at all, and these costs do not even count toward the plan's out-of-pocket maximums. When plans do have out-of-network coverage, patients still must pay considerably more out-of-pocket, and the cost-sharing reductions that the ACA provides lower-income patients are not available out-of-network.

There are good reasons to believe that normal market forces cannot, on their own, fully police network adequacy. The relevant information is difficult to assess, even when network directories are accurate and up to date (which they commonly are not).¹⁴ People often cannot anticipate their specific health care needs for an entire enrollment period, and thus they may not know what to look for when shopping among network options. Moreover, even if consumers know what range and types of providers to look for, health plans do not provide information about network capacity – that is, whether there are enough of each provider type for their overall enrollment (patient/provider ratios).

Better information might alleviate some of these problems, but there are limits to how much information ordinary health insurance consumers can process, and how well they can do so. Accordingly, there is essentially no disagreement among policymakers and stakeholders that some form of network adequacy regulation is needed. When HMOs first became commonplace, state regulation of network adequacy became commonplace as part of health plan licensure. In order to sell coverage, HMOs must establish that their provider networks are adequate in the geographic areas where they market. The Affordable Care Act also calls for oversight of network adequacy for health plans that sell through the “marketplace” exchanges. Federal regulators, however, have chosen to defer to existing state oversight for this purpose.¹⁵

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¹¹ For instance, in 2015, 14 percent of plans offered through the federally facilitated ACA exchange entirely lacked any physician from at least one of nine major specialties. Stephen C. Dorner, et al., Adequacy of Outpatient Specialty Care Access in Marketplace Plans under the Affordable Care Act, *JAMA* 314(16):1749–50 (2015).

¹² Mark Shepard, Hospital Network Competition and Adverse Selection (NBER, Sept. 2016), <http://www.nber.org/papers/w22600>; Caroline Pearson & Deirdre Parsons, Patient Access to Oncology Care in ACA Exchange Plans, *Am. J. Managed Care* 21(16):Sp551 (Dec. 2015), <http://www.ajmc.com/journals/evidence-based-oncology/2015/december-2015/patient-access-to-oncology-care-in-aca-exchange-plans>; Laura Yasaitis, Justin E. Bekelman Bekelman, & Daniel Polsky, Relation Between Narrow Networks and Providers of Cancer Care, *J. Clin. Onc.* 35 (2017). The ACA's risk adjustment program is meant to counteract insurers' incentive to skimp on care for high-cost patients, but that program is imperfect and thus some risk-avoidance incentive still remains. See Paul D. Jacobs, Michael L. Cohen, & Patricia Keenan, Risk Adjustment, Reinsurance Improved Financial Outcomes For Individual Market Insurers With The Highest Claims, *Health Aff.* 36(4):755-763 (2017); Jonathan P. Weiner, et al., Adjusting for Risk Selection in State Health Insurance Exchanges Will Be Critically Important and Feasible, But not Easy, *Health Aff.* 31(2):306-15 (2013).

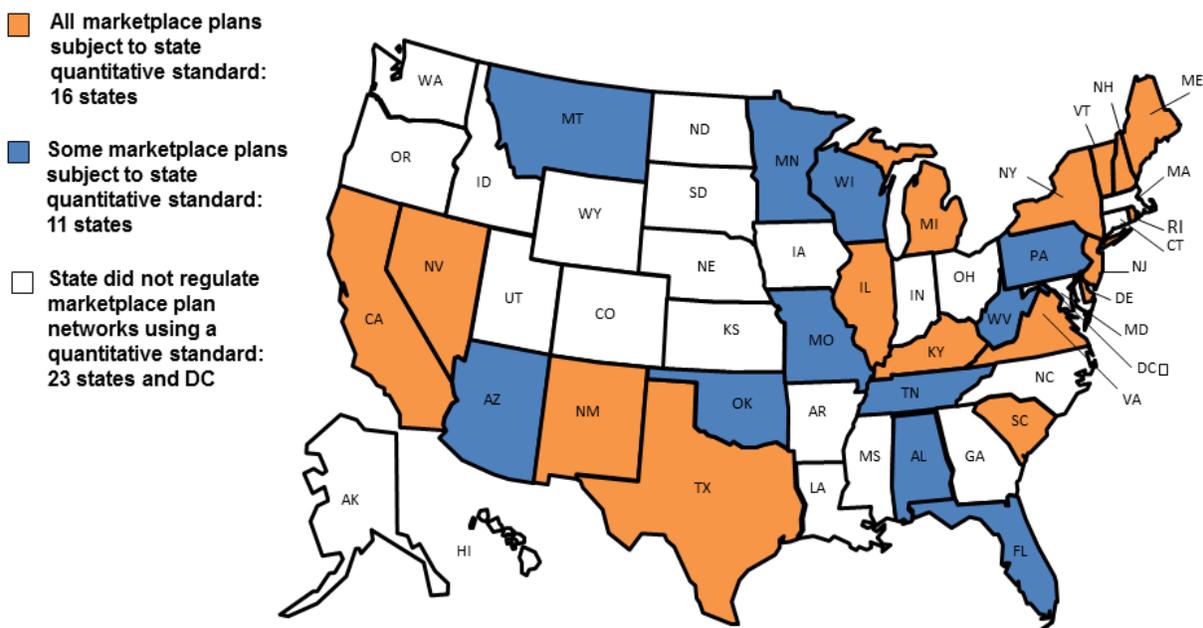
¹³ Mark A. Hall, et al., Solving Surprise Medical Bills (Brookings Institution, Oct. 2016), <https://www.brookings.edu/wp-content/uploads/2016/10/sbb1.pdf>.

¹⁴ Simon F. Haeder, David L. Weimer, & Dana B. Mukamel. Secret Shoppers Find Access To Providers And Network Accuracy Lacking For Those In Marketplace And Commercial Plans, *Health Aff.* 35(7): 1160-1166 (2016); Jay Hancock, Insurers' Flawed Directories Leave Patients Scrambling for In-Network Doctors, *NY Times*, Dec. 3, 2016.

¹⁵ 82 Fed. Reg. 10980 (Feb. 17, 2017) (proposed “market stabilization” rule). The Obama administration had moved toward using quantitative adequacy standards. Center for Consumer Information and Insurance Oversight (CCIIO), 2017 Letter to Issuers in the Federally-facilitated Marketplaces (Feb. 29, 2016), <https://www.cms.gov/ccio/resources/regulations-and-guidance/downloads/final->

Among state regulators, there is a shared sense that the first-generation regulation of managed care networks needs to be revisited. The original set of regulations is now a quarter century old, and both markets and medical practice have evolved considerably. As shown in Exhibit 1, many states have no quantitative standards to guide health plans and regulators in determining what is adequate; instead, they require only a general attestation of adequacy, coupled with a health plan’s articulation of how it chooses to determine adequacy. Also of importance, many states call for full oversight of provider networks only for HMOs, but not for other types of health plans that might have equally restrictive networks, such as “exclusive provider organizations” (EPOs), which are offered by health plans that are otherwise regulated as PPOs.¹⁶

Exhibit 1. States with Marketplace Plans Subject to One or More Quantitative Standards for Network Adequacy (January 2014)



Source: Justin Giovannelli, Kevin W. Lucia, and Sabrina Corlette, Implementing the Affordable Care Act: State Regulation of Marketplace Plan Provider Networks (Commonwealth Fund, May 2015).

... [2017-letter-to-issuers-2-29-16.pdf](#) . However, the Trump administration reverted to relying either on state oversight, private accreditation, or health plans’ attestation that they meet a general standard of “a network that is sufficient in number and types of providers ... to assure that all services will be accessible to enrollees without unreasonable delay.”

¹⁶ Sally McCarty & Max Farris, ACA Implications for State Network Adequacy Standards (Robert Wood Johnson Foundation, Aug. 2013), <http://www.statenetwork.org/wp-content/uploads/2014/02/State-Network-Georgetown-ACA-Implications-for-State-Network-Adequacy-Standards.pdf>; Health Management Associates, Ensuring Consumers’ Access to Care: Network Adequacy State Insurance Survey Findings and Recommendations for Regulatory Reforms (Nov. 2014), http://www.naic.org/documents/committees_conliaison_network_adequacy_report.pdf.

