McDermott Will & Emery

Challenges Facing "Narrow" Provider Networks on the ACA Health Care Insurance Exchanges

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SPECIAL REPORT

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Health care insurers are trimming the number of contracted providers for their health care plans offered through the health benefit exchanges and the Medicare Advantage (MA) program. To ensure that these "narrow networks" adequately meet the health care needs of the burgeoning population of consumers purchasing health care insurance plans through state-based exchanges, state regulators and legislators are racing to (i) develop standards to determine whether the numbers of physicians and hospitals included in these narrower networks are sufficient, (ii) provide guidelines for out-of-network notifications, (iii) require development of accurate in-network provider lists, (iv) mandate out-of-network options for no additional cost when the number of in-network providers is insufficient, and (v) identify whether quality standards are being maintained. The Centers for Medicare & Medicaid Services (CMS) has adopted specific guidance for MA Organizations with respect to provider network transparency, including an obligation to contact providers to confirm network status monthly. CMS has indicated that it is considering adopting more stringent network adequacy and transparency requirements for plans sold through the Federally Facilitated Marketplace (FFM).

Providers' views on the narrower network trend are divided. Some providers oppose this trend, including those who have been involuntarily terminated or excluded from existing broad networks, whereas others have embraced it by agreeing to accept lower contract rates in return for the promise of higher patient volumes. Still other providers, including some of the most highly regarded, have chosen not to participate in networks for exchange plans for reasons unrelated to the narrower network trend. Although some consumers of health care insurance plans embrace the less costly hospital, physician and ancillary services afforded by narrower networks, patient advocates are expressing concern about patients losing their ability to choose providers and access higher quality care.

There have been attempts to constrain or facilitate the implementation of narrower provider networks through legislation, regulation and litigation. This article highlights the conflicts between the competing fiscal imperatives of insurers, providers and patients, as well as developments at the state and federal level to resolve these conflicts.

The Driving Forces Behind the Trend Toward Narrower Networks

Generally, exchange plans reimburse providers at significantly lower rates than nonexchange plans. Insurers attribute this difference to several factors, including the Affordable Care Act (ACA) requirement that Qualified Health Plans (QHPs) sold through the FFM and state-based exchanges must offer broad health care benefit coverage and cannot vary premiums based on age. Faced with the prospect of receiving comparatively lower reimbursement for patients insured through exchange plans (as well as delays in receiving payment and increased administrative expenses attendant to those delays), a number of providers have declined to participate in exchange plans' provider networks. For instance, several highly esteemed institutional and physician providers have opted out of the exchanges.[1]

Also, as insurers find that consumers perceive price to be the paramount factor in differentiating the plans offered on the exchanges, insurers are trying to lower their premiums by reducing payments to providers. Smaller networks facilitate insurers offering lower premiums because insurers can negotiate lower reimbursement rates with some hospitals and physicians in return for increased patient volume. Higher cost providers that are unwilling to accept lower payments in return for more patients are excluded from these networks. Consequently, these narrow networks allow for more price control in the face of recent provider consolidations, which could have allowed certain providers (*e.g.*, hospital systems) to achieve greater market power and thereby raise prices for their services. The increasing exclusion of higher cost providers from exchange plans' networks, whether by choice of the provider or the insurer, fuels the dual trends towards narrower networks and lower reimbursement rates received by providers participating in exchange plans' networks.

QHPs available on the FFM and state-based exchanges predominately feature narrower provider networks. A December 2013 study by McKinsey & Company (updated in June 2014) found that about 70 percent of the lowest priced products on the exchanges are narrowed in one of three fashions:

[1] Tori Richards, *Top Hospitals Opt Out of Obamacare*, U.S. News and World Report, Oct. 30, 2013.

- Tiered (placing hospitals into different tiers depending on cost-sharing requirements)
- Narrow (30–69 percent of 20 largest hospitals not participating)
- Ultra-narrow (at least 70 percent of 20 largest hospitals not participating)[2]

The study also found that broad hospital networks (less than 30 percent of the 20 largest hospitals in the service area are not participating) result in 13–17 percent higher median costs than plans with smaller networks sold by the same insurer.[3] Broad networks are available to almost 90 percent of the population.[4] Narrow networks—which are available to 92 percent of the population—make up 48 percent of all exchange networks available nationwide and 60 percent of networks in the largest city in each state.[5]

The Trade-Off

LOWER PREMIUMS?

Proponents of narrow networks argue that the new influx of health care consumers purchasing plan coverage on the exchanges will be willing to accept a reduced choice of providers in return for lower premiums. A February 2014 tracking poll conducted by the Kaiser Family Foundation found that those who are most likely to be exchange customers (the uninsured and those who purchase their own coverage) are significantly more likely to prefer cheaper plans with narrower networks over more expensive plans with broader networks (54 percent versus 35 percent).[6] By contrast, those who currently get their insurance through an employer—and thus are less sensitive to the cost of coverage—have the opposite preference: 55 percent prefer a more expensive plan with a broader network, while only 34 percent would rather have a lower cost narrow network plan.[7]

The current narrower network trend can be compared to managed care organizations' early efforts to lower costs by reducing access to providers using Preferred Provider Organization (PPO) or Health Maintenance Organization (HMO) networks in the late 1980s and early 1990s. Proponents of the recent trend claim that the current narrower networks are more sophisticated and oriented toward the needs of a different type of consumer than were the 1990s' narrow network offerings.[8] These proponents argue that the reduced networks of the 1990s were used mostly in employer-sponsored plans that did not pass on the savings to plan members; in contrast, today's consumers purchasing individual coverage on an exchange pay significantly lower premiums for narrower network products. Moody's Investors Service reports that forcing health insurers to widen their networks may increase premiums, making health insurance coverage much less affordable and potentially driving away consumers.[9]

A recent study of such limited networks suggests that consumers may be able to reduce their spending without decreasing their quality of care, if the narrower network plan directs insureds towards primary care providers and away from downstream health care spending (specialists, and emergency and inpatient hospital care).[10] In this study, which examined the insurance plan for Massachusetts state employees, economists reported that the narrower network option tended to reduce health care spending by a third without decreasing the quality of inpatient hospital care.[11] Notably, while primary care spending tended to rise, the

[2] Erica Coe, *et al.*, *Hospital networks: Configurations on the exchanges and their impact on premiums*, McKinsey Center for U.S. Health System Reform, *available at* http://healthcare.mckinsey.com/sites/default/files/Hospital_Networks_Configurations_on_the_Exchanges_and_Their_Impact_on_Premiums.pdf, Dec. 2013, at 2; Noam Bauman, *et al.*, *Hospital Networks: Updated national view of configurations on the exchanges*, McKinsey Center for U.S. Health System Reform, *available at* http://healthcare.mckinsey.com/sites/default/files/McK%20Reform%20Center%2020Hospital%20networks%20national%20update%20%28June%202014%29_0.pdf, Jun. 2014, at 2 [hereinafter Updated McKinsey Brief].

[3] Updated McKinsey Brief at 2.

[4] *Id.*

[5] *Id.*

[6] Liz Hamel, *et al.*, *Kaiser Health Tracking Poll: February 2014,* The Henry J. Kaiser Family Foundation, *available at* http://kff.org/health-reform/poll-finding/kaiser-health-tracking-poll-february-2014, Feb. 26, 2014.

[7] *Id*.

[8] Christopher Cheney, *Two decades after a consumer backlash drove many health maintenance organizations out of business, narrow provider networks are back in a big way*, HealthLeaders Media, