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# Health Policy Brief

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## Regulation of Health Plan Provider Networks.

## Narrow networks have changed considerably under the Affordable Care Act, but the trajectory of regulation remains unclear.

### WHAT'S THE ISSUE?

Health insurance plans with limited networks of providers are common on the Affordable Care Act's (ACA's) health insurance Marketplaces. Recent studies have found that these "narrow network" plans constituted nearly half of all Marketplace offerings in the first two years of coverage, with one analysis concluding that about 90 percent of all consumers had the option of buying such a plan if they chose.

Plans with limited networks are not new and are not confined to the Marketplaces. Yet there is reason to believe that they have grown in prevalence partly because of the ACA. Many of the health law's consumer protections—prohibitions on health status underwriting, increased standardization of benefits, a maximum limit on out-of-pocket spending, and the elimination of annual and lifetime limits on benefits, for example—have foreclosed traditional strategies used by insurers to keep costs in check. Meanwhile, other elements of reform, including online Marketplaces that make it easier for consumers to compare plans based on premiums and a financial assistance framework that links the amount of a person's premium tax credit to the cost of the second cheapest plan available to them at the silver metal tier, explicitly encourage insurers to compete on price. These developments appear to have led many insurers to design Marketplace health plans that combined a comparatively low premium with a more restricted choice of providers.

Limited network plans might offer value to consumers. Coverage that pairs a low premium with a network that provides meaningful access to health care might meet the needs of many enrollees, no matter the network's overall size. Negotiations between insurers and providers over network participation might encourage more efficient delivery of care. And the power to contract selectively might allow insurers to create networks comprising a subset of providers who meet raised standards of quality, potentially resulting in higher-value care.

But these plans also pose risks. A network can be too narrow, jeopardizing the ability of consumers to obtain needed services in a timely manner. This can happen if the network contains an inadequate mix of provider types. For example, a recent examination by Harvard researchers of the network composition of health plans offered on the federal Marketplace during 2015 found that nearly 15 percent of the sampled plans lacked in-network physicians for at least one specialty. Or a network might have an insufficient number of providers: There might be too few physicians who are taking new patients, who are available for an appointment within a reasonable time, or who speak the same language as the enrollee. Certain network limitations also


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**22%**

In 2015 about 22 percent of Marketplace plan networks were narrow—defined as having between 30 percent and 70 percent of area hospitals in-network.

might have the effect of discouraging enrollment by sicker consumers, potentially skewing the risk pool. Plans that provide limited or inadequate access to in-network providers make it more likely that enrollees will obtain care from out-of-network sources, exposing them to significant expenses and the possibility of surprise medical bills.

Surveys show that many consumers are open to trading network breadth for a lower premium. They also suggest that, in practice, large numbers of consumers do not find network designs to be transparent. If the features of a plan's network are inadequately explained or its list of participating providers is inaccurate, it might be impossible for consumers to make an informed decision about whether the plan's combination of network and price is right for them.

Consumers' experiences with narrow network plans since the ACA's implementation have defied easy characterization. Surveys of the insured, including those with Marketplace coverage, suggest that the vast majority are satisfied with their plan's choice of doctors. Yet anecdotal complaints about networks have proliferated, and the exclusion by some health plans of high-profile hospitals and care facilities has generated media headlines.

In light of these developments, and as part of a larger effort to keep pace with changes to the health insurance markets since passage of the ACA, lawmakers and regulators have devoted significant attention to determining how networks should be regulated to ensure they are adequate and transparent. This work has involved efforts to establish or update standards for evaluating the sufficiency of a plan's network, improve the accuracy of provider directories, and protect enrollees from surprise bills from out-of-network providers. This brief offers an overview of state and federal actions that address the first two categories—network standards and provider directories—with a focus on rules that govern plans sold on the ACA's health insurance Marketplaces.

## WHAT'S THE BACKGROUND?

*Network basics*

One way that many health plans seek to control costs is by creating a provider network. Plans contract with doctors, hospitals, and other medical professionals who, in exchange for their participation within the network and an expectation of greater patient volume, agree to deliver care to the plan's enrollees at negotiated rates. This ability to contract selectively—and exclude, or threaten to exclude, a high-cost provider—gives insurers leverage to bargain for lower health care prices and can help moderate premiums.

For consumers, network design can be critical (see Exhibit 1). Enrollees typically receive a more generous insurance benefit if they visit in-network providers: Cost sharing is usually markedly lower than for out-of-network care, and most in-network charges are subject to an ACA-established overall annual limit on out-of-pocket spending. Meanwhile, some network plans might not cover any nonemergency care costs if a consumer obtains services from a nonparticipating provider. Even if a plan does offer an out-of-network benefit, enrollees who receive care outside their network might be billed by the provider for the difference between the plan's payment and the provider's charge—a practice known as "balance billing."

Network plans vary not only in their design but also in their breadth. Studies by the McKinsey and Company consulting firm found that, in 2015, about 22 percent of Marketplace plan networks were narrow—defined as having between 30 percent and 70 percent of area hospitals in-network—while 17 percent were "ultra-narrow," with hospital participation rates below 30 percent. Researchers at the University of Pennsylvania likewise have observed significant variation in Marketplace network breadth in terms of physician participation; for example, about 41 percent of 2014 plans had small or very small networks, with fewer than a quarter of area physicians participating.

These findings have also suggested that the link between a plan's network design and size has eroded over time. Knowing a plan's type—whether it is a health maintenance organization (HMO) or a preferred provider organization (PPO), for example—can shed important light on its benefit structure for out-of-network care but is of increasingly limited use in understanding how big or small the plan's network might be.

*State regulation of network adequacy for commercial health plans, pre-ACA*

Regulation of private health insurance traditionally has been a state responsibility. In an effort to ensure that health plans can de-

liver on the insurance benefits they promise, most states have long had in place rules governing plan networks. However, the content and scope of these requirements have varied substantially.

Historically, most states first established network rules for HMOs. Over time, as insurers' network designs changed, some, but not all, states modified their regulatory regimes to encompass other plan types—mainly PPOs. Sometimes, a state's network regulations were crafted to treat PPOs and HMOs similarly. But often, given differences in their network design, rules developed somewhat differently across products or have been administered by different regulatory bodies. (In some states, for example, the department of insurance regulates PPOs, while the state's health agency oversees HMOs.)

Perhaps unsurprisingly, state efforts to ensure compliance with network standards also differ among the states in process and substance. In many states, regulators have conducted network adequacy reviews only when an insurer initially seeks licensure, upon notice of a significant change in a plan's network, or in response to complaints. Ongoing oversight has been much less common.

*Qualitative standards*

By 2014, the year when Marketplace coverage started, nearly every state had on the books a flexible, qualitative standard obligating HMOs, PPOs, or, in some cases, all managed care plans, to maintain an adequate network. For example, Kansas requires managed care plans to have a "sufficient" mix of in-network providers so enrollees can access all covered services "without unreasonable delay." As is common in other states, insurers in Kansas might demonstrate compliance with this standard by showing that they adhere to "any reasonable criteria" the insurer might select, including, but not limited to, quantitative measures of network sufficiency.

*Quantitative standards*

A little more than half of states supplemented their subjective standard with an objective one, requiring plans to meet at least one quantitative test of network adequacy. Most frequently, states specified the maximum amount of time and distance an enrollee can be asked to travel to access covered services. Standards typically identified the type or types of providers to which plans must preserve access. Requirements around primary care providers were most common, although

**EXHIBIT 1**

**Types of network plans and pricing designs**

| Type of plan | Description |
|---|---|
| Health maintenance organization (HMO) | An HMO plan provides coverage for health care services received from providers directly employed by the plan or contracted with it. HMO plans generally require enrollees to select a primary care physician who manages their care and serves as a gatekeeper for other health services: Enrollees must obtain a referral from their primary care physician before receiving care from another in-network provider. An HMO plan typically does not cover any costs associated with services obtained outside of its network. |
| Point-of-service (POS) plan | A POS plan is similar to an HMO in that an enrollee is typically required to designate a primary care physician and obtain a referral prior to receiving care from a network specialist. Unlike an HMO plan, a POS plan provides benefits for services received out-of-network, although usually with higher cost sharing. |
| Exclusive provider organization (EPO) | An EPO plan provides coverage through a network of contracted providers. An EPO plan allows enrollees greater flexibility to visit in-network providers than do HMO plans: EPO plans do not require designation of a primary care physician or referrals to specialists. But, like an HMO, an EPO plan does not provide any coverage for care received out-of-network. |
| Preferred provider organization (PPO) | A PPO plan provides coverage through a network of contracted providers. PPO plans generally provide enrollees the greatest level of flexibility to visit a desired provider. Plans do not require designation of a primary care physician or referrals to specialists, and they do include coverage for care received outside of the network, although usually with higher cost sharing. |
| Tiered network | Some network plans use a tiered design. Tiered networks subdivide in-network providers based on factors that include cost or quality. Enrollees pay lower cost sharing when they obtain care from providers in the preferred tier and higher cost sharing when they obtain care from providers in less-preferred tiers. |
| Reference pricing | Some network plans employ a reference pricing design. Such plans agree to pay a fixed amount—the reference price—for a particular procedure, which certain providers accept as payment in full. Enrollees who obtain care from a provider who does not accept the reference price generally must pay the difference between the reference price and the provider's contracted rate. |

**SOURCE** Author's analysis.

**"Surveys show many consumers are open to trading network breadth for a lower premium."**

some states enumerated travel limits for health care facilities and specialists. For example, New Jersey requires its managed care plans, including HMOs, to have available at least two primary care physicians within ten miles or thirty minutes driving or public transit time of 90 percent of their enrollees. The state also requires plans to provide access to various specialized services, including, for example, hospitals providing perinatal and tertiary pediatric services, within specified time and distance limits.

Sometimes, states created time and distance requirements that vary depending on population density or geography. In New Mexico, for example, plans serving areas with 50,000 or more residents must ensure that two contracted primary care physicians are within twenty minutes or twenty miles of 90 percent of the enrolled population; for plans serving more sparsely populated areas, the standard is relaxed to sixty minutes or sixty miles.

States adopted other quantitative standards, as well. Nearly a dozen states sought to assure timely access to care by imposing limits on how long enrollees can be made to wait for appointments for nonemergency services. For example, Montana requires certain network plans to ensure access to urgent care within twenty-four hours; nonurgent care with symptoms within ten days; immunizations within twenty-one days; and routine or preventive services within forty-five days. A similar number of states attempted to ensure networks contained a sufficient number of providers by requiring plans to meet ratios of providers to enrollees. Regulatory agencies in California, for example, require that all network plans have at least one full-time-equivalent primary care physician for every 2,000 enrollees.

*Network transparency*

Consumers rely on provider directories to find out which providers are in a plan's network and to learn other basic information about them, including office location, specialty, and whether they are accepting new patients. Most states regulated the content, distribution frequency, or format of these directories. Few, however, had specific regulatory provisions designed to ensure that provider lists were kept current throughout the year. By 2014 fewer than a dozen states required insurers to update provider directories at least semi-annually or within a specified time frame of any change in network composition.

## WHAT'S THE LAW TODAY?

*The ACA's network adequacy provisions*

With state regulation of network adequacy widespread but fragmented, the drafters of the ACA sought to establish a uniform baseline standard that would apply to the health plans sold through the law's new insurance Marketplaces. Section 1311(c) of the health law contains the first-ever federal network adequacy protections applicable to commercial health insurance markets. The provisions require all qualified health plans available on the Marketplaces to maintain a "sufficient choice of providers" and "provide information to enrollees and prospective enrollees on the availability of in-network and out-of-network providers." The law also requires qualified health plans to include within their networks "essential community providers": those providers "that serve predominately low-income, medically-underserved individuals," such as federally qualified health centers, family planning clinics, Indian health care providers, and Ryan White HIV/AIDS program providers.

*Federal implementation of the ACA's network requirements*

Federal regulations and guidance further define the network standard contained in the health law. Much like the approach taken by many states, the federal framework is based on a flexible qualitative standard. Qualified health plans must maintain a network that is "sufficient in number 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." Plans must also disclose their provider directories to the Marketplace for online publication and indicate those providers who are not accepting new patients.

With these requirements serving as a regulatory floor, the ACA gives states significant latitude to continue to address network issues. States can choose to exercise primary responsibility for insurer oversight and compliance with the federal standard and retain authority to enforce additional state-specific network rules, so long as they do not conflict with federal law. Thus, for example, states that use quantitative measures of network adequacy can apply those standards to qualified health plans just as they do for non-Marketplace plans.

**40%**

More than 40 percent of new enrollees in 2015 were unaware of their plan's network configuration.

Since initial implementation, federal regulators have gradually strengthened qualified health plan network requirements. The approach has evolved furthest in states with a federally facilitated Marketplace, where officials at the Centers for Medicare and Medicaid Services (CMS) are responsible for certifying qualified health plans for sale. In 2015 CMS began to evaluate plans seeking certification on the federally facilitated Marketplace using a "reasonable access" standard. As part of this analysis, CMS now requires insurers to submit detailed network provider data and gives close scrutiny to provider types—such as hospital systems, mental health providers, oncology providers, and primary care providers—that have historically raised network adequacy concerns.

Federal officials initially proposed to modify their regulations to incorporate quantitative standards into the qualified health plan certification process beginning in 2017. Under the proposal, CMS would rely on state reviews of plan networks in states that use a recognized quantitative measure of adequacy, such as a time and distance standard or a provider-to-enrollee ratio. In states that declined to use a quantitative standard, CMS would perform its own analysis using a federal default time and distance metric. This proposed regulatory change was ultimately tabled. Nevertheless, CMS has signaled through subregulatory guidance that it will use time and distance standards going forward, as part of its "reasonable access" review for qualified health plans on the federally facilitated Marketplace.

Early experiences also have led federal officials to adopt more stringent requirements for network transparency. Marketplace plans are now required to update their provider directories at least once each month; include additional information about their providers, including specialties and institutional affiliations; and ensure that the general public can easily access these lists online without logging into or creating an account. In the coming year, CMS will implement a process to define the breadth of each federally facilitated Marketplace qualified health plan's network, as compared to other qualified health plans available in the same geographic area and will display this information on HealthCare.gov.

Federal officials have invoked the ACA's provisions to regulate emerging network designs, as well. In a series of guidance documents, regulators have sought to explain how the ACA's cap on out-of-pocket spending, an important protection that limits what consumers can be made to spend each year for most care received from network providers, applies to plans that use reference pricing or a "similar network design." Officials have made clear that plans that merely set a reference price for a service, but do not use a reasonable method to ensure consumers have adequate access to quality providers who accept that price, have not established a network for purposes of federal law. Such plans therefore must count any amount paid by an enrollee in excess of the reference price toward the enrollee's out-of-pocket spending limit.

## WHAT'S THE DEBATE?

*Limited provider networks: Value is in the eye of the beholder*

For insurers, limited networks offer the opportunity to tamp down on costs. Flexibility to create these networks allows for a wider range of plan designs and a greater variety of coverage options for consumers. Moreover, to the extent insurers consider quality when forming their networks, the power to contract selectively—including stronger performing providers, excluding weaker ones—might encourage the delivery of high-value care.

For many providers, the narrowing of networks runs counter to a preference for fewer restrictions on consumers' choice of providers. To the extent such designs give insurers greater leverage in rate negotiations, it might affect providers' bottom lines. Many providers are also skeptical of the degree to which insurers actually use networks to promote quality and their ability to capture provider performance accurately.

For consumers, narrow network plans present a critical trade-off. Some might value the premium savings associated with limited networks more than they do a broad choice of providers. Others might be willing to pay more in up-front premium costs for greater network flexibility or to secure access to a specific physician or care facility. In the first two years of Marketplace coverage, consumers on both ends of this spectrum had options from which to choose: Analyses by McKinsey and Company concluded that the overwhelming majority of Marketplace shoppers had access to both narrow and broad network plans and that the quality of such networks—judged in terms of hospital performance—was not meaningfully different.

**"All indications suggest plans with limited networks will persist on and off of the ACA's Marketplaces."**

At the same time, evidence indicates that consumers might not have had enough information about their plan choices or knowledge about health insurance and network designs, more generally, to make an informed decision about what premium and network combination to select. Surveys by the Commonwealth Fund have shown that about 20–25 percent of Marketplace enrollees did not know that the plans they were picking among had different networks, while McKinsey and Company has found that more than 40 percent of new enrollees in 2015 were unaware of their plan's network configuration. As noted earlier, enrollees' satisfaction with their choice of providers has remained high, and hard numbers on consumer complaints have so far been difficult to come by; but persistent anecdotal reports suggest that some consumers ended up in plans with networks that were narrower than they anticipated.