Finally, PPOs themselves have evolved from conventionally broad structures to more tiered structures that divide networks according to which providers the health plan determines offer the best value, similar to the structure of tiered pharmacy benefits. Although subscribers are still able to see any provider in the network they want, a tiered PPO requires them to pay higher copayments or deductibles for providers that are less preferred, but in most states there is no assurance that the most favorable tier has a full panoply of providers.

The challenges that these various market innovations pose for the conventional regulatory regime call for a thorough rethinking of how best to oversee network adequacy. In 2015, the National Association of Insurance Commissioners (NAIC) undertook that effort, producing a new “Health Benefit Plan Network Access and Adequacy Model Act”¹⁷ that covers all types of health plans (such as EPOs and tiered PPOs, in addition to HMOs). However, most states have not yet updated their network adequacy laws.¹⁸

Prompt regulatory updating is hampered by the fact that the new NAIC model leaves unresolved the core issue of what exactly constitutes adequacy. The Act requires networks that are “sufficient in numbers and appropriate types of providers ... to assure that all covered services ... will be accessible without unreasonable travel or delay,” but the Act does not specify how to determine what is “sufficient” or “unreasonable.” Instead, the Act provides a long list of factors that regulators “may” consider, along with “any [other] reasonable criteria” regulators might like to consider. Included on this non-binding list are: ratios of providers to patients, geographic accessibility (proximity) of providers, and wait times for appointments. However, no actual metrics are provided for these quantitative benchmarks. Instead, a drafting note observes, unhelpfully, that “specific quantitative standards” of some sort “could be incorporated into a law ... [or] regulations.”¹⁹

Another reason that many lawmakers have hesitated to update their network adequacy rules is concern about over-regulating. The managed care “backlash” in the mid-1990s produced a set of state regulations that, in the view of many observers, weakened market-based efforts to contain health care costs, ushering in an inflationary period that lasted a decade or more.²⁰ Although many of these regulations are now seen as necessary consumer protections, some were viewed as protecting providers’ interests more than patients’ interests.²¹ A prime example of first-generation state laws that are widely criticized are the so-called “any-willing provider” laws that prohibit insurers from excluding providers that were willing to accept

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¹⁷ National Association of Insurance Commissioners, Network Adequacy (NAIC, July 2016), http://www.naic.org/cipr_topics/topic_network_adequacy.htm.

¹⁸ Justin Giovannelli and Ashley Williams, Regulation of Narrow Networks: With Federal Protections in Jeopardy, State Approaches Take on Added Significance (Commonwealth Fund, Feb. 2017), <http://www.commonwealthfund.org/publications/blog/2017/feb/regulation-of-narrow-networks>

¹⁹ NAIC, Network Adequacy.

²⁰ Maxim L. Pinkovskiy, The Impact of the Political Response to the Managed Care Backlash on Health Care Spending: Evidence from State Regulations of Managed Care (Federal Reserve, April 2014), https://www.newyorkfed.org/medialibrary/media/research/economists/pinkovskiy/Impact_of_Political_Backlash_on_Health_Care_Costs.pdf.

²¹ Mark A. Hall, Managed Care Patient Protection or Provider Protection? A Qualitative Assessment, *Am. J. Med.* 117:932-7 (2004).

insurers' payment terms.²² These laws make it difficult for insurers to funnel a greater volume of patients to a smaller set of select providers as a way to negotiate the best prices.²³ They also can interfere with insurers' ability to select or reward providers with better value performance measures, such as those who more effectively manage patients' chronic conditions.

Current lawmakers are understandably cautious about adopting more stringent network adequacy rules that might repeat perceived mistakes from the past, or otherwise squelch beneficial marketplace developments. Indeed, we are seeing some renewed calls for adoption of any-willing provider laws or regulations.²⁴ While it may be relatively obvious that any-willing-provider laws should be viewed cautiously, and network adequacy oversight of some sort is essential, it is not at all obvious what forms of this oversight might have a similarly inhibiting market effect. Regulators would not want to disarm insurers from the most powerful tool they have to address increasing provider leverage. For instance, a strict quantitative standard in a thinly populated area could give the few existing providers extraordinary bargaining power if an insurer has no choice but to include them in order to be certified to sell in that area. The same might be true in a more populous area if most of the key providers have integrated into a single system that negotiates as a unit. On the other hand, allowing insurers to omit entire areas of medical practice could sacrifice essential consumer protection.²⁵ But, it is not at all clear how to avoid regulations that are too strict or too lenient.

In sum, there is broad agreement that network adequacy oversight should be improved, but no consensus yet on how best to do so, both because of the complexity of regulatory options and the high cost of going too far. This White Paper aims to advance understanding of the underlying issues so that state and federal lawmakers can take more effective action. The Paper reviews competing proposals for how regulators should oversee network adequacy. It then develops a "layered" approach to regulation (summarized at the end) that provides key consumer safeguards without unduly hampering potentially beneficial market developments.

II. Regulatory Dilemmas

Broadly speaking, there are two approaches to regulating network adequacy: qualitative standards and quantitative standards. The qualitative approach, which has predominated previously, articulates a broad,

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²² Ashley Nobel, Health Insurers and Access to Health Care Providers: Any Willing Providers (National Conference of State Legislatures, Nov. 2014), <http://www.ncsl.org/research/health/any-willing-or-authorized-providers.aspx>; Martin Gaynor, Farzad Mostashari, & Paul B. Ginsburg, Making Health Care Markets Work (Brookings Institution, March 2017), <https://www.brookings.edu/research/making-health-care-markets-work-competition-policy-for-health-care/>.

²³ Soheil Ghili, Network Formation and Bargaining in Vertical Markets: The Case of Narrow Networks in Health Insurance (Oct. 2016) (estimating that "tighter" regulations, "which force insurers to include more than 85% of the hospital-systems in the market, raise the average reimbursement rates paid by some insurers by at least 28%").

²⁴ Sabrina Corlette, et al., Narrow Provider Networks in New Health Plans: Balancing Affordability with Access to Quality Care (May 2014), <http://www.urban.org/sites/default/files/publication/22601/413135-Narrow-Provider-Networks-in-New-Health-Plans.PDF>; Jay Hancock, Narrow Networks Trigger Push-Back from State Officials, Kaiser Health News, Nov. 25, 2013, <http://khn.org/news/states-balk-at-narrow-networks/>.

²⁵ Stephen C. Dorner, et al., Adequacy of Outpatient Specialty Care Access in Marketplace Plans under the Affordable Care Act.

general standard of adequacy, such as “sufficient in number and type of providers ... to assure that all services will be accessible without unreasonable delay.”²⁶ This approach then leaves it either to the discretion of regulators or insurers to determine how to measure compliance. The most common approach that state regulators use is to require insurers simply to articulate how they go about determining and measuring adequacy for their networks.²⁷ Once regulators approve an insurer’s network adequacy plan, typically they then leave it to insurers to self-monitor their own compliance. Rather than conducting routine audits or requiring periodic reports of actual compliance, state regulators usually rely on consumer complaints to highlight situations that might require investigation.²⁸ This more passive or reactive regulatory approach is not at all universal; many states are more prescriptive and proactive. However, self-certification under a general qualitative standard is the approach still used by almost half the states in the private insurance market.²⁹

When provider networks were typically much broader, this more laissez faire approach may have sufficed. But, now that many networks have become much narrower, consumer advocates stress that the conventional regulatory approach is insufficient to ensure adequate provider access. Another potential concern about purely qualitative standards is that, as regulators oversee adequacy more actively, vague standards could give providers with social or political power more opportunity to press for unnecessarily broad inclusion rulings.³⁰ Some observers, for instance, point to vocal complaints by prominent hospitals, especially children’s hospitals, about being omitted from narrow networks in the ACA exchanges as evidence of this potential for pressuring regulators to intervene in market dynamics.³¹

The opposite of an exceedingly general adequacy standard is a precise quantitative standard that can be monitored actively and applied objectively. The federal government uses quantitative adequacy standards for Medicare Advantage plans, as do most states that have Medicaid managed care plans. As shown in Exhibit 2,³² there are three basic types of quantitative measures: 1) minimum **ratios** of providers to enrolled

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²⁶ 45 CFR 156.230.

