



**SECOND IN A SERIES**

# Regulating Provider Networks: A Changing Landscape



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# Regulating Provider Networks:

## A Changing Landscape

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## Introduction

*The Colorado Division of Insurance is among the regulatory bodies across the nation considering whether to toughen rules and step up enforcement to address a trend toward narrower provider networks.*

*Regulators at both the state and federal levels are responding to concerns about whether the narrower networks provide consumers with sufficient access to health care providers. They are also addressing worries that consumers aren't able to easily understand which providers are in-network when they shop for insurance or decide where to get care.*

The federal government on November 20 issued a proposal that sets minimum network adequacy standards for plans purchased through the federal online insurance marketplaces beginning in 2017.

The proposed rules are stronger than model legislation passed by the National Association of Insurance Commissioners (NAIC) on November 22. Rather than quantitative standards, the NAIC recommendation lets state insurance regulators set their own standards.

While Colorado isn't subject to the federal rules because it has a state-based exchange, state regulators are beginning to collect data that could support quantitative standards down the road. Meanwhile, Colorado's policymakers will continue to face questions about whether the state's regulatory and enforcement framework sufficiently protects consumers while ensuring affordable health plan choices.

In this paper, the second in a series examining the issue of whether provider networks are

adequate, the Colorado Health Institute (CHI) looks at the laws and rules in Colorado and nationally.

The research highlights different approaches to overseeing provider networks and examines the challenges faced by states in a rapidly changing marketplace.

Finally, it outlines strengths and weaknesses of Colorado's authority to influence the size, reach and transparency of provider networks and provides key considerations for policymakers in charge of network adequacy rules.

Key findings:

- Colorado does not have measurable *quantitative* standards to monitor network adequacy. Instead, like a number of other states, it relies instead on *qualitative* standards such as the geographic distribution of providers without any prescriptive standards.

- Insurers have leeway in interpreting Colorado's standards. Some consumer advocates believe they have too much leeway.
- Enforcement in Colorado, as in many states, often relies on reviewing consumer complaints rather than conducting independent investigations.
- While networks are not currently reviewed by the state using quantitative standards, in some cases the Division of Insurance (DOI) has required carriers to add providers in underserved geographic areas.
- The NAIC's model legislation provides only limited guidance to Colorado and other states on how to develop quantitative standards for monitoring networks. It does, however, provide some direction on how to address whether there is enough transparency for consumers to make informed choices and to provide them with financial protections.
- Consumer groups likely will urge Colorado policymakers to adopt quantitative standards for measuring adequacy – much like the standards in the federal proposal. These proposed standards could be resource-intensive to administer, however, and must consider the state's diverse

geographic areas and provider distribution if they are to succeed.

- The Division of Insurance began to collect baseline data on networks in 2014 to prepare for the possibility that Colorado will adopt quantitative network standards in the future.
- Regardless of legislative or regulatory changes, active monitoring by regulators will require increased resources.

### *Oversight of Health Insurance Plans and Provider Networks: State and Federal Roles*

States are the primary regulators of insurance and they have long held statutory authority over health care provider network access issues.

In Colorado, the DOI is charged with overseeing insurers. It reviews premiums, proposed rate and benefit changes, provider networks, marketing materials and other aspects of the health insurance market.

DOI regulates insurance companies selling products through the online marketplace, Connect for Health Colorado, as well as those that sell through brokers and other channels.

## The Debate

Many health insurance plans sold through the new online marketplaces offer a limited selection of health care providers in their networks, a development that has prompted concerns regarding network adequacy standards in Colorado and nationally.

The Affordable Care Act (ACA) cuts back on the levers available to insurers to impact price. Offering narrower provider networks is one remaining tool they can use, insurers say, to

appeal to cost-conscious consumers.

Insurers are finding that many Colorado consumers like these lower-priced plans. But consumer advocates want to ensure that consumers understand the limits of their networks when they buy coverage.

