Narrow Networks: The Need for Enhanced Guidelines and Transparency

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I. INTRODUCTION

The Patient Protection and Affordable Care Act of 2010 (The Affordable Care Act, or ACA) provides for establishing Health Benefit Exchanges that offer health plans to individuals and employers.\(^1\) These exchanges, now called “marketplaces,” are available in every state, either through a state or federally operated marketplace.\(^2\) Health insurance marketplaces offer five categories of plans: Bronze, Silver, Gold, Platinum, and Catastrophic.\(^3\) While marketplace plans must have “adequate provider networks” in place, in practice this term is open to varying interpretations.\(^4\)

Current research indicates that while most marketplace consumers are satisfied with their coverage, some have responded negatively to their new plans limiting their access to a relatively small number of providers, including hospitals and doctors.\(^5\) This limitation is referred to as a “narrow net-

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\(^2\) Id. §1321 of the ACA provides that if a State does not elect to operate its own exchange, or has not taken steps necessary to implement its exchange, the Secretary of the Department of Health and Human Services shall establish and operate the exchange within the state. Id. § 18041 (West, WestlawNext through Pub. L. No 113-163 (excluding Pub. L. No. 113-128) approved Aug. 8, 2014).


\(^5\) Id.
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work. While the ACA does not mandate narrow networks, it does promote competition among insurers. Faced with more limited cost-control options, insurers turned to narrow networks as a competitive solution. To compete on price, insurance companies will control the costs of their customers’ care by contracting selectively with doctors and hospitals that charge less.

Despite their potential for cost-containment, narrow networks may leave consumers disappointed when they are no longer able to see their regular doctor or when newly insured individuals face limited choices. In 2009, almost a year before he signed the ACA into law, President Obama addressed the American Medical Association. In his speech, the President promised, “If you like your doctor, you will be able to keep your doctor, period.” After the ACA was passed and implementation began, consumers began to learn that this promise was a qualified one. In response to regulations guiding insurers, many insurers made changes to their plan benefits, meaning that the plan was no longer “grandfathered.” As consumers were moved to new plans, they were not, in fact, always able to keep their doctors. Unfortunately, barely a quarter of marketplace customers knew the scope of the network they were enrolling in when they signed up for cover-

6. Id.
8. Id.
9. Id.
10. See Long Engelhard, *supra* note 4 (discussing narrow networks as one of the least expensive and limited plans in the marketplace).
12. Id.
This sparked debate as to whether a connection exists between the cost of health care and the quality of a provider, resulting in actions such as lawsuits brought over adequate coverage and state actions.

This article begins by reviewing the ACA and related requirements for health plans participating in the marketplace, including requirements for their provider networks, before exploring the ACA’s role in the return of the narrow provider network. This article then explores the resulting state and federal response to the narrow network backlash and ultimately concludes that although the ACA calls for increased transparency from insurers, network scope remains opaque for many consumers. Until insurance companies provide greater transparency on their networks, consumer satisfaction will suffer and litigation and regulatory involvement will continue.

II. THE PATIENT PROTECTION AND AFFORDABLE CARE ACT OF 2010

President Obama signed the Affordable Care Act into law on March 23, 2010. A sweeping and interdependent legislative pastiche, the ACA created various health insurance reforms that would “roll out” over a minimum

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15. See Kessler, supra note 13 (reporting that many people were receiving notices that their old plan was cancelled because it did not meet the expected requirements).


Key features of the legislation included consumer protections, access to insurance for uninsured Americans with pre-existing conditions, and the creation of a health insurance marketplace. Originally dubbed “Health Benefit Exchanges” in the ACA, marketplaces exist in every state, either through a state or federally operated marketplace.