*How prescriptive should network adequacy standards be?*

As we have seen, officials tasked with regulating network adequacy have followed two basic approaches. The first requires health plans to adhere to preestablished quantitative standards for network sufficiency, such as time and distance limits or provider-to-enrollee ratios. The second is more subjective, relying on a qualitative assessment of whether, for example, a network is "sufficient" to provide access to covered services "without unreasonable delay." Numeric measures might play a role in the qualitative framework: As noted above, many states permit insurers to demonstrate compliance with adequacy standards through a self-assessment that might incorporate quantitative criteria. But in these cases, specific, regulator-defined requirements are absent.

Proponents of qualitative standards favor their flexibility. They argue that it is important for network standards to account for regional differences in market dynamics, geography, and population and provider density, and suggest it can be challenging for regulators to craft static requirements that do this efficiently. They assert that rules that are too prescriptive might reduce insurers' leverage to negotiate for lower reimbursement rates, potentially undermining cost containment efforts and jeopardizing innovation in plan design.

Those supportive of quantitative standards are skeptical that a subjective review of adequacy, often based on insurers' own assessments of their networks, can provide consumers meaningful assurance that their access to covered services is protected. They see value in measurement standards that are transparent to the public and applied consistently across plans. Many also agree that these metrics can and often should vary across and within states to account for regional differences but do not see this as an insurmountable obstacle to their adoption and use. They observe that a number of states and—in the context of Medicare Advantage—the federal government have experience developing tailored quantitative standards that serve as benchmarks for assessing network adequacy in diverse settings.

*Compliance and enforcement*

While the questions of whether and on what basis to establish quantifiable metrics for network adequacy have absorbed significant attention, these are, to some degree, threshold issues. However regulators and policy makers decide to resolve them, they still must consider other, equally important questions about how to apply and enforce their chosen framework. For example, what circumstances should trigger regulatory review of a plan's network? What information will regulators use to assess compliance with applicable standards? And what role will the insurer play in facilitating an adequacy determination?

Proactive oversight of network rules, whatever their content, can be a complex and resource-intensive process. It is partly for this reason that many states depend on self-reporting by insurers or accreditation determinations by outside organizations, and why fairly few states conduct regular reviews of plan networks after their initial creation.

State efforts to assess compliance on an ongoing basis instead have relied heavily on consumer complaints. A 2014 survey of state departments of insurance found complaint data was the primary tool used by regulators to monitor network adequacy, with consumer feedback "highly value[d]" and tracked, with varying degrees of detail, by almost all respondents.

Most agree that an oversight approach should be attuned to consumers' actual experiences with their networks. Yet complaints, on their own, might be of limited utility in evaluating adequacy, given that many consumers do not understand their right to complain and do not know who they should complain to. A recent *Consumer Reports* survey found that

87 percent of Americans were unaware of what agency or department in their state is tasked with handling health insurance complaints and that 83 percent have never complained to a government agency about any issue.

As part of the yearly certification process for Marketplace health plans on the federally facilitated Marketplace, CMS has required insurers to submit progressively more network data to demonstrate they meet federal adequacy requirements. Although this federal review remains focused on the certification stage, officials note they continue to monitor network sufficiency throughout the plan year.

Recent policy making at the state level has also tended to emphasize oversight. In 2014 at least half a dozen states acted to bolster the ability of regulators to monitor and enforce network standards. California, for example, enacted legislation that requires regulators to perform annual reviews of plans' compliance with state standards and to post their findings, including any waivers or alternative standards that regulators approved, online.

*Network transparency*

The value proposition of networks—particularly narrow ones—is in large part dependent on consumers understanding how they work. Thus, there is broad agreement, in principle, that network designs should be transparent and that provider directories must be accurate and up-to-date. Nevertheless, the reliability of directories has long been a problem, and until recently, little effort has gone into developing formal and consistent definitions of network breadth.

Focus on these issues has increased, however. Consumer advocates have been vocal in calling for uniform standards for the content and format of directories and specific requirements regarding how frequently they must be updated. These proposals have found a receptive audience among federal officials—who, as noted above, have tightened provider directory requirements for qualified health plans and have introduced a system for characterizing the network breadth of plans sold on the federally facilitated Marketplace—and the states, approximately a dozen of which have strengthened their disclosure rules since 2014.