For a full discussion of this subject, see [Narrow Networks in Colorado: Balancing Access and Affordability](#), the first paper in this series.<sup>2</sup>

# Rules, Regulations and Oversight in Colorado

Colorado law requires carriers to create networks that are “sufficient in numbers and types of providers” to ensure that enrollees have access without “unreasonable delay.”

DOI-required “access plans” must by law consider these factors:

- Ratio of enrollees to health care specialists;
- Ratio of enrollees to primary care providers;
- Geographic location of providers;
- Waiting times for appointments;
- Hours of operation at providers;

- Technological and specialty services available;
- Acute care hospital services within a reasonable distance or travel time.

Colorado, however, doesn’t go into detail about these factors and it doesn’t have specific goals that carriers must meet.

In addition, the state requires carriers to include Essential Community Providers — providers who serve medically needy patients and have a commitment to low-income populations — in their marketplace networks.

## Who’s in Charge?

*Different government agencies regulate types of insurance policies.*



- The Centers for Medicare & Medicaid Services (CMS) regulates provider networks in the Medicare and Medicaid public insurance programs, including Medicare Advantage and Medicaid managed care plans.
- CMS oversees many commercial market plans — coverage offered outside of government programs — through its regulation of Qualified Health Plans (QHPs) on the marketplaces.



**COLORADO**  
Department of Health Care  
Policy & Financing

- States ensure that Medicaid enrollees have sufficient access to providers.<sup>1</sup> In Colorado, this is the Department of Health Care Policy and Financing.



**COLORADO**  
Department of  
Regulatory Agencies

- States have oversight of health plan networks in the fully insured private insurance market. Colorado’s Division of Insurance has this authority.

If there isn't an in-network provider for a covered benefit, the plan must offer enrollees a referral to an out-of-network provider at no greater cost to the consumer. And, finally, plans must promise to disclose any material change to a network, including resulting billing changes.<sup>3</sup>

Still, the DOI doesn't rigorously monitor compliance with its network adequacy rules, relying mostly on consumer complaints to trigger a review. Colorado, like many other states, says it hasn't had the resources to do this work in a thorough way.

However, the DOI has asked carriers to expand their networks if they didn't include particular specialists. For the past two years, DOI has collected baseline data on the adequacy of provider networks, laying the groundwork for increased scrutiny of provider networks in the future.

The DOI and Connect for Health Colorado, the insurance marketplace, have additional network requirements for health plans on the marketplace beyond access plans and Essential Community Provider data. They must

also submit provider directories — lists of participating providers in the plan's network — annually to the state and monthly to the marketplace.

Together, the state's laws and regulations provide a framework for evaluating network adequacy. Even so, consumer advocates point out that the law allows carriers to decide for themselves what constitutes "reasonable criteria" for network sufficiency.

The Colorado Consumer Health Initiative (CCHI), in a recent letter to the DOI, recommends that the state establish quantitative standards for network adequacy. It suggests drive-time requirements to address concerns about timely access for enrollees in rural areas and those who take public transportation.

CCHI also suggests that the DOI create measurable standards for provider-enrollee ratios and appointment waiting times.

Enforcement of quantitative standards is likely to be resource intensive.

## Colorado's Regulatory Framework: Strengths and Limitations

State approaches to regulating provider networks vary. Some are prescriptive, holding insurers to measurable standards. Others are more descriptive, providing insurers with leeway to interpret the rules.

Colorado's network adequacy rules fall into the more descriptive category. The oversight framework accommodates changing market dynamics, permitting health plans to design provider networks to meet a variety of consumer needs.

In Colorado, this has meant a wide range of plans available through Connect for Health Colorado at a variety of price points. But it has also meant that plans in Colorado don't have to meet specific quantitative standards. And the state doesn't conduct in-depth quantitative reviews of network adequacy.

This is the heart of the debate: a tension between protecting consumers with rigorous standards and more enforcement or maintaining flexibility so plans can create competitively priced health insurance products.

Colorado is not unique in its approach to regulating network adequacy.