²⁷ Health Management Associates, Ensuring Consumers’ Access to Care: Network Adequacy State Insurance Survey Findings and Recommendations for Regulatory Reforms.. Similarly, the industry’s leading accreditation organization, National Committee for Quality Assurance (NCQA) requires only that health plans “have standards to ensure access to medical care,” and “measure [their] performance and make improvements when needed.”
http://www.ncqa.org/Portals/0/Programs/Accreditation/HPA/2016_HPA_SGs.pdf?ver=2017-01-21-153134-880

²⁸ Health Management Associates, Nov. 2014.

²⁹ Justin Giovannelli, Kevin W. Lucia, and Sabrina Corlette, Implementing the Affordable Care Act: State Regulation of Marketplace Plan Provider Networks (Commonwealth Fund, May 2015), <http://www.commonwealthfund.org/publications/issue-briefs/2015/may/state-regulation-of-marketplace-plan-provider-networks>; Regulation of Health Plan Provider Networks (Health Affairs July 2016), http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=160 .

³⁰ David H. Howard, Adverse Effects of Prohibiting Narrow Provider Networks.

³¹ Deborah Farringer, Everything Old is New Again: Will Narrow Networks Succeed Where HMOs Failed?, *Quinnipiac L. Rev.* 34:299-345 (2016), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2779760 .

³² See also Sally McCarty & Max Farris, ACA Implications for State Network Adequacy Standards (Robert Wood Johnson Foundation, Aug. 2013), <http://www.statenetnetwork.org/wp-content/uploads/2014/02/State-Network-Georgetown-ACA-Implications-for-State-Network-Adequacy-Standards.pdf> .

population; 2) minimum **time or distance** for enrollees to travel to providers; and 3) maximum **wait times** to secure an appointment.

Exhibit 2. State Quantitative Standards for Network Adequacy Applicable to at Least Some Marketplace Plans, January 2014

Network standard	States
Maximum travel time or distance	23 states: AL*, AZ*, CA, DE, FL*, IL, KY, MI, MN*, MO*, MT*, NV, NH, NJ, NM, NY, OK*, PA*, SC, TN*, TX, VT, WV*
Provider-to-enrollee ratios	10 states: CA, DE, IL, ME, MT*, NV, NM, NY, SC, WV*
Maximum appointment wait time	11 states: AZ*, CA*, DE, FL*, MO*, MT*, NH, NJ, NM, TX, VT

*Standard applies only to specific types of network plans.

Source: Justin Giovannelli, Kevin W. Lucia, and Sabrina Corlette, Implementing the Affordable Care Act: State Regulation of Marketplace Plan Provider Networks (Commonwealth Fund, May 2015).

For instance, a state might say (as California does), that networks must have at least one physician for every 1,200 patients, or, (as New Mexico does) that at least two primary care physicians be within 20 miles or 20 minute drive time of 90 percent of enrollees in populous areas. Or, a state might rule (as Arizona does for Medicaid) that, regardless of the number of providers available, for non-urgent care a patient must be able to secure a primary care appointment within three weeks, or a specialist appointment within 45 days.

Using precise regulatory standards obviously has several key advantages. Consumers, health plans and regulators all know exactly what is required. And, having precise measures allows more objective monitoring. A quantitative approach, however, faces a number of difficulties, on account of which most states with quantitative metrics still also employ qualitative standards.

First, regulators must decide which of these several different types of quantitative standards to use. Each type measures something distinctly different: Provider-population ratios determine how many providers are theoretically available in a services area. Distance or drive-time measures determine how easily providers are reached. And, maximum wait times determine how much actual capacity network providers have to see enrolled patients. In theory, regulators could use some or all of these measures in combination – for instance, requiring that timely appointments be available within a specified driving time, or that the network contain the requisite number of providers within a minimum distance of where most subscribers live or work. More typically, however, regulators employ just one or two of these measures but not the other(s).³³

Also, when more than one measure is used, each measure is usually used separately rather than in combination, which leaves potential gaps. For instance, Medicare Advantage requires that, for most metro areas, at least one primary care physician be within 20 minutes and 10 miles of at least 90 percent of

³³ Ellen Weber, Fifty-State Survey: Network Adequacy Quantitative Standards (Univ. of Maryland, Aug. 2016), <http://insurance.maryland.gov/Consumer/Documents/agencyhearings/UMD-LawSchool-DrugPolicyClinic-NetAdqSurvey10182016.pdf>; Justin Giovannelli, Kevin W. Lucia, and Sabrina Corlette, Implementing the Affordable Care Act: State Regulation of Marketplace Plan Provider Networks.

enrolled patients, and that Medicare Advantage plans have 1.67 primary care physicians for every 1,000 members.³⁴ However, Medicare does not measure whether the minimum number of physicians is within the required distance of the population served. Instead, a provider counts toward the health plan's minimum if it is within the defined driving radius to even just one person in the service area.

Similarly, wait time maximums appear to apply to the network or service area as a whole rather than to the unique set of providers that are within a given distance of each subscriber.³⁵ Thus, in an otherwise adequate network, patients still could face lengthy delays in receiving treatment nearby if only providers at a distance have sufficient capacity.

One barrier to using multiple quantitative measures is complexity. Geo-mapping programs now make it feasible to determine how close (either by time or distance) subscribers are to providers, but networks contain many different types of providers (primary care, specialists, and various types of facilities), and so subscribers can be close to some but not others – especially over a broad geographic market area. Wait times for appointments can also be complicated to measure. They vary throughout the year, according to fluctuation in patient demand (e.g., flu season), and there are no ready means to measure them other than simply calling to ask.

Another difficulty presented by quantitative standards is determining what is the appropriate standard. There is not a clear evidence-based consensus on what provider-population ratios, drive times, or wait times are minimally adequate. Federal standards for Medicare Advantage plans, summarized in Exhibit 3, are frequently mentioned as a widely applicable set of standards, but those standards are based on the care needs of elderly and disabled patients, who require more service on average. For broader populations, we might look instead to standards for Medicaid managed care plans, but these vary widely across states, indicating lack of easy consensus. For instance, maximum distance to providers in urban areas ranges under Medicaid from 5 to 30 miles for primary care, and from 15 to 100 miles for specialists.³⁶ Similarly, states that have quantitative standards for private insurance also vary widely in their precise details.³⁷

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³⁴ CMS, Medicare Advantage Network Adequacy Criteria Guidance (Jan. 2017), https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/Downloads/MA_Network_Adequacy_Criteria_Guidance_Document_1-10-17.pdf.

³⁵ We hedge with “appear to” because state rules on appointment times do not clarify what radius of providers they apply to, and we were unable to determine how they are interpreted or enforced in practice.

³⁶ DHHS Office of Inspector General, State Standards for Access to Care in Medicaid Managed Care (Sept. 2014), <https://oig.hhs.gov/oei/reports/oei-02-11-00320.asp>

³⁷ Health Management Associates, Making Affordable Care Act Coverage a Reality: A National Examination of Provider Network Monitoring Practices by States and Health Plans (Oct. 2015), <https://www.healthmanagement.com/wp-content/uploads/HMA-Final-Report-RWJF-Project-Provider-Network-Monitoring-Compliance-Survey-Oct-2015.pdf>; Ellen Weber, Fifty-State Survey: Network Adequacy Quantitative Standards (Univ. of Maryland, Aug. 2016), <http://insurance.maryland.gov/Consumer/Documents/agencyhearings/UMD-LawSchool-DrugPolicyClinic-NetAdqSurvey10182016.pdf>; Leonard Davis Institute of Health Economics, Network Adequacy and Travel Standards Dataset (Robert Wood Johnson Foundation, April 2015), <http://www.rwjf.org/en/library/research/2015/01/network-adequacy-and-travel-standards-dataset.html>.

