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# Is Federal Regulation the Greatest Obstacle Facing Narrow Network Exchange Plans?

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Among the health care provider networks being offered by qualified health plan (QHP) insurers or "issuers" on the health insurance exchanges (referred to as exchanges or marketplaces) created under the Patient Protection and Affordable Care Act (ACA), narrow provider networks have been the most popular offering.[1] In fact, the exchanges are full of these narrow networks. Narrow networks offer a limited number of health care providers and often include only a minority of the major health systems within a particular service area. One report found that these narrow networks make up 70% of all the networks offered by QHPs, meaning that the vast majority of networks exclude 30%-85% of the largest 20 hospitals within a 50-mile geographic area.[2] As noted in the report, not only do these narrow networks appear to satisfy the federal network adequacy requirements, but they also correlate with lower premiums.[3]

Narrow networks are facing various challenges on multiple fronts, including by providers excluded from narrow networks, patients whose providers have been excluded, and some state legislatures. However, as the dust from these challenges has begun to settle in recent weeks, it appears that the mostly likely obstacle to narrow networks as they exist today is coming from the primary federal regulator of these networks, the Centers for Medicare & Medicaid Services (CMS). CMS recently issued a proposal to change its own network adequacy review standards to give itself a more flexible and expanded role in the review of QHP networks. As discussed further below, while private and state efforts to challenge narrow networks appear unlikely to result in material changes, the CMS policy could potentially have a major impact.

**Existing CMS Policy's Deference to State Insurance Department and Accrediting Organization Network Adequacy Review Standards**

CMS' current policy on QHP network adequacy generally is to defer to the network adequacy standards and findings of states and accrediting organizations. For the current plan year 2014, a QHP issuer must ensure that the provider network of each of its QHPs meets all of the following standards:

- First, it must include essential community providers (ECPs).[4] ECPs are providers that serve predominantly low-income, medically underserved individuals.[5] QHP issuers must have a "sufficient number and geographic distribution of [ECPs], where available, to ensure reasonable and timely access to a broad range of such providers" for its members.[6] No QHP issuer is required to contract with any ECP that "refuses to accept the generally applicable payment rates" of the QHP issuer.[7]
- Second, it 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.[8]
- Third, it must be consistent with the network adequacy provisions of Section 2702(c) of the Public Health Service Act that govern certain circumstances when an issuer may deny coverage.[9]

With respect to the first standard for ECP inclusion, CMS created a "safe harbor" standard for a QHP network where CMS will not challenge the adequacy of a network if the network includes 20% of ECPs in its service area.[10] However, under CMS' alternative minimum expectation standard, a network may include as few as 10% of ECPs in its service area if it provides an acceptable justification to CMS.[11]

In *Federal Register* preamble commentary regarding the network adequacy rule, CMS disclosed that it was only establishing "minimum" standards.[12] It believed that its standards would avoid limiting an exchange's ability to establish more "rigorous" standards for network adequacy.[13] Further, it saw its rules as striking a balance between consumer access and "the historical flexibility and responsibility given to States in this area."[14]

While CMS agreed with comments it received that QHP networks should provide access to "a range of health care providers," CMS instead sought to ensure access to the "full range of covered services" or essential health benefits.[15] Still, CMS "urged" states to develop network adequacy standards that identified the provider types that are essential in a state.[16]

To carry out this policy, where a state has sufficient network adequacy review laws, CMS evaluates a QHP network by relying on the state's analysis and recommendation.[17] For states without sufficient network adequacy laws, CMS relies on an issuer's accreditation

(commercial or Medicaid) from an approved accrediting entity.[18] In those states, if the issuer is not accredited, CMS requires the submission of a network access plan.[19] Overall, this policy has served to limit the need for CMS to make independent network adequacy determinations through its deference to decisions made by states and accrediting organizations.