As with other aspects of network adequacy regulation, much of the debate about directories concerns mechanisms for securing compliance with standards and ramifications when errors occur. Insurers argue that plans and providers have a shared responsibility for ensuring that directories are accurate and have sought to facilitate timely reporting by providers of changes to their network participation and other practice data. Consumer groups and providers have suggested other proactive efforts that insurers should take to promote the reliability of directories, including establishing a process for the public to report inaccuracies, conducting periodic audits of a sample of their provider lists, and contacting providers who have not submitted claims for a period of time. These provisions were all included in legislation recently enacted in Georgia. The new Georgia statute also contains a protection, supported by consumer groups, under which enrollees might be shielded from out-of-network cost sharing if they received out-of-network care after relying on materially inaccurate information in the insurer's provider directory.

*A model law?*

In response to the proliferation of managed care plans in the late 1980s and early 1990s, the National Association of Insurance Commissioners (NAIC) developed a model law for states to use as a foundation when considering legislation to regulate network adequacy. Adopted in 1996, the Managed Care Plan Network Adequacy Model Act (now known as the Health Benefit Plan Network Access and Adequacy Model Act) endorsed a qualitative standard for judging network sufficiency that resembles those used by many states and that served as a template for the current federal network adequacy regulation for qualified health plans.

As network issues have gained renewed prominence, the NAIC determined to modernize the model law. After more than a year of discussions among regulators and with extensive input from a range of stakeholders and consumer groups, the NAIC unanimously adopted a substantially revised version of the model in late 2015.

The new model act contains numerous provisions, as well as "drafting notes" that provide states guidance and options for determining the regulatory course that suits their needs. Among its key components, the model law:

- Continues to define network adequacy qualitatively. However, the act makes explicit that state insurance departments, and not the health plan itself, must determine whether the

plan's network is sufficient. Drafting notes also suggest that states might consider establishing quantitative standards for adequacy, either through law or by regulation.

- Requires plans to provide regulators with additional details about their networks. This includes the factors used to build each network and the efforts made by the plan to address the needs of enrollees—including but not limited to children and adults; those with limited English proficiency or illiteracy; those with diverse cultural or ethnic backgrounds; and those with physical or mental disabilities and serious, chronic, or complex medical conditions.

- Sets new standards for provider directories. Provider lists must be updated monthly and contain descriptive information including consumer-friendly language explaining how providers were selected and, if applicable, the criteria the plan used to tier providers and the tier of each provider. The model act also requires insurers to periodically audit their directories and provide the public with a mechanism for reporting inaccuracies.

## WHAT'S NEXT?

All indications suggest plans with limited networks will persist on and off of the ACA's Marketplaces, and with them, debate over their value and risks. Likewise, policy makers and regulators likely will continue to devote attention to determining whether current network adequacy rules meet the needs of consumers and stakeholders and, if not, how they should be modified.

Since the launch of the Marketplaces in 2014, more than a dozen states have chosen to act. Most made modest revisions to existing regulatory frameworks; some departed significantly from their old approaches—to bolster regulators' oversight and rulemaking authority (for example, Oregon) or to add substantial new quantitative requirements (for example, Washington State) or directory standards (for example, Georgia and Maryland).

With the approval, in November 2015, of its network adequacy model act, the NAIC committed to prioritize adoption of the model by a majority of states within three years. By mid-2016 few state legislatures had introduced, let alone advanced, a bill based on the model. The pace of legislative action might accelerate next year, with more time having elapsed to digest Marketplace developments—and the model law itself. For the NAIC's goal of rapid and widespread adoption to be realized, it will need to.

Should state interest in the model act instead remain limited, the likelihood that federal regulators take their own steps to strengthen network requirements for Marketplace plans will increase. Federal officials already use quantitative standards to evaluate the networks of Medicare Advantage plans and have issued regulations requiring numeric measures for the Medicaid managed care market beginning in 2018. The primary explanation given by CMS for declining to finalize its proposal requiring quantitative standards for qualified health plans was that, with passage of the model act, states should have time to adopt its provisions. If most states ultimately decline to implement the model, the focus will shift to CMS to revisit, as it has promised, this thorny issue. ■

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