III. PLAN REQUIREMENTS AND THE MEANING OF “ADEQUATE”

The ACA requires that insurers cover a set of ten essential health benefit (EHB) categories, which they must offer within the actuarial value limits of the various plan levels. In addition, federal regulation requires that insurers provide an adequate provider network to their consumers. The Centers for Medicare & Medicaid Services’ (CMS) Center for Consumer Information and Insurance Oversight (CCIIO) stated that network adequacy standards are designed to provide a “basic level of consumer protection”

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21. Id.; see also Sara Rosenbaum, The QHP Certification Process in Federally-Facilitated Exchanges: Network Adequacy and Essential Community Providers, HEALTHREFORMGPS (Mar. 27, 2013), http://www.healthreformgps.org/resources/the-qhp-certification-process-in-federally-facilitated-exchanges-network-adequacy-and-essential-community-providers/ (describing the ACA’s insurance reforms, including, but not limited to, a bar on annual and lifetime limits on coverage; a ban on unjustified rescissions and on discriminatory premiums that address variables other than age, use of tobacco, family status and geographic rating area; coverage for young adults up to age 26; and appeals procedures).
23. Id.
24. See 45 C.F.R. § 156.135 (2014) (describing the actuarial value calculation for determining the level of coverage).
25. 42 U.S.C.A. § 18022; David Cusano & Amy Thomas, Narrow Networks Under The ACA: Financial Drivers and Implementation Strategies, HEALTHAFFAIRS BLOG (Feb. 17, 2014), http://healthaffairs.org/blog/2014/02/17/narrow-networks-under-the-aca-financial-drivers-and-implementation-strategies/; U.S. Ctrs. for Medicare & Medicaid Servs., Essential Health Benefits, HEALTHCARE.GOV, https://www.healthcare.gov/glossary/essential-health-benefits/ (last visited Oct. 1, 2014). EHB include items and services for ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care. Id.
26. See 45 C.F.R. § 156.230 (setting forth the network adequacy standards).
while still allowing Qualified Health Plan (QHP) issuers to compete for business.\textsuperscript{27} CMS emphasized its intent to avoid duplicating a state review and acknowledged that if network adequacy is part of a state’s issuer license review, the federal process will rely on state review and recommendations.\textsuperscript{28} In an effort to leave states as much flexibility as possible, the U.S. Department of Health and Human Services (HHS) only incrementally provided guidance on what constitutes an adequate network.\textsuperscript{29} 

When first proposing regulations that would establish the marketplace, HHS described an adequate network as one that provides a “sufficient choice of providers.”\textsuperscript{30} Current regulations go further, requiring that QHPs include essential community providers\textsuperscript{31} in their network and “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.”\textsuperscript{32} In addition, regulations also require a QHP issuer make its QHP provider directory available to the exchange for online publication and to potential enrollees in hard copy upon request.\textsuperscript{33}

IV. THE RETURN OF THE NARROW PROVIDER NETWORK

Implementation of the health insurance marketplace in 2014 left many


\textsuperscript{28} Rosenbaum, supra note 21.


\textsuperscript{31} See 45 C.F.R. § 156.235 (providing that Essential Community Providers are those that serve predominantly low-income, medically underserved individuals).

\textsuperscript{32} \textit{Id.} § 156.230.

\textsuperscript{33} \textit{Id.}
consumers happy with their coverage, but left others angry that their new plans limited their access to a relatively smaller number of providers.\textsuperscript{34} This limitation is referred to as a “narrow network.”\textsuperscript{35} Narrow networks are health insurance plans that limit the providers that are available to subscribers.\textsuperscript{36} An insurer can create a narrow network with two approaches: (1) by not paying at all if a subscriber visits a doctor outside of the narrow network; or (2) by charging a higher co-pay to see an out-of-network doctor.\textsuperscript{37}

Narrow networks are nothing new. They are, in fact, something of a retrospective, first emerging in the early 1990s when managed care organizations employed them to control spending.\textsuperscript{38} Although they proved unpopular and insurers moved back to broader networks,\textsuperscript{39} they have returned with employer-based health insurance.\textsuperscript{40} As employers strived to control health insurance costs, narrow network plans expanded from fifteen percent of employer insurance plans to twenty-three percent of plans between 2007 and 2012.\textsuperscript{41} Narrow network employer plans provided cost savings between ten percent and twenty-five percent.\textsuperscript{42} This, presumably, is in exchange for networks that are anywhere from fifteen percent to thirty-five percent smaller than standard preferred provider panels.\textsuperscript{43}