Exhibit 3. Maximum Time and Distance Requirements for Providers, Medicare Advantage

Provider Specialty	Metro		Micro		Rural	
	Time (min)	Distance (miles)	Time (min)	Distance (miles)	Time (min)	Distance (miles)
Primary Care	15	10	30	20	40	30
Cardiology	30	20	50	35	75	60
Pulmonology	45	30	60	45	75	60
Neurosurgery	60	40	100	75	110	90

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Source: CMS, HSD Reference File (Jan. 2017), <https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/index.html>.

There are good reasons for considerable variation. Quantitative standards need to reflect widely different demographic and geographic realities. In sparse, frontier areas, there are far fewer providers to go around,³⁸ and residents are well accustomed to travel much further for many basic needs. Providers can be much more concentrated in urban areas, but these too can have “medical deserts.” And, those who rely on public transportation face barriers not common to typical suburbanites. Reflecting this diversity, the time/distance standards under Medicare Advantage vary from 5 to 60 miles, and from 10 to 70 minutes, between dense center cities and frontier areas – with additional, intermediate standards for suburban, small, and rural counties.³⁹

Although standard setters could, conceivably, take these various factors into consideration, doing so in great detail runs the risk of ossifying delivery structures in conventional patterns that could make useful innovation more difficult.⁴⁰ For instance, developments in telemedicine could make proximity measures obsolete, or counterproductive, in some clinical areas.⁴¹ Also, both patients and insurers might benefit from using regional or national “centers of excellence” for complex, high-cost courses of treatment. For example,

...
³⁸ Aaron Wesolowsk, Matthew Green, & Lily McCutchan, Assessing the State of Provider Networks in Federally-Facilitated Marketplaces (NORC, Sept. 2016), http://www.norc.org/PDFs/IB_NORCFormat_8%2030%2016.pdf; AHIP, Impact of Physician Workforce Supply on Health Care Network Adequacy (Jul 2016), https://www.ahip.org/wp-content/uploads/2016/07/Workforce_DataBrief_7.14.16.pdf

³⁹ CMS, HSD Reference File (Jan. 2017), <https://www.cms.gov/medicare/medicare-advantage/medicareadvantageapps/index.html>.

⁴⁰ KPMG, Are Adequate Networks Adequate Enough? (2016), <http://www.kpmg-institutes.com/content/dam/kpmg/healthcarelifesciencesinstitute/pdf/2016/network-adequacy.pdf>; NCQA, Network Adequacy & Exchanges: How Delivery System Reform and Technology May Change How We Evaluate Health Plan Provider Networks (2013), https://www.ncqa.org/Portals/0/Public%20Policy/Exchanges&NetworkAdequacy_2.11.13.pdf

⁴¹ Sandy Ahn, Sabrina Corlette, & Kevin Lucia. Can Telemedicine Help Address Concerns with Network Adequacy? Opportunities and Challenges in Six States (April 2016), <http://www.urban.org/sites/default/files/publication/79551/2000736-Can-Telemedicine-Help-Address-Concerns-with-Network-Adequacy-Opportunities-and-Challenges-in-Six-States.pdf>.

some specialized surgeries such as organ transplants are done most effectively and economically by specialized, high-volume providers with a track record of superior performance on both quality and cost. And, integrated provider systems operating as “accountable care organizations” might want to directly enter the insurance market without having to contract with unaffiliated competitors.⁴² Quantitative standards need to be set in a manner that leaves room for these and other potentially valuable innovations.

Also, quantitative standards should be sensitive to the type of market structure in which they operate. In competitive insurance markets where consumers have the motivation and means to choose between broad and narrow networks, regulators have good reason to specify only minimally acceptable adequacy standards, leaving it to market forces to determine what levels above the minimum might be broadly acceptable or optimal. However, under Medicaid, many patients have little or no choice about which managed care plan covers them, or, if they have choice, they suffer from vulnerabilities that impair consumer engagement. Where market forces are less active, regulatory protections, with good reason, tend to be stronger.⁴³ Standards might also be greater when government is selecting which among various licensed health plans to contract with for a particular program. For instance, a state might be more demanding of insurers that it includes in an “active-purchaser” exchange than it is when merely determining whether to bar an insurer from any part of the market. These additional reasons for variation further contribute to difficulty in reaching consensus in choosing governing standards.

Recognizing that network adequacy is measured in different market segments by different regulators highlights yet another difficulty with some quantitative standards. Two of the commonly-used metrics -- population ratios and travel time/distance -- measure only whether providers are theoretically available in sufficient number or proximity for a particular enrolled population. However, the same network likely serves multiple different products that the insurer sells under different programs. For instance, a network certified to serve individual (nongroup) subscribers will usually also serve fully insured groups and self-insured employers. The same network might also serve Medicare and Medicaid patients. Each of these different market segments is governed by a separate regulatory review.⁴⁴ Even if an insurer meets each program’s standard separately, there is no system in place to determine whether a particular network (or an overlapping set of networks) simultaneously satisfies adequacy for all of the products combined.⁴⁵

Measures for appointment wait times avoid this problem by assessing actual capacity more directly. But wait times inherently fluctuate and so they are better suited for ongoing monitoring and problem-spotting, as discussed below, rather than for initial or recurrent licensing.

Even more mind-boggling dilemmas arise when considering how standards should vary for different types of providers. For physicians, standards sometimes differentiate between primary care and specialists, as

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⁴² David H. Howard, Adverse Effects of Prohibiting Narrow Provider Networks.

⁴³ Health Management Associates, Making Affordable Care Act Coverage a Reality: A National Examination of Provider Network Monitoring Practices by States and Health Plans.

⁴⁴ Self-funded employer plans are governed by the Department of Labor (DOL), which has only very limited network adequacy rules. See DOL, FAQs About Affordable Care Act Implementation (April 2015), <https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-31.pdf>

⁴⁵ Health Management Associates, Making Affordable Care Act Coverage a Reality: A National Examination of Provider Network Monitoring Practices by States and Health Plans; Jane B. Wishner and Jeremy Marks, Ensuring Compliance with Network Adequacy Standards: Lessons from Four States (March 2017), http://www.urban.org/sites/default/files/publication/88946/2001184-ensuring-compliance-with-network-adequacy-standards-lessons-from-four-states_0.pdf.

broad groups. But within each broad group, there are many different areas of practice. Primary care includes pediatrics, internal medicine, gynecology, and geriatrics. It would seem that, for population ratios, separate standards would be desirable for each of these, and, of course, likewise for any of a large number of common specialists (cardiology, dermatology, ophthalmology, orthopedics, rheumatology, radiology, urology, oncology, neurology, surgery, etc., etc., etc.). Medicare Advantage, for instance, has time/distance and population ratio standards for each of about 50 types of facilities and specialists.⁴⁶

Finally, specialties include subspecialists. Not all surgeons are general surgeons, and many types of surgery are best done by surgical sub-specialists, such as cardiac surgeons, or sub-sub-specialists, such as pediatric cardiac surgeons. The same is true for many other specialties. A comprehensive ophthalmologist might well handle the majority of the eye problems that typically arise in a general population, but retina detachment is usually handled by retina subspecialists who are more practiced in the delicate surgery required to avoid blindness, and some retina surgeons may specialize in particular types of patients (e.g., children) or conditions (e.g., diabetic-related). Countless other examples could be posed. Clearly, there is a limit to how thoroughly regulatory standards can specify minimum provider access standards throughout the range of medicine.

Naturally, no regulatory scheme is perfect, and so we certainly should not let the elusiveness of perfection hamper the search for improvement. Nevertheless, well-designed regulation of network adequacy is not easy to achieve. Because no single regulatory approach is likely to be sufficient, we need to think more in terms of a layered approach – one that thoughtfully melds together different dimensions and techniques of oversight.