**Provider Challenges to State Insurance Department Approvals of Narrow Networks**

While at least one hospital has initiated a lawsuit in response to its exclusion from QHP networks,[20] the primary mechanism providers are using to challenge their exclusions has been the administrative hearing processes of state insurance departments. This is the case in Washington and New Hampshire where two hospitals have survived the initial efforts by the state insurance department and QHP issuers to have their petitions for hearings dismissed.

*Seattle Children's Hospital*

In Washington the pediatric hospital, Seattle Children's Hospital (SCH), initially found itself excluded from four QHP networks. While SCH first filed a lawsuit against the Washington Office of the Insurance Commissioner (OIC),[21] it has since shifted its focus to the OIC's administrative hearing process.[22]

On February 20, 2014, the OIC Hearings Unit issued orders favorable to SCH allowing it to survive separate motions to dismiss by the OIC and the QHP issuers who intervened in the hearing.[23] The orders made two initial findings. First, they found that SCH had standing as an "aggrieved" person who was entitled to the hearings because it was a provider whose exclusion from the QHP networks may have been a result of the OIC's alleged failure to follow Washington law in approving the networks. As noted by the Hearings Unit, the OIC did not dispute this point.[24]

Second, the orders also rejected the OIC and QHP issuers' arguments that SCH's claims were not justiciable. The OIC and the QHP issuers characterized SCH's challenge as an attempt to force the QHP issuers to resolve private contracting and pricing disputes in SCH's favor and on its terms. According to the OIC, SCH was using the OIC hearing process "to coerce carriers into entering all or nothing tying contracts with reimbursement rates for routine services dictated by [SCH] at levels that far exceed competitive rates."[25] One QHP issuer echoed this concern, claiming that SCH would only accept "full commercial rates," which the issuer characterized as "the highest payment rates available."[26] In such case, they argued that the issue was not justiciable and should be dismissed.[27]

Although the Hearings Unit agreed that they "may be correct" that it has no jurisdiction "to force any health carrier to contract with any particular provider,"[28] it disagreed with their characterization of SCH's claims. Instead, it concluded that

> contrary to the OIC's characterization of the issue, SCH's Demand challenges the validity of the [OIC] Commissioner's actions in approving the Exchange filings and is not asking that these three carriers be forced to contract with SCH. Therefore, the OIC's argument here is without merit.[29]

The OIC also argued that the Hearings Unit could provide "no final, conclusive or effective remedy for [SCH's] alleged injury."[30] The Hearings Unit acknowledged that the remedy was uncertain. However, its primary concern appears to be not rectifying any existing injury but preventing a future one, concluding:

> while what remedy can be had remains for a decision after the merits of the case are presented and considered, it should be noted that as a practical and legal matter it is likely that this same issue will arise again in a few short months when the Exchange plans are under consideration for renewal.[31]

Therefore, after finding that SCH's claims have a proper basis and that a remedy is possible even if uncertain at this point, the Hearings Unit concluded that SCH's claims are justiciable. The Hearings Unit will now move beyond these procedural considerations and hear the merits of SCH's claims.

*Frisbie Memorial Hospital*

In New Hampshire, Frisbie Memorial Hospital (FMH) also initiated an administrative hearing to challenge its exclusion from Anthem Blue Cross Blue Shield's (Anthem) QHP networks.[32] Initially, the appeal appeared to be a road map for what providers should not argue. The hospital alleged that it was aggrieved by the New Hampshire Department of Insurance (DOI) "because it has been excluded, without notice or an opportunity to participate, in the networks available" under the QHPs offered on the exchange.[33] The Insurance Commissioner noted that FMH did not "allege that the [QHP] network does not meet [New Hampshire's network adequacy standards]; rather, [FMH's] claims focus on the fact that the [QHP issuer] did not include a specific provider . . . in the provider network for its Marketplace plans."[34] Given this alleged injury, the Commissioner concluded,

> Even if the [DOI's] network adequacy review violated the Insurance Code in some substantive respect (which Petitioners do not allege, other than their allegation that the [DOI] did not conduct a hearing, which the Code does not require), the

> [DOI] has no authority to order Anthem to contract with any particular provider.[35]