Twenty-one states<sup>4</sup> have similar qualitative oversight strategies. Twenty-seven states have quantitative standards that apply to some or all plans that they regulate. Most of these rules are in regulations, not statutes.

A recent Commonwealth Fund analysis<sup>5</sup> found these quantitative standards: maximum travel time or distance (23 states), provider-enrollee ratios (10 states) and maximum appointment wait times (11 states).

For example, Delaware requires plans to have a primary care physician within 20 miles, or a 30-minute drive, from an enrollee's home. Montana requires one mid-level primary care practitioner for every 1,500 enrollees or one physician per 2,500 enrollees.<sup>6</sup>

Most states don't rely on ongoing oversight to ensure network compliance. A survey of 38 state DOIs found that consumer complaints are the primary tool to monitor network adequacy. The survey also found that states rarely use enforcement actions when problems arise.<sup>7</sup>

At this point, Colorado relies on consumer complaints to trigger monitoring and high-level network scans to identify where no providers of a particular specialty exist within a network. This may change in the future.

### **Statement of the Colorado Association of Health Plans**

The Colorado Association of Health Plans, a member organization representing many health plans doing business in Colorado, provided this statement when asked about its position on network adequacy regulations in Colorado:

"Provider networks have been a mainstay of private health insurance coverage for more than 35 years, serving to promote safe, quality care, as well as affordability. High-value networks ensure that patients have sufficient access to high-performing providers and facilities that deliver a wide-range of medical services, including specialty care. Health plan flexibility to develop and design various network arrangements is essential to providing consumers with affordable choices and coordinated, high-value care."

Most states review plan networks when the carrier applies for licensure, but fewer conduct ongoing reviews, in part due to limited resources and expertise. In addition, most states acknowledge the need for greater consumer education on networks, but are challenged in providing consumer-friendly resources.<sup>8</sup>

## How the ACA Regulates Network Adequacy

The ACA placed new provider network requirements on insurers offering plans through the marketplaces. However, these requirements generally avoid prescriptive standards.

Similar to rules already in place in Colorado, the ACA's rules require that the provider network

must be "sufficient in numbers 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."

Beyond this framework, the law requires insurers



to include Essential Community Providers in their marketplace networks. ACA drafters felt strongly about maintaining the role of Essential Community Providers in serving medically needy patients and low-income populations.

The law also requires plans available through the marketplaces to provide access to online provider directories that note which providers are accepting new patients.<sup>9</sup>

CMS published new provider directory

## New Proposal: Sweeping Federal Rules

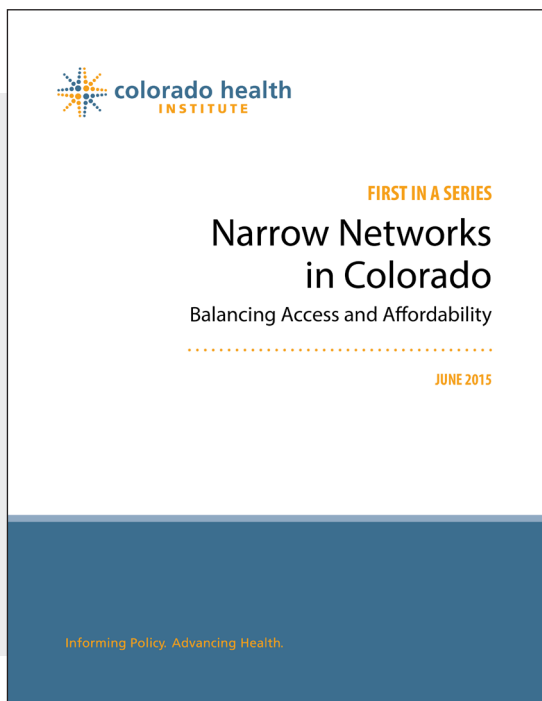
The Centers for Medicare & Medicaid Services (CMS) issued a notice of proposed rule-making on November 20 containing wide-ranging changes to plans purchased through the federal marketplace, including a requirement that states evaluate plans based on quantifiable minimum network adequacy standards. CMS has yet to publish a list of acceptable network adequacy standards for these plans. However, they will include, but not be limited to, minimum

requirements in February 2015 that require monthly updates of the provider directories and information on the networks of plans sold in the marketplace.<sup>10</sup>