III. A Layered Approach

In this section, we step back and consider what a fully-constructed, multi-layered approach to network adequacy might consist of. For guidance, we look to the seminal health policy work of Avedis Donabedian, a physician who launched the field of quality measurement. In his classic schema, Donabedian sees quality oversight consisting of three distinct elements: structure, process, and outcomes.⁴⁷ In our context, quantitative measures of network size, composition and distribution aim at structure – the resources available to provide good access. A qualitative standard used to evaluate access is a process measure, aimed at requiring insurers to develop, and regulators to review, access plans. What is missing so far is a measure aimed more at actual network outcomes – do patients actually receive adequate access,⁴⁸ and do they have effective remedies in situations where network adequacy falls short? Also needed is more

⁴⁶ CMS, HSD Reference File (Jan. 2017), <https://www.cms.gov/medicare/medicare-advantage/medicareadvantageapps/index.html>.

⁴⁷ Avedis Donabedian, Evaluating the Quality of Medical Care, *Milbank Quarterly*, 83(4): 691–729 (2005, reprinted from 1966 reprint), <https://www.milbank.org/quarterly/articles/evaluating-quality-medical-care/>.

⁴⁸ The literature on access measures makes this same distinction in terms of “potential” versus “realized” access. R. Andersen, L.A. Aday, Access to Medical Care in the U.S.: Realized and Potential, *Med. Care* 16(7):533-46 (1978).

thoughtful analysis of how these three dimensions of structural, process-based, and outcomes-based oversight can work together cohesively.

We have seen that, even though there is good reason to seek greater quantification of adequacy standards than has previously existed in many states, those standards should be crafted to work well as just one part of a multidimensional oversight system. Accordingly, some additional form of safeguard is needed for the areas not specified. And, if that safeguard is sufficient to cover regulatory gaps, we can then reconsider how best to devise quantitative measures for the primary landscape of medical services. Viewed in this layered fashion, we come to see that, rather than quantitative standards having to bear the primary weight of consumer protection on their own, they should be complemented by an effective process that protects patients in the inevitable event that network adequacy falls short.

A. Process Protections

A well-constructed process to protect patients when network resources are inadequate in specific cases could serve as a regulatory backstop that eases, or possibly even eliminates, a good bit of the burden of preventing any problems from ever arising at the outset. We envision a two-component procedural system. The primary part uses existing external review by independent medical experts to determine when patients should be allowed to go out of network to meet their medical needs. The second part addresses the financial implications of doing so.

One obvious remedy for patients who do not have timely access to services they need is to require insurers to pay or reimburse the cost of seeking care out of network. This is required by the NAIC's Model Act,⁴⁹ and by many (but not all) states.⁵⁰ Whatever standard might govern network adequacy, if a health plan violates it, patients should be held financially harmless for needing to seek care elsewhere (subject to qualifications noted below). Avoiding this financial liability is a good incentive for insurers to maintain adequate access, and enforcing this obligation could safeguard patients when insurers fail to do so.

For this approach to work, a viable procedure is needed for patients to assert a claim for out-of-network access in a manner that can be resolved fairly and expeditiously. One such process -- external review by independent medical experts -- has already been devised for resolving insurance disputes over whether treatment is "medically necessary." This external review process can also be well suited to resolving whether network resources are adequate to meet a patient's medical needs.

Undoubtedly some improvements could be made to the existing external review process,⁵¹ but on the whole the existing approach to resolving "medical necessity" has been demonstrated to function reasonably well

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⁴⁹ The Act states that insurers "shall have a process to assure ... [access] to a covered benefit at an in-network level of ... cost-sharing, from a non-participating provider, ... [when the insurer] has an insufficient number or type of participating provider available to provide the covered benefit ... without unreasonable travel or delay."

⁵⁰ For instance, California Code of Managed Health Care Regulations, 1300.67.2.2 (c)(6); Minnesota Code of Insurance Regulations, 20:400-7.095(3)(C)1.C.

⁵¹ Principally, it appears unnecessarily burdensome to require patients, as some states do, to pursue *two* rounds of *internal* review with the insurer before seeking external review. Also, analysts recommend publishing the results of external review so that others know which kinds of appeals are likely or not likely to succeed. See Katherine Vukadin, *Hope or Hype?: Why the Affordable Care Act's New External Review Rules for Denied ERISA Healthcare Claims Need More Reform*, Buffalo L. Rev. 60:1201-53 (2012).

as fair and efficient consumer protection. As summarized by one group of scholars, “[s]tates have attempted to strike a balance between consumer-friendly, simple processes and procedures ensuring sound decision-making.”⁵² Seeking external review of health insurers’ coverage denials is inexpensive, and patients often receive assistance from ombudsmen. Review is conducted promptly, and under expedited schedules for urgent care. Reviewers are physicians with relevant clinical expertise who are independent from the insurer. Roughly half the time, they have ruled in the patient’s favor.⁵³

About half the states have these external review systems in place. For those that do not, there is a federally-contracted review mechanism. And, federal law applies this review system to self-insured employers as well as to regulated insurers.⁵⁴ A few states explicitly make their external physician review systems available for determining when patients should be allowed to seek care out of network due to inadequate network coverage.⁵⁵ Similarly, current regulations that implement the federal review system specify that it is available for patients who seek out-of-network access because they believe their treatment “cannot be effectively provided in network.”⁵⁶

This external review should be focused on whether the particular patient’s medical needs are being met, rather than on whether the health plan is in technical compliance with regulatory requirements. Even with quantitative standards in place, the ultimate question is whether available network resources are adequate for a patient’s particular needs. An insurer that meets quantitative standards is not absolved from this obligation. Nor should it be the case that, simply because a patient must travel somewhat further than normal, or wait longer than normal, the patient automatically has a right to go out of network. Quantitative regulatory standards apply to networks as a whole and not necessarily to each patient’s specific case. Thus, for instance, travel distance standards usually are met even if up to 10 percent of patients are outside the prescribed limits. And, wait time standards do not specify the distance that patients must look in order to secure an appointment. These quantitative standards, discussed more above, are designed for threshold entry into the market or for ongoing monitoring of network performance. They are not meant, necessarily,

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⁵² John Jacobi, et al., Health Insurer Market Behavior After the Affordable Care Act: Assessing the Need for Monitoring, Targeted Enforcement, and Regulatory Reform, Penn. State L. Rev. 120:109-179 (2015), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2802876.

⁵³ GAO, Data on Application and Coverage Denials (March 2011), <http://www.gao.gov/new.items/d11268.pdf>. However, more recent data from a small sample (10) of larger “qualified health plans” under the ACA indicate that external reviewers rule in favor of patients only one quarter of the time. CMS, Health Insurance Marketplace Public Use Files, Transparency in Coverage PUF, <http://download.cms.gov/marketplace-puf/2017/transparency-in-coverage-puf.zip>.

⁵⁴ This federal review system was created by the Affordable Care Act. Leading Republican proposals for ACA replacement to not eliminate this aspect of the ACA.

⁵⁵ Karen Pollitz, et al., Assessing State External Review Programs (Kaiser Family Foundation, March 2002), <https://georgetown.app.box.com/s/1bk4e4owpwjy48vu88xgnvwheuc88fty>; David Studdert & Carole Gresenz, Enrollee Appeals of Preservice Coverage Denials at 2 Health Maintenance Organizations, JAMA 289:864-870 (2003); Patient Advocate Foundation, A Patient’s Guide to Navigating the Insurance Appeals Process, <http://www.patientadvocate.org/requests/publications/Guide-Appeals-Process.pdf>. See, for instance, NY Dept. of Financial Services, Out-of-Network Law (OON) Guidance, http://www.dfs.ny.gov/insurance/health/OON_guidance.htm; New York State External Appeal, <http://www.dfs.ny.gov/insurance/extapp/extappqa.htm>; Washington State Office of Insurance Commissioner, How to Appeal a Health Care Insurance Decision: A Guide For Consumers (Jan. 2016), <https://www.insurance.wa.gov/your-insurance/health-insurance/appeal/documents/appeals-guide.pdf>.

⁵⁶ 45 CFR 147.136(d).

to resolve specific cases. Nevertheless, these standards can be useful guides for internal and external review of whether a general adequacy standard is met for a particular patient.