Even if FMH could provide that the QHP network was "inadequate" under New Hampshire's network adequacy standards, the Commissioner concluded that "the only remedy within the [DOI's] authority would be to order Anthem to address any deficiencies by contracting with additional providers. These additional providers would not necessarily include [FMH]."[36]

Unlike SCH in Washington, FMH was joined in its challenge by a patient. The patient alleged that she would have to change medical providers if she chose to purchase Anthem's coverage through the exchange.[37] As with FMH's alleged harm, the Commissioner dismissed this harm as being "beyond the purview of the [DOI's] regulatory authority."[38]

After reviewing the claims, the Commissioner concluded,

> In sum, both Petitioners lack standing because they have alleged no harm that a decision of the [DOI] could remedy. There is no legal authority that would allow the [DOI] to grant their requested relief of ordering Anthem to contract with Petitioner [FMH]. It would serve no purpose, and waste both agency and judicial resources, to allow an appeal of any agency decision when the agency does not have the power to grant the requested relief.[39]

As a result, the Commissioner concluded that neither petitioner was "aggrieved" and found that the DOI was not required to hold an adjudicative hearing on the matter.[40]

> Despite this setback, FMH and its patient filed a motion for a rehearing, in which they alleged that Anthem's QHPs do not meet the state network adequacy standards.[41] Even though the Commissioner disagreed that the original Petition contained this allegation, the Commissioner concluded that it would permit them the opportunity to make further arguments and factual assertions regarding the issue of standing "in the interest of procedural fairness."[42]

Therefore, FMH and its patient have received a second chance to challenge Anthem's QHP network. While the Commissioner has yet to issue an order on the petitioners' supplemental filing concerning their standing, it is clear that they have now brought their alleged harms in line with those alleged in Washington by SCH.[43] Rather than focusing on alleged harms to themselves, the petitioners have narrowed their argument to the alleged inadequacy of Anthem's QHP network under New Hampshire law. Nevertheless, given that the New Hampshire Commissioner (as quoted above) has already made clear that the "only remedy" would be to order Anthem to address deficiencies in its network

by contracting with additional providers, who may not necessarily include FMH, it seems unlikely that the Commissioner would issue a finding that would materially impact narrow network in the state.

*Implications of State Insurance Department Administrative Hearings for Narrow Networks*

Once the administrative hearings initiated by SCH and FMH come to an end, the Washington OIC and the New Hampshire DOI may each find that a QHP network was inadequate under a state network adequacy law. That finding could lead to the inclusion of SCH or FMH in one or more QHP networks. Still, questions will remain as to the implication of these hearings for narrow networks overall heading into the QHP certification applications for plan year 2015. After all, the reason one of the networks may be inadequate could be the amount of distance a covered member might need to travel for health care. It could be that no contracted provider provides a particular service that the state insurance department wants to see within the capability of the contracted network. In either case, the state insurance department would not be acting to prohibit narrow networks but to help define the limits as to how narrow a network may be. Therefore, regardless of the outcomes of these administrative hearings, it would appear they pose no significant obstacle to the continued viability of narrow networks.

**State Legislatures Rejecting Laws Cracking Down on Narrow Networks**

*Any Willing Provider Laws*

In response to the popularity of narrow network QHPs, a number of states have considered legislation proposing laws referred to as “any willing provider” or “AWP” laws. These states include Mississippi, New Hampshire, Pennsylvania, and South Dakota.

AWP laws vary but generally require an insurer to contract with certain classes of providers who are willing to accept an insurer’s baseline terms and conditions, including rates. In New Hampshire, the proposed AWP law would have required insurers participating in the exchange to negotiate in “good faith” with any willing provider to participate in its exchange network.[44] Mississippi and South Dakota proposed comparable laws that would have required insurers to contract with any provider who is located within the geographic coverage area of the plan and is willing to meet the terms and conditions of participation established by the plan.[45] Pennsylvania proposed a law similar to Mississippi and South Dakota but included an exception from the law in the case of products that compensated providers on a capitated basis or under which providers accept significant financial risk in a formal arrangement approved by federal or state authorities.[46] In each case, however, the legislation has failed or appears to be

stalling; although, in South Dakota, the failed legislation will appear among the measures on the 2014 voting ballot.[47]

*Network Disclosure Laws*

While a number of states have considered AWP laws, Maine proposed a law purporting to increase narrow network transparency by requiring upfront disclosures regarding participating providers.[48] The legislation has been in committee since December 23, 2013.