The regulation also addresses instances in which coverage changes while an enrollee is in the midst of treatment. It encourages, but does not require, insurers to continue care with an existing provider for at least 29 days in the event of a coverage change.

provider-to-covered population ratios and time and distance standards. CMS said in a fact sheet that any state that does not choose an appropriate metric will hand off oversight to the U.S. Department of Health and Human Services.

While the proposed changes don't affect Colorado now, they are a good indication of the direction favored by federal regulators.



## ABOUT THIS SERIES

This paper is the second in the Colorado Health Institute's examination of network adequacy in Colorado.

The first brief provided an introduction to the issue of narrow networks, with an overview of the debate and key terms.

Read the first brief here:

[www.coloradohealthinstitute.org/key-issues/detail/health-coverage-and-the-uninsured/network-adequacy](http://www.coloradohealthinstitute.org/key-issues/detail/health-coverage-and-the-uninsured/network-adequacy)



## Accreditation: Non-Governmental Review

Meanwhile, virtually all insurers are reviewed by accrediting bodies. They include the National Committee for Quality Assurance (NCQA) and URAC, formerly known as the Utilization Review Accreditation Commission, and the Accreditation Association for Ambulatory Health Care (AAAHC). These organizations evaluate business processes to ensure compliance with national quality standards.

While these organizations require carriers to have network adequacy strategies in order to receive accreditation, they don't have specific quantitative standards for networks. While they review strategies for provider networks, the process is subjective.

URAC requires insurers to use such tools such as geo-access software that maps provider locations and secret shoppers who determine whether doctors are accepting new patients. These efforts help insurers evaluate their provider networks.

NCQA has released a new category of standards for 2016 — network management — that will require insurers to evaluate access to

### *Accrediting Bodies: A Primer*

NCQA, URAC and AAAHC are non-governmental bodies that set national standards for health organizations, including health plans. Accreditation from these groups is considered a “seal of approval,” indicating compliance with widely accepted business practices.

Plans may be accredited by one or more organizations. Accredited plans have undergone review of their systems and procedures and are measured against broadly accepted industry standards. NCQA and URAC boards have a diverse set of stakeholders, including providers, health plans, employers and academics.

specialty care and the accuracy of their provider directories.<sup>11</sup>

While these standards must be met for accreditation, they are qualitative and not monitored on an ongoing basis.



## On the Horizon: National Association of Insurance Commissioners (NAIC) Proposed Changes

A great deal of attention was focused on efforts by the NAIC to update its Managed Care Plan Network Adequacy Model Act of 1996, which is designed to help states develop legislation. Colorado's network adequacy rules generally align with the 1996 model act.

An NAIC subgroup engaged stakeholders to obtain input over the past year. The Colorado

DOI is a member of this subgroup, which adopted the updated model act in November. The full organization approved it on November 22, 2015.

The updated model reasserts that insurers must provide networks with sufficient numbers and types of providers. It also restates that each plan's network sufficiency should be assessed.<sup>12</sup>

The model law contains new criteria for states to evaluate network sufficiency, including geographic variations, ability to meet the needs of low-income and chronically ill enrollees, and the availability of telehealth and other health care delivery options.

The draft does not include new quantitative standards for network adequacy. The drafters have suggested that while some states may include these requirements in statute, specific measures are more likely to be in regulation.<sup>13</sup>

Changes in the model act emphasize consumer protections and transparency. Colorado's rules already address some of these issues.

For example, services from an out-of-network provider must be covered at the in-network cost if there isn't an available provider in the network. Coverage of care after a contract is terminated is also required in special circumstances.

Still, the model act update includes key changes that aren't already addressed in Colorado's rules. (See Box 1 on Page 12.)