One difficulty in making external review routinely available for network inadequacy is needing a clear triggering event to seek review. For coverage denials, the insurer's refusal to authorize payment gives patients notice of their right to seek review, and starts the clock running for doing so. For network access, the need arises simply from a patient's inability to secure an adequate, timely appointment or referral. Unless a patient or provider seeks, and is denied, prior authorization, there is no crystallized decision point.⁵⁷ Therefore, extra efforts would be needed to inform subscribers, and their primary care physicians, about the opportunity to seek expedited permission for out-of-network care when network resources are inadequate, and to further seek expedited external review if the insurer initially denies permission.

Patients and referring physicians should be notified not only of the opportunity to seek relief from network inadequacy, but also of the *obligation* to do so while it is still possible for insurers to address the issue. If patients go out of network without first notifying their insurer, the insurer has a legitimate concern that it was not given an opportunity to locate network resources the patient or referring physician may not be aware of, or to make more affordable arrangements out-of-network, if needed.

Patients who face inadequate networks do not necessarily have the right to insist on any particular provider out of network, but only to have some provider who reasonably meets the patient's medical needs, without the patient incurring any extra financial cost. Insurers might provide this access through "spot contracts," that is, specially-arranged agreements with select providers who otherwise are outside the network to accept a limited number of patient referrals as needed for a negotiated price.⁵⁸ Insurers could maintain standing agreements of this sort, or could negotiate them as the need arises.

If patients facing inadequate access fail to petition the insurer first before seeking care out-of-network, they should not automatically lose their procedural and substantive protection. Some conditions, such as retina detachment, require immediate attention from subspecialists to avoid serious permanent injury. Thus, if it is determined on review after the fact that a patient was forced by urgency and network inadequacy to seek care elsewhere, the insurer should be obligated to pay as much as it would have had to pay if it had been given a chance to arrange an out-of-network referral. In such circumstances, the insurer's obligation would be determined – under what is known a "reference pricing" approach – by the lowest amount that a reasonably qualified provider in the area would have charged for the service.

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⁵⁷ The NAIC's Model Act requires notice of review rights only in circumstances where the patient "is diagnosed with a condition or disease that requires specialized health care services ... and [the insurer] does not have a participating provider of the required specialty with the [necessary] professional training and expertise ... without unreasonable travel or delay." In these circumstances, the Act does not specify the particular process that insurers must use to review out-of-network requests, but it suggests that normal utilization review processes could be used, and, indeed, many plans currently provide an internal appeals process to review these issues.

⁵⁸ Valarie Blake, *Narrow Networks, the Very Sick, and the Patient Protection and Affordable Care Act*, Minn. J. Law, Science & Technology 16:64-143 (2015), <http://scholarship.law.umn.edu/mjlst/vol16/iss1/4/> .

This qualification adds an additional element to the dispute, focused not just on medical need but on reasonableness of cost. The cost dimension, however, is not one that is best determined through the medical expertise of external review. Therefore, a secondary dispute resolution mechanism should be used, as with other non-medical aspects of coverage disputes.

Indeed, if network adequacy disputes proliferate, states might consider creating a tailor-made dispute resolution process to deal directly with the financial rather than the clinical aspects. When medical review determines that patients should be permitted out-of-network access, insurers should be required to hold patients financially harmless, by waiving any increased cost-sharing and paying the reasonable charges from non-participating providers. But, what if out-of-network charges are exorbitant? Insurers' hold-harmless obligation should not be limitless. On the other hand, patients should not be stuck with "balance bills" from providers' excess charges that insurers justifiably refused to pay, when it was not the patient's choice to go out of network.

The solution for this dilemma is the same as that crafted to deal with so-called "surprise" balance billing.⁵⁹ States have created mechanisms for independently reviewing the reasonableness of charges from nonparticipating providers, when patients have done all they reasonably can to remain in network.

In sum, it is possible to resolve most of the issues raised by network adequacy disputes using existing regulatory and contractual remedies. However, a specially devised process for resolving excessive billing might be advisable if we start to see a large number of such disputes.

An external review system would relieve some, and perhaps much, of the pressure on the regulatory system to specify and enforce exact levels of network adequacy. If quantitative standards are not in place for the particular type of provider in question, or if an insurer has a deficit in meeting the standard, the external review can determine the adequacy of available network resources under a general standard of medical need. This combined approach could be used for any type of provider, but it would be especially helpful with regard to sub-specialists. Even if an insurer's network is sufficient under either qualitative or quantitative standards for a broader specialist category, such as surgery, or cardiac surgery, the particular type of heart surgery needed might call for someone (such as a pediatric specialist)⁶⁰ whose particular skills and experience are not available in an otherwise adequate network.

Coverage of subspecialists poses issues similar to the coverage of specialized prescription drugs, under health plan "formularies." Even though insurers cover prescription drugs broadly across all areas of medical care, they do not necessarily cover all the particular specialized drugs within each "therapeutic class." Insurers' pharmaceutical specifications are known as formularies. An insurer's formulary might, for instance, allow one or two blood pressure medications but exclude others, based on favorable pricing the insurer has negotiated with pharmaceutical companies or suppliers, as well as evidence about how well different drugs work. Physicians may seek exceptions from these restrictive formularies, however, when they have good reason to think that the preferred drug is not adequate for particular patients.

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⁵⁹ Mark A. Hall, et al., Solving Surprise Medical Bills.

⁶⁰ Charlene Wong, et al., Pediatric and Adult Physician Networks in Affordable Care Act Marketplace Plans, *Pediatrics* 139(4):e20163117 (2017).

This ability to seek formulary exceptions relieves some of the pressure on regulators to determine precisely which pharmaceutical restrictions are and are not defensible, thus giving insurers more leverage to seek deeper discounts. Although some initial review of formularies is needed to prevent insurers from discouraging high-risk enrollees, regulators, realizing that formulary exceptions can be granted as needed, have not felt the need to insist on comprehensive formularies. For instance, the federal rules for “essential health benefits” under the ACA currently allow as few as one drug in each therapeutic class, but require that health plans have an expedited process to seek an exception for “clinically appropriate drugs” not covered by the formulary.⁶¹ Also, current federal rules allow patients to seek external review if the health plan denies any such request. The existing external review process is similarly well suited to review the medical appropriateness of seeking care outside a limited network.

B. Quantitative Capacity Measures

With a robust review process as a backstop to network adequacy protections, we can now consider what substantive standards regulators might adopt. At the outset, to maintain a license, regulators should require network insurers to contract with a minimally acceptable number of higher-volume providers in the major areas of primary care and specialty practice. This minimum standard could be purely qualitative, or it could be a mix of quantitative elements that, to the extent feasible, specify not only the overall ratio of providers to enrolled population, but also the proximity of primary care physicians, hospitals, and high-volume specialties to the enrolled population.

Quantitative standards do not need, however, to cover all areas of medical practice. A qualitative standard inevitably will need to fill in those areas where quantitative specification is not feasible or desirable. Also, travel time/distance standards should be presumptive rather than strictly binding. To give insurers leeway to develop innovations such as telemedicine, or referrals to regional/national centers of excellence, regulators typically allow insurers to submit and justify special arrangements that obviate the need for normal proximity limits.

Several approaches can be taken to making the judgment calls necessary to settle on the governing metrics. Although judgments made by others vary widely, as documented above, they do provide guideposts. Thus, standard setters could begin by considering the median or modal values among states with current standards for the private market,⁶² or they can choose from within the range used currently for Medicaid managed care plans, seen in Exhibit 4.⁶³ Medicare Advantage provides the most well-established set of standards,⁶⁴ but these are set with the service patterns for elderly and disabled patients

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⁶¹ 45 C.F.R. 156.122(c).

⁶² Health Management Associates, Ensuring Consumers’ Access to Care: Network Adequacy State Insurance Survey Findings and Recommendations for Regulatory Reforms; Leonard Davis Institute of Health Economics, Network Adequacy and Travel Standards Dataset (Robert Wood Johnson Foundation, April 2015), <http://www.rwjf.org/en/library/research/2015/01/network-adequacy-and-travel-standards-dataset.html>.