**Proposed CMS Policy for QHP Network Adequacy Review Standards for Plan Year 2015**

In its "Draft 2015 Letter to Issuers in the Federally-facilitated Marketplaces,"[49] CMS is proposing major changes to its current policy, as summarized above, for reviewing the adequacy of QHP networks. Unlike the 2014 plan year QHP certification process, CMS would abandon its use of an issuer's accreditation status, its deference to states with network adequacy review processes as stringent as the standard established by federal law, and its collection of network access plans when evaluating a QHP's network adequacy.[50] Instead, for the 2015 plan year, CMS wants issuers to submit a provider list that includes "all in-network providers and facilities for all plans for which a QHP certification application is submitted."[51] In reviewing the provider list, CMS now intends to use a "reasonable access" review standard.[52]

While this "reasonable access" review standard is not clearly defined in the draft letter, the goal of the standard appears to be to identify networks "that fail to provide access without unreasonable delay."[53] The focus of the review will be on "those areas which have historically raised network adequacy concerns," such as hospital systems, mental health providers, oncology providers, and primary care providers.[54]

Further guidance from CMS on this new review standard will be forthcoming. However, it appears intended to move CMS away from its existing policy of deferring to state insurance departments and accrediting organizations. CMS instead would have the flexibility to identify those providers it believes should be included in a network and to take action accordingly.

The federal policy on network adequacy is not the only change CMS is proposing that could directly impact QHP networks. CMS has also proposed changes to the ECP standards. For example, CMS has proposed to raise the safe harbor to 30% and to eliminate the minimum expectation standard.[55] Nevertheless, CMS does not expect this ECP policy change to impact QHP certification applications. Despite the plethora of

narrow QHP networks, CMS noted that only one QHP issuer submitted a justification for relying on the minimum expectation standard.[56]

**Future of Narrow Network Exchange Plans**

At least in the near future, neither state legislatures nor state insurance departments appear to pose a significant obstacle to narrow networks as they exist today. Relevant proposed legislation that would be adverse to existing narrow networks has failed or appears to be stalling. Ongoing state insurance departments' administrative hearing processes are in their early stages but appear unlikely to take a position that would materially undermine the offering of narrow networks QHPs.

Rather, the most likely threat to narrow networks appears to be coming from CMS. While the recent CMS draft letter to QHP issuers does not expressly reference narrow networks, CMS is most certainly aware of the issue.[57] It remains to be seen whether CMS' newly proposed "reasonable access" review standard for network adequacy will lead to significantly broader networks, result in no material changes to existing networks, or create a situation where CMS will continue to accept narrow networks but require networks to add providers on a case-by-case basis. The final option would appear to be administratively burdensome for CMS. Further, CMS will need to weigh the impact that broader networks will have on insurance premiums given the correlation between narrow networks and lower, more affordable premiums. Regardless, in proposing a policy to move away from its current deference to the network adequacy findings of states and accrediting organizations, CMS is positioning itself to exert greater influence on who will be included in QHP narrow networks going forward.

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[1] McKinsey&Company, "Hospital Networks: Configurations on the Exchanges and Their Impact on Premiums" (Dec. 14, 2013), *available here.*

[2] *Id.* at 1.

[3] *Id.* at 2.

[4] 45 C.F.R. § 156.230(a)(1).

[5] 45 C.F.R. § 156.235(a)(1).

[6] *Id.*

[7] 45 C.F.R. § 156.235(d).

[8] 45 C.F.R. § 156.230(a)(2).

[9] 45 C.F.R. § 156.230(a)(3).