Consumer representatives urged the NAIC to require states to develop quantitative measures of network sufficiency, to practice greater oversight of tiered networks, and to more actively review network access plans.

Consumers are recommending that all plans include Essential Community Providers in their

### Tiered Networks

**Tiered networks** encourage plan members to use economical providers by offering lower out-of-pocket costs. Providers are categorized in tiers based on efficiency, and plans offer consumers graduated cost-sharing between tiers with lowest cost-sharing for the most efficient providers. These networks may or may not require providers to meet performance standards.

networks and suggest that states implement standardized reporting about how often consumers use out-of-network services.<sup>14</sup>

Insurers, meanwhile, asked the NAIC to provide enough flexibility to allow them to experiment with delivery and payment systems that support quality and efficiency reforms. They also emphasized the need for rules that account for different challenges in different states.

The model act was finalized in November 2015.

This means that most state legislatures won't consider the act's provisions until 2016 at the earliest. Most insurers, however, will be developing their 2017 offerings in early 2016. So, any state legislative changes would first have an impact on 2018 health insurance products.

## Efforts in Colorado

The Colorado DOI and Connect for Health Colorado have signaled their intent to develop new network adequacy standards after collecting 2015 data that will inform them about network practices.






The DOI plans to engage stakeholders in developing standards and recently engaged the

health care community in discussions.

The DOI is a member of the subgroup that completed the NAIC model act that includes provisions on network adequacy.

So stakeholders should anticipate that the state will strongly consider the model act in development of any new policy.

**Box 1: NAIC 2015 Model Act Compared to Current Colorado Law**

Policy Provision Highlights	In Colorado
<b>Network Access Plans</b>	
 <p>Health plans must file network access plans with the state. Insurance commissioners may conduct a review as a condition of network approval. Access plans must be made publicly available, including on-line availability.</p>	<p>Colorado requires only that the access plans be filed. State has authority to review the plans but is not required to do so. Information is made available to the public on request.</p>
<b>Provider Directories</b>	
 <p>Health plans must provide consumers with information on the criteria used to build provider networks and the process to update provider directories. Plans must update directories monthly.</p>	<p>Colorado does not have these requirements. Connect for Health Colorado does require monthly directory updates.</p>
<b>Mediation Process</b>	
 <p>Health plans must establish a mediation process for payments to out-of-network providers at in-network facilities.</p>	<p>Colorado does not require mediation between plans and providers.</p>
<b>Out-of-Network Request Documentation</b>	
 <p>Health plans must document all enrollee requests for covered benefits from out-of-network providers.</p>	<p>Colorado does not require this.</p>
<b>Continuity of Care</b>	
 <p>Health plans must establish procedures to ensure enrollees in “active treatment” maintain continuity of care if a provider leaves the network.</p>	<p>Colorado requires managed care plans to allow covered persons to continue to receive care for 60 days from the date a provider leaves the network when individuals are not given sufficient advanced notice.</p>



## Conclusion

While Colorado's rules are largely flexible and have likely contributed to a more competitive health insurance market, it is becoming increasingly clear that some consumers don't understand the provider network options of their health insurance plan. Consumers also may not always have access to health care providers.

Colorado's decision to conduct only limited reviews of network adequacy is not unlike the direction many states are taking. Many states also struggle with creating network transparency for consumers.

The model legislation approved by the NAIC provides only limited guidance to Colorado and other states on how to address quantitative standards. Colorado policymakers who are concerned about ensuring consumers greater

access to providers are likely to look for policy changes not included in the draft legislation.

However, it provides greater insights into how states and some stakeholders are thinking about protecting consumers in a time of narrower networks. And the federal proposal goes even further.

These new ideas, such as greater transparency about network access plans and disclosure of in-network provider information, are worth evaluating as part of a broader debate in Colorado.

Ultimately, the process of updating Colorado's regulatory framework must address the tension between offering consumers access to timely health care and the ability of carriers to develop affordable insurance.



## End Notes

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