⁶³ DHHS Office of Inspector General, State Standards for Access to Care in Medicaid Managed. Although standards for publicly financed coverage might be less demanding than the network sizes that generally prevail in the private market, these public insurance standards should reflect what is generally considered to be a “decent minimum,” that is, a floor below which private markets should also not fall.

⁶⁴ CMS, Medicare Advantage Network Adequacy Criteria Guidance.

in mind. For a broader population, states could construct minimally acceptable standards using the norms (and standard deviations) reflected in all-payer claims datasets (using either their own datasets, or that of a similar state).

Exhibit 4. Examples of Different Quantitative Standards, Medicaid Managed Care, 2013							
		Tennessee		Texas		Pennsylvania	
		Primary Care	Specialist	Primary Care	Specialist	Primary Care	Specialist
Time Standards (Minutes)	Urban	30	--	--	--	30	30
	Rural	30	--	--	--	60	60
Distance Standards (Miles)	Urban	20	60-90*	30	75	--	--
	Rural	30	60-90*	30	75	--	--
Appointment Wait Times (Days)	Routine	21	30	14	30	10	10/15***
	Urgent	2	2	1	1	1	1

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*Within 60 miles for 75 percent of enrollees, within 90 miles for all enrollees

***10 days for select specialists; 15 days for others.

Source: DHHS Office of Inspector General, State Standards for Access to Care in Medicaid Managed Care (Sept. 2014),

<https://oig.hhs.gov/oei/reports/oei-02-11-00320.asp>.

In choosing the right metrics for competitive private markets, lawmakers should think in terms of low-bar thresholds rather than aiming at optimal provider levels and distribution. The primary goal is to determine whether an insurer should be allowed to enter, or remain in, a market. One conceptual gauge is to preclude only those networks that few informed consumers would find acceptable. Beyond that threshold, market forces should be given substantial leeway to determine tradeoffs between premiums and desirable network breadth, where markets function reasonably well.

For market forces to work well, however, consumers need better information about the networks from which they can choose. Without a doubt, better information means current, accurate, and user-friendly directories of who is and is not in the network. Much improvement is still needed on this score. Also, better information includes data about the quality of competing networks, including measures of provider access. But, there are inherent limits to how effective consumer information can be to assure network adequacy, especially considering that network composition changes throughout a plan year, after subscribers have enrolled and before they have another opportunity to change plans.

To leave sufficient flexibility, regulators should let insurers seek exceptions from quantitative standards when market conditions do not reasonably allow full compliance, despite best efforts. Generally speaking, relevant market conditions can be defined in two ways. The most demanding approach looks only to whether there is a shortage or absence of active providers in the relevant area.⁶⁵ A more forgiving approach also considers whether existing providers are willing to negotiate on reasonable terms. It can be challenging, however, to determine whether negotiations have been conducted reasonably and in good faith. Accordingly, under Medicare Advantage, the federal government will not consider “inability to contract” as grounds for an exception. (The only deviation from this position is for providers who will not contract under any circumstances, for instance, when they have an exclusive contract with another insurer.)

Medicare Advantage is distinctive, however, in that if providers decline to join a Medicare Advantage network, Medicare rules limit what they can charge Medicare beneficiaries “out of network.” That limit makes it considerably easier to form networks for Medicare Advantage than for private insurance in many markets.⁶⁶ This difference in the background regulation of provider pricing could justify states giving greater consideration to private insurers’ requests for exemption from adequacy rules based on inability to contract with the relevant provider.

This still leaves the difficulty, however, of determining when contract negotiations genuinely fail despite the insurer negotiating in good faith. To do this, regulators could look to whether other, competing insurers in the same area have been able to secure adequate network contracts with the type of provider in question.⁶⁷ Also, a state might consider using dispute resolution processes, like the ones we have recommended for “surprise balance billing,”⁶⁸ that use an arbitrator to determine whether an insurer has offered reasonable terms to providers.

Thus, in order to effectively oversee network adequacy without distorting market dynamics, it may sometimes be necessary to evaluate whether or not providers are demanding unreasonable reimbursement levels. In provider markets that are at least somewhat competitive, regulators can stand by and let market forces determine what rates insurers need to pay in order to form an adequate network. But, when adequacy rules apply to markets where one or more facilities or physician specialty practices exercise strong market power, regulators face a dilemma: they can decide simply to let insurance prices reflect the absence of competitive provider pricing, or they can use network oversight to improve market conditions.

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⁶⁵ Medicare Advantage, for instance, permits exceptions when the “existing landscape of providers/facilities does not enable the organization to meet the current CMS network adequacy criteria,” and the health plan contracts with enough out-of-area providers that it can offer a level of access equivalent to that offered by standard Medicare. CMS, Medicare Advantage Network Adequacy Criteria Guidance.

⁶⁶ Robert A. Berenson, et al., Why Medicare Advantage Plans Pay Hospitals Traditional Medicare Prices, *Health Aff.* 34(8):1289-1295 (2015).

⁶⁷ Jane B. Wishner and Jeremy Marks, Ensuring Compliance with Network Adequacy Standards: Lessons from Four States (March 2017), http://www.urban.org/sites/default/files/publication/88946/2001184-ensuring-compliance-with-network-adequacy-standards-lessons-from-four-states_0.pdf.

⁶⁸ We describe a “final offer” arbitration process (also known as “baseball-style”) that encourages the parties to reach agreement by limiting the arbitrator’s options to picking the final best offer of one side or the other, rather than striking a compromise. Mark A. Hall, et al., Solving Surprise Medical Bills.

Taking the first approach (hands off) would enable providers to use strict adequacy rules to force insurers to agree to inflated prices.⁶⁹ But, granting an exception still leaves patients exposed to those, or even greater, prices out-of-network. Unless regulators decide to simply ignore extreme conditions in provider markets, they will need some mechanism to determine when providers' price demands are excessive. This can be done either in reviewing insurers' request for regulatory exceptions based on inability to contract, or in holding patients financially harmless when they are forced to seek care outside of inadequate networks.

C. Outcome Measures

Clearly, then, a thoroughgoing regulatory approach demands considerable administrative resources. In attempting to reduce the complexities of regulating the structure of provider networks, we might instead consider whether the regulatory focus should be on the ultimate outcome of network adequacy: achieving actual access to care. Metrics for the minimum size, composition and distribution of provider networks are useful to determine whether insurers may enter or remain in a market, but these alone do not assure adequacy. Having a sizeable number of providers in the network does little good if they have limited availability due to being overbooked.

Critically, providers can be overbooked, despite robust quantitative measures, because a given network can serve enrollees in various products that an insurer sells through multiple different private and public sector markets. Thus, a network that on paper may be adequate for either the individual or the group market, or for Medicare or Medicaid, might not be adequate for both or all combined – yet no regulatory structure readily exists to make a cumulative assessment. We might rely on providers to avoid signing up for too many networks simultaneously, but they have no easy way to gauge how many patients they will see from various networks, especially considering that narrow networks channel enrollees to a small number of providers. Accordingly, network providers vary in how much existing capacity they have, and so network membership may not translate into appointment availability.

The best direct test for actual network capacity is wait times for appointments. Because wait times fluctuate, they do not work well as an entry-level threshold, but they can serve as an excellent measure of ongoing performance. In particular, wait times could be a key metric for consumer shopping. Hospitals with underutilized emergency departments are known to advertise current wait times on electronically-refreshed highway billboards.⁷⁰ Similarly, health plans could either be encouraged, or required, to report typical or average wait times for primary care appointments and common specialist referrals, giving consumers information to evaluate when they shop for insurance. Standard methods could be devised by which network providers report their wait times periodically, or external evaluators can assess wait times as “secret shoppers.”⁷¹

Although on first reflection this type of monitoring may seem intrusive, it is not much different than the forms of monitoring that health plans and providers currently engage in through consumer surveys. These surveys

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⁶⁹ Regulation of network adequacy under Medicare and Medicaid avoids this problem because providers are not permitted to freely “balance bill” those beneficiaries. But, under private insurance, providers can charge “whatever the market will bear.”