[10] CMS, "Letter to Issuers on Federally-facilitated and State Partnership Exchanges," at 7 (Apr. 5, 2013).

[11] CMS, "Letter to Issuers on Federally-facilitated and State Partnership Exchanges" at 7 (Apr. 5, 2013).

[12] 77 Fed. Reg. 18309, 18419 (Mar. 27, 2012).

[13] *Id.*

[14] *Id.*

[15] *Id.*

[16] *Id.*

[17] CMS, "Letter to Issuers on Federally-facilitated and State Partnership Exchanges" at 6 (Apr. 5, 2013).

[18] *Id.*

[19] *Id.*

[20] Seattle Children's Hospital vs. Office of the Insurance Commissioner of the State of Washington, No. 13-2-34827-6 SEA, Petition for Judicial Review (Sup. Ct. Wash. Oct. 4, 2013).

[21] *Id.*

[22] Demand for Hearing, In re Demand of Seattle Children's Hosp., No. 13-0293 (Oct. 22, 2013).

[23] Order on Intervenors' Motion for Summary Judgment, In re Demand of Seattle Children's Hosp., No. 13-0293 (Feb. 20, 2014); Order on OIC's Motion to Dismiss, In re Demand of Seattle Children's Hosp., No. 13-0293 (Feb. 20, 2014).

[24] Order on OIC's Motion to Dismiss, In re Demand of Seattle Children's Hosp., No. 13-0293, at 4 (Feb. 20, 2014).

[25] OIC Staff's Motion to Dismiss Demand for Hearing and to Terminate Adjudicative Proceeding, In re Demand of Seattle Children's Hosp., No. 13-0293, at 12 (Jan. 15, 2014).

[26] Intervenors' Joint Motion for Summary Judgment, In re Demand of Seattle Children's Hosp., No. 13-0293, at 8 (Jan. 17, 2014).

[27] *Id.* at 1.

[28] Order on OIC's Motion to Dismiss, In re Demand of Seattle Children's Hosp., No. 13-0293, at 7 (Feb. 20, 2014).

[29] *Id.*

[30] *Id.*

[31] *Id.* at 8.

[32] Petition for Hearing, In re Petition of Frisbie Memorial Hospital, et al., INS No 13-038-AR (Nov. 6, 2013).

[33] *Id.* at 5.

[34] Order, In re Petition of Frisbie Memorial Hospital, et al., INS No 13-038-AR at 5 (Dec. 12, 2013).

[35] *Id.* at 7.

[36] *Id.*

[37] *Id.* at 5.

[38] *Id.* at 8.

[39] *Id.*

[40] *Id.* at 9.

[41] Petitioners' Request for Rehearing, In re Petition of Frisbie Memorial Hospital, et al., INS No 13-038-AR (Jan. 10, 2014).

[42] Ruling on Request for Rehearing, In re Petition of Frisbie Memorial Hospital, et al., INS No 13-038-AR (Jan. 17, 2014).

[43] Petitioners' Supplemental Filing Concerning Standing, In re Petition of Frisbie Memorial Hospital, et al., INS No 13-038-AR (Feb. 18, 2014).

[44] N.H. House Bill 1294 (2014).

[45] M.S. Senate Bill 2709 (2014); S.D. House Bill 1142(2013).

[46] P.A. House Bill 222 (2013).

[47] *See* http://ballotpedia.org/South_Dakota_Insurance_Provider_Measure_%282014).

[48] M.E. LD 1629, SP 620.

[49] CMS, Draft 2015 Letter to Issuers in the Federally-facilitated Marketplaces (Feb. 4, 2014).

[50] *Id.* at 19.

[51] *Id.*

[52] *Id.*

[53] *Id.*

[54] *Id.*

[55] *Id.* at 21.

[56] *Id.*

[57] *See, e.g.,* Letter to K. Sebelius, Secretary, U.S. Dept. of Health and Human Services, from M. Cooke, M.D., President, American College of Physicians (Feb. 11, 2014).


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