While the ACA does not mandate narrow networks, it does incentivize these networks to compete for business while it simultaneously controls the ways in which they can do so.\textsuperscript{44} Insurance companies seeking to control the

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\item \textsuperscript{34} Long Engelhard, supra note 4.
\item \textsuperscript{35} Id.
\item \textsuperscript{36} Kliff, supra note 16.
\item \textsuperscript{37} Id.
\item \textsuperscript{38} Long Engelhard, supra note 4.
\item \textsuperscript{39} Id.
\item \textsuperscript{40} Kliff, supra note 16.
\item \textsuperscript{41} Id.
\item \textsuperscript{43} Id.
\item \textsuperscript{44} Blumenthal, supra note 7.
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costs of their customers’ care may do so by contracting selectively with
doctors and hospitals that charge less.\footnote{Id.} Not only do narrow networks pro-
vide a competitive edge, they also give insurers more leverage—as they buy
services in bulk from preferred providers, they are able to negotiate better
prices for the future.\footnote{Kliff, supra note 16.}

Although narrow networks may allow insurers to contain costs and re-
main competitive, they are not always well received by consumers. In fact,
they may prove frustrating to consumers who find that the network excludes
their regular or preferred doctors.\footnote{Long Engelhard, supra note 4.} For some patients with several health
problems, a narrow network might mean difficulty accessing a particular
specialist.\footnote{Id.} Critics also argue that although insurers may not discriminate
against people with pre-existing conditions, they may “subtly discourage”
sicker patients from enrolling by limiting the provider network.\footnote{Robert Pear, Lower Health Insurance
Rust, chairman of Barnes & Thornburg’s national health care practice, ex-
plains: “If a health plan has a narrow network that excludes many doctors,
that may shoo away patients with expensive pre-existing conditions who
have established relationships with doctors.”\footnote{Id.}

The effect of the narrow network may also be felt disproportionately on
those with the greatest need for insurance coverage. Since cost is often the
greatest factor when a consumer chooses a health plan, those consumers
who purchased products via the marketplace often opted for less expensive
plans with narrow networks.\footnote{Long Engelhard, supra note 4.} A recent study revealed that while nearly half
of the networks on the insurance marketplace had limited networks, nearly
seventy percent of the least-expensive plans had very restricted networks.\textsuperscript{52}

Although insurance companies and some researchers suggest that there is little connection between the cost of health care and the quality of a provider,\textsuperscript{53} many consumers and states disagree. In 2013, before the federal marketplaces went into effect, a New York resident brought suit against United Healthcare for failure to provide adequate mental health coverage.\textsuperscript{54} More recently, thirty-three Anthem subscribers in California sued the insurer, accusing it of misrepresenting the size of its networks.\textsuperscript{55} In some cases, the consumers claim Anthem canceled their plans with broader networks, forcing them to incur large, unforeseen medical bills when they visited out of network providers.\textsuperscript{56}

As America debates the value of narrow networks, researchers are finding consumers under-informed with respect to their selected plan’s network: disturbingly, only twenty-six percent of marketplace customers knew the scope of the network when they enrolled.\textsuperscript{57} With so few informed selections in the marketplace’s first year, advocacy groups are calling for increased payer transparency to enable consumers to make better decisions.\textsuperscript{58}


\textsuperscript{53} Kliff, supra note 16; see also Margot Sanger-Katz, Narrow Health Networks: Maybe They’re Not So Bad, N.Y. Times (Sept. 9, 2014), http://www.nytimes.com/2014/09/10/upshot/narrow-health-networks-maybe-theyre-not-so-bad.html?_r=0 (highlighting a study published as a working paper with the National Bureau of Economic Research which followed Massachusetts state workers who selected a narrow network plan, and found that when done correctly, a narrow network can be successful in both saving money and providing patients with appropriate health care).