⁷⁰ Scott G. Weiner, Advertising Emergency Department Wait Times, 14(2) West. J. Emerg. Med. 77-8 (2013).

⁷¹ California is a leader in this regard. Calif. Dept. of Managed Health Care, Timely Access Compliance and Annual Provider Network Reporting, <https://www.dmhc.ca.gov/LicensingReporting/SubmitHealthPlanFilings/TimelyAccessReport.aspx> .

assess consumer experience with wait times for appointments (for instance, “[were you] able to get an appointment as soon as you needed?”). Although these are often subjective measures, it is quite possible to include a more objective report of time until appointment. For instance, the widely-used Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey contains supplemental items that ask how many days it took to receive routine or urgent care.⁷²

It is a separate question, though, whether regulators should set maximum wait times for appointments as a mandatory test for network adequacy. About a dozen states do so,⁷³ but a majority do not, nor does the federal government for Medicare Advantage plans. Although the ease of getting appointments is, in many ways, the ultimate test for actual provider accessibility, enforcing maximum wait times poses several practical problems. First, conventional ways to measure wait times do not address actual regulatory requirements. Patient surveys measure only experience with the providers where patients choose to seek care, and not whether a suitable appointment is available elsewhere in the network. Secret shopper surveys tell us which providers do and do not have ready availability, but they do not reveal whether those with availability are located near the patients who need appointments. No existing assessments (that we are aware of) measure the relevant dimensions simultaneously – whether patients are able to secure a timely appointment somewhere within the part of the network where they reside – probably because doing so would be a large undertaking.

Nevertheless, standards for maximum wait times can be a useful adjunct to other components of network adequacy regulation. First, rather than a strict compliance measure, these standards can be a gauge that points to potential problem areas, or that indicates strong performance – either the canaries in the mine or the song birds of spring. Second, wait time standards can be a non-binding guide to help resolve disputes under more qualitative standards, about whether patients should be permitted in particular cases to go out of network, at no extra cost, in order to receive adequate care.

In theory, maximum wait times could be applied more strictly, in a fashion that entitles patients to automatically go out of network (at no extra cost) whenever timely appointments are not available. If wait time standards were used this way, it would be important to set them at a minimally acceptable level rather than a level that is optimal or midrange. Doing that, however, might lessen their usefulness as a performance measure. Also, it would be necessary to specify a geographic range within which a maximum wait time applies. However, we are unaware of any states that do so, suggesting that we currently lack sufficient practical experience with wait time standards to comfortably mandate them in this case-specific fashion.

In sum, maximum wait times have an important role in a layered approach to network adequacy oversight. They best address the “outcomes” dimension of effective, multifaceted quality measurement. However, caution should be exercised in applying maximum wait times with the same regulatory force as provider/population ratios or travel distance. Instead, considering the current state of practice and experience, wait times are best used to determine whether structural measures are achieving their goals,

⁷² AHRQ, Supplemental Access Items for the CAHPS Health Plan Survey 5.0, <https://www.ahrq.gov/cahps/surveys-guidance/item-sets/hp/suppl-access-items-hp-survey50-adult.html>.

⁷³ Justin Giovannelli, Kevin W. Lucia, and Sabrina Corlette, Implementing the Affordable Care Act: State Regulation of Marketplace Plan Provider Networks.

and to help inform (but not determine) the process of determining available network resources are adequate to meet a particular patient's needs.

IV. Putting the Pieces Together

To ensure the adequacy of provider networks, neither general qualitative standards (“sufficient to avoid unreasonable delay”) nor quantitative standards (specified capacity, provider distribution, or wait times) are sufficient, either alone or in combination. Qualitative standards are too general to be self-enforcing, and quantitative standards can be too complex or inflexible. Both kinds of standards are designed more for threshold entry into the market as a whole than for resolving patients’ rights in particular cases. To do that, what is required is a suitable process to hold patients financially harmless when networks are inadequate to meet their particular medical needs within a reasonable time and distance. Having this back-stop dispute process in place would resolve a good bit of the regulatory burden of ensuring at the outset that a given network can meet all likely medical needs. And, in turn, looser regulatory reigns on network composition would give health plans more flexibility to adapt to market conditions and to adopt promising innovations in care delivery.

This layered approach to network adequacy consists of the following recommended elements:

- A general qualitative standard for network adequacy is needed, such as that proposed in the NAIC’s Health Benefit Plan Network Access and Adequacy Model Act.⁷⁴
- Insurers should provide reasonably up-to-date and user-friendly network directories, and network size should be more clearly labeled for consumers.
- Some basic baseline quantitative standards should be considered that are fairly easy to administer, such as a minimally acceptable number of higher-volume providers in the major areas of primary care and specialty practice, and at least one such provider within a defined distance of most of the plan’s enrolled population.
 - These capacity standards should not attempt to cover all areas of medical practice. The qualitative standard inevitably will need to fill in those areas where quantitative specification is not feasible or desirable.
 - These metrics should not be overly exacting. The range of values currently used by states or by Medicare or Medicaid could be considered, with due regard for differences among the populations served. Or, states with all-payer claims datasets could analyze those to determine the range of prevailing service utilization norms.

...
⁷⁴ The Act requires networks that are “sufficient in numbers and appropriate types of providers ... to assure that all covered services ... will be accessible without unreasonable travel or delay.”

- Quantitative standards should be presumptive, but not conclusive.
 - These metrics should be subject to exceptions for innovations in care delivery (telemedicine, centers of excellence), or when market conditions do not reasonably allow full compliance, despite best efforts.
 - Capacity standards can help resolve individual disputes, but they should not be strictly determinative. Even in plans that meet these standards, patients still might face inadequate access (for instance, due to excessive wait times), and plans that are not in complete compliance might still be able to arrange adequate access for particular patients, either from elsewhere in the network or via “spot contracts.”
- If quantitative standards are adopted, consideration should be given to maximum wait times (rather than simply number and distribution of providers). Wait times can be useful to monitor actual ability to receive timely care, and to help resolve individual disputes.
 - However, wait times should not be used in a strict regulatory fashion that allows patients automatically to go out of network simply because their preferred physician or facility is not available in time.
- Regardless of the substantive adequacy standards in place, a backstop dispute resolution process is also needed to protect patients who might face inadequate access due to a restricted network.
 - The existing external review process by independent medical experts that is used to resolve “medical necessity” dispute can also be used to determine when patients should be allowed to go out of network to meet their medical needs.
 - The reviewer should determine a specific patient’s need for out-of-network services based on both the patient’s particular medical case and the state’s general standard of adequacy, as informed (but not necessarily bound) by any specific metrics the state has adopted for health plan licensure.
- Patients should be held financially harmless when a reviewer determines there are grounds to receive care out of network.
 - To allow health plans to arrange for needed services at reasonable costs, patients should be required to pursue external review in a timely manner, prior to treatment if feasible.
 - To facilitate timely review, patients should be given adequate notice of the opportunity for expeditious external review, and referring physicians should also be informed that this opportunity exists.
- If network adequacy requirements might add substantially to the cost of insurance, then states should consider creating an additional dispute resolution process focused on financial implications.

- This second component could be combined with the dispute resolution process used to resolve “surprise” out-of-network medical bills.
- This process could determine both whether an out-of-network provider’s charges are reasonable in a particular case, and whether health plans whose networks fail to meet initial licensing standards have attempted to negotiate with the relevant providers in good faith, thus justifying a potential exception from an adequacy standard.
- A robust dispute resolution process can ease the administrative burden of overseeing network adequacy.
 - Effective external review reduces the need for states to prescribe, monitor and enforce specific adequacy metrics across the full range of medical care.
 - The results from specific disputes can also assist with ongoing regulatory monitoring. Regulators might view an unusually high number of external review losses as reason to further investigate a health plan. Health plans that purposefully skirt adequacy standards without sufficient justification could be subject to administrative sanctions.

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