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PERSPECTIVE

Cracking down on health insurers' narrow networks

By Molly Moriarty Lane

As of Jan. 1, the Patient Protections and Affordable Care Act (ACA) mandated that certain health insurance plans include or eliminate a number of features that health insurers had previously relied upon for purposes of controlling costs and reducing premiums. For example, plans are now required to provide coverage for "essential health benefits," which include many benefits that were previously limited or excluded from coverage such as mental health and substance abuse services and habilitative services. In addition, insurers are now required to provide coverage to those with pre-existing conditions and their ability to impose lifetime or annual limits on coverage has been curtailed. One of the strategies that insurers have used to contain costs and maintain reasonable premiums in the face of these new requirements has been the use of "narrow" networks of providers with whom they contract to provide reimbursable services to their members.

Narrow networks are not a novel idea. For years, HMO plans have relied on tight networks of providers in an effort to provide a lower cost health insurance alternative. In addition, many self-insured employer groups have insisted on narrow networks in an effort to reduce their costs. There are several different ways in which insurers and employers have structured their narrow networks. Many have simply excluded higher priced providers or negotiated lower rates for a smaller population of providers who are willing to accept those rates for an increased volume of patients. Some insurers have created "tiered" networks that reimburse services at a higher percentage for "preferred" providers and at a lower percentage for providers at a lower tier. And still others have rewarded the most effective and efficient providers with a place in their network through a provider ranking program.

While the establishment of narrow networks offers insurers a device to lower costs and premiums, such networks have been drawing increased scrutiny from regulators, providers, and consumer groups. One of the focal points for this scrutiny is whether narrow networks meet the adequacy requirements under federal and state law. The ACA requires insurers to maintain a provider network that is "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." 45 CFR 156.230(a)(2). California law likewise requires insurers to provide an "adequate" network by setting forth maximum travel times and distances and minimum provider-to-enrollee ratios. See 28 CCR Sections 1300.67.2, 1300.67.2.1 and 1300.67.2.2.

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At the urging of the California Medical Association, the California Department of Managed Health Care has initiated an investigation of plans in California to determine whether they have violated the state's network adequacy laws in developing their exchange networks. In addition, in 2014, the Center for Medicare & Medicaid Services (CMS) simply relied on state regulators and collected network access plans in assessing insurers' network adequacy for qualified health plans offered in a federally facilitated marketplace. Earlier this year, however, CMS announced that, in 2015, it "will assess provider networks using a 'reasonable access' standard, and will identify networks that fail to provide access without unreasonable delay." CMS also notified insurers that it will focus on areas that have "historically raised network adequacy concerns" including hospital systems, mental health providers, oncology providers and primary care providers. See 2015 Letter to Issuers in the Federally-facilitated Marketplaces.

In addition to increased regulatory scrutiny, both providers and members have recently filed a number of lawsuits across the country against both insurers and regulators as a result of the establishment of narrow networks. The providers' primary complaint is that they were improperly excluded from a network, while the members complain that they no longer have access to their favorite providers. For example, on Oct. 4, 2013, in *Seattle Children's Hospital v. Office of the Insurance Commissioner of the State of Washington*, Seattle Children's Hospital filed an action against the Office of the Insurance Commissioner of the State of Washington claiming that the OIC failed to follow the provision of the ACA that requires qualified health plans to include with their plan networks "essential community providers" when it approved narrow networks established by two health plans that excluded Seattle Children's Hospital. Seattle Children's Hospital's claims are still pending.

And, just last month, a class action was filed against Blue Shield of California in San Francisco County Superior Court alleging claims relating to Blue Shield's network of providers for members of its PPO plans. In *Harrington v. Blue Shield of California*, the plaintiffs allege that Blue Shield made misrepresentations regarding or concealed that its provider network for PPO plans available under the California insurance exchanges is narrower than the network available to members of other Blue Shield PPO plans. The plaintiffs further allege that they researched providers on the Blue Shield website, identified providers from whom they wanted to receive treatment, and confirmed with those providers that they were members of the Blue Shield's PPO network. After the plaintiffs received treatment from those providers, they discovered that the providers were not, in fact, members of Blue Shield's exchange PPO plans and, thus, their services were not covered. One of the plaintiffs alleges that the plan he purchased offered access to only one physician in San Francisco who practiced medicine within the field of the treatment he required. Blue Shield has not yet responded to the allegations in the complaint.

The mounting battlefield over the adequacy of narrow networks is likely to revolve around the issues of: (1) whether narrow networks comply with the state and federal network adequacy requirements; (2) how the state and federal requirements should be interpreted, applied and perhaps expanded; and (3) whether insurers have adequately disclosed and represented their provider networks. But now that insurers have been divested of many of the traditional devices previously used to reduce the cost, and therefore, premiums for health insurance, it is unlikely that we will see the demise of narrow networks any time soon. Given the tension between the desire for low premiums and increased consumer choice, it is also likely that we will continue to see a continued increase in regulation and litigation over the adequacy of and the disclosures relating to narrow networks.

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