Washington Healthcare News®

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Network Adequacy Laws - Only as Good as Their Enforcement

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"Network adequacy" is one of those soulless terms used in the health care industry that does not convey how critically important the stakes are for patients and providers. Although Washington's Office of the Insurance Commissioner (OIC) has long been concerned with inadequate networks, the Affordable Care Act (ACA) of 2010 greatly increased the need for vigorously enforced network adequacy laws.

Increasing the number of insureds would result in a corresponding increase in demand for providers' services. Hence, the ACA included a provision requiring insurers to maintain an "adequate network," one large enough to ensure patients have access to a sufficiently broad range of providers and can obtain appointments within a reasonable time.[1]

But "reasonable times" and "sufficient providers" are vague terms, open to competing and selfserving interpretations. Network adequacy is generally overseen by state insurance commissioners. To assist commissioners and states to define "reasonable times," "sufficient providers," and what generally constitutes an adequate network, the National Association of Insurance Commissioners released a Network Adequacy Model Act.[2] The OIC revamped Washington State's network adequacy rules last year, adding concrete distance standards, establishing provider ratios for primary care providers, and defining allowable wait times.[3] These rules apply to all health insurance plans issued in Washington State, not just ACA plans. This article examines some of the new rules, which rely on OIC enforcement to be meaningful.

Legally defining an adequate network becomes especially critical to patients as insurance carriers narrow networks. Carriers are promoting various narrow networks, including "high quality" networks comprised of selected providers and tiered networks in which the carrier reimburses more and insureds pay less for allegedly low-cost providers, and carriers reimburse less and insureds pay more for allegedly high-cost providers. In plan year 2015, 45 percent of all U.S. exchange networks were comprised of narrow network plans and tiered plans.[4]

Consumers, likely unaware of the economic risks they face with a narrow network, are drawn to these plans due to the lower premiums. In 2014, such plans accounted for approximately 70% of all health plan sales.[5] However, a recent study of 135 ACA "silver" plans sold in 34 state marketplaces raises concerns that a number of these networks are so narrow they are inadequate.[6] In fact, almost 15 percent of the plans failed to include an in-network physician for at least one specialty.[7] The plans spanned the country and included rural and urban areas. Under such plans, consumers are burdened with paying anywhere from 50 percent to the full cost of out-of-network care.

Carriers can use a network to cost-shift to consumers who may be shocked to discover their plan's provider list is much smaller than anticipated. At some hospitals and clinics, consumers are at risk of receiving significant

out-of-network bills when they unknowingly receive care from an out-of-network provider, such as a radiologist, anesthesiologist, or pathologist, working within an in-network hospital or clinic. Patients mistakenly assume that if the clinic or hospital is in-network, other providers caring for them there are also in-network. Since they rarely know beforehand who will provide ancillary services, they lack the ability to make informed provider choices and face being balance-billed.

Carriers have great freedom in devising networks, but ultimately, networks are supposed to be adequate. If an insurer fails to maintain an adequate provider network, the OIC can find the network deficient and compel the insurer to hold harmless patients who face additional out-of-network costs such as higher co-payments and co-insurance when they seek covered services. It appears the OIC has not taken such actions since adopting its revised rules in April, 2014.

During the public comment period to the new rules, the OIC received multiple comments expressing concerns about balance billing, some indicating it "is a symptom of an inadequate network and is unfair to patients."[8] The Commissioner stated his "authority to regulate balance billing is limited to situations where an enrollee receives care from an out-of-network provider," and that the new rules attempt to limit situations where it might occur.[9]

Of concern is the circumstance in which a previously adequate network becomes inadequate because a carrier terminates its relationship with a key provider. Insurers are obliged to ensure that access for patients remains uninterrupted, at no greater cost to patients than they would have incurred had the providers remained in network, or make other arrangements acceptable to the Commissioner.

Providers risk exclusion and economic harm from narrow networks, which can harm consumers. Academic medical centers and specialty providers, such as cancer centers and children's hospitals, are sometimes left out of a network entirely or moved to the tier with the lowest reimbursement rate. In-network providers can be intimidated by the threat of termination if they balk at reduced reimbursement rates.

When a payor terminates a key provider from a network for failing to accept a low reimbursement rate, there is a real concern as to whether the network is still "adequate."[10] If the carrier wants to claim it can provide enrollees alternate access to a similar provider, it must file with the OIC maps that show the identity and location of the in-network providers. In addition, the carrier is required to provide "substantial evidence of good faith efforts on its part to contract."[11] "Good faith efforts" has not yet been defined by the courts, but the Commissioner thinks the minimum would include contract offer dates and a record of the communications between the issuer and provider, including a list of the disputed terms and quantification of the extent to which the parties disagree.[12] If the carrier offered no contract, it is required to submit specific documentation explaining why.[13] The Commissioner decided that "the rules are not intended to arbitrate whether a particular provider…should be included in a network," leaving it to his discretion whether to consider rebuttal information from providers.[14] The Commissioner must decide whether the carrier terminating the provider rendered the network inadequate, which will indirectly impact payor-provider negotiations.

In sum, network adequacy protections are only as effective as their enforcement, especially in Washington State where one or two commercial insurers dominate. Network adequacy laws must be applied diligently as provider networks narrow since the design of a provider network can threaten consumers' and providers' interests. The value of our network adequacy law rests on the prospect of OIC involvement. Whether the OIC will champion consumer rights and robustly enforce network adequacy laws is an unanswered question.

[1] 45 CFR § 156.230.
[2] http://www.naic.org/.
[3] WAC 284-43-200.
[4] Noam Bauman & Jason Bello, et al., Hospital networks: Evolution of the configurations on the 2015 exchanges, McKinsey on Healthcare, April 2015, http://healthcare.mckinsey.com/2015-hospital-networks.
[5] http://kff.org/health-reform/poll-finding/kaiser-health-tracking-poll-february-2014/.
[6] Stephen Dorner, Adequacy of outpatient specialty care access in marketplace plans under the Affordable Care Act, Journal of the American Medical Association, October 27, 2015.
[7] *Id.*
[8] Concise Explanatory Statement, at 10.
[9] *Id.*
[10] WAC 284-43-200(5).
[11] *Id.*
[12] Concise Explanatory Statement, at 16.
[13] *Id.*
[14] Concise Explanatory Statement, at 17.