\textsuperscript{54} See Demand for Jury Trial, supra note 17, at 2.


\textsuperscript{57} Bauman et al., supra note 52.

\textsuperscript{58} Keith Griffin, Narrow Networks: Obamacare’s Broken Promise and How Doctors and Patients Can Fight Back, Medical Economics (Mar. 24, 2014), http://medical.economics.modernmedicine.com/medical-economics/news/narrow-networks-obamacares-
V. STATE AND FEDERAL RESPONSE

Advocacy groups are not alone in calling for further refinements to insurance reform. Many states are taking action in response to the perceived threat that narrow networks provide.\textsuperscript{59} Maine regulators stopped Anthem BlueCross BlueShield from switching customers to a marketplace plan that excluded six hospitals in the state.\textsuperscript{60} New Hampshire lawmakers authored legislation forcing insurers to expand provider networks after 2014 marketplace plans excluded more than one third of the state’s hospitals.\textsuperscript{61} The Washington State Insurance Commissioner initially blocked several health plans from the online exchange due to “inadequate caregiver networks” and recently took action after discovering one plan would have patients drive more than one hundred miles just to see a gastroenterologist.\textsuperscript{62} In South Dakota, Pennsylvania, and Mississippi, legislators are contemplating “any-willing provider” laws that would require insurers to accept more providers in their networks.\textsuperscript{63} In September 2014, California Governor Jerry Brown signed legislation that increases scrutiny of provider networks.\textsuperscript{64} These state actions often result in appeals, further litigation, state legislative action, and/or additional lawsuits.\textsuperscript{65}

In addition to the robust state response, the National Association of Insurance Commissioners is revising its model regulations for network ade-

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\textsuperscript{59} See Hancock supra note 18. \\
\textsuperscript{60} Id. \\
\textsuperscript{61} Id. \\
\textsuperscript{62} Id. \\
\textsuperscript{63} Id.; Paul Demko, Reform Update: Narrow-Network Concerns Spur Legal, Regulatory, Political Action, MODERN HEALTHCARE (Sept. 26, 2014, 4:00 PM), http://www.modernhealthcare.com/article/20140926/NEWS/309269967 (discussing South Dakota’s pending “any willing provider” legislation, which predated Marketplace implementation, and acknowledging that 2014 was a “tricky” year for legislatures, as many were far into their sessions or had adjourned before constituents began using marketplace health plans and discovered problems with narrow networks). With 2014’s experience behind them, many legislatures may start with increased attention on this topic in 2015. Id. \\
\textsuperscript{64} Demko, supra note 63. \\
\textsuperscript{65} See Hancock supra note 18 (noting also that tensions over narrow provider networks have been especially high in California).
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The federal government also proposed guidelines that will allow CMS and HHS to scrutinize plan networks. In a final letter dated March 14, 2014, CCIIO notified issuers in the Federally-facilitated marketplaces that in the 2015 benefit year, CMS will assess provider networks using a “reasonable access” standard. In evaluating whether a network meets this standard, CMS will assess those areas that have “historically raised network adequacy concerns,” including hospital systems, mental health providers, oncology providers, and primary care providers.

VI. CONCLUSION

Although the ACA calls for increased transparency from insurers, network scope remains opaque for many consumers. Until insurance companies provide greater transparency on their networks, consumer satisfaction will suffer, and litigation and regulatory involvement will continue. Fortunately, there are signs that network transparency will improve in the near future.

Recent federal guidelines on network adequacy, as well as regulations requiring issuers to provide network information to the marketplace, provide opportunity not only for adequate networks, but for more informed consumer choice. That choice may be aided by one or more transparency tools, including requiring announcements online and on printed materials that alert potential enrollees the network is limited and urge them to review

66. Demko, supra note 63.
69. Id.
the provider directory before choosing a policy.70 Alternatively, issuers could achieve greater transparency by posting online a map showing the location of each provider in a network.71 Whatever the mechanism, enhanced network transparency will increase the likelihood that those who choose a narrow network are picking the right plan for their circumstances.

71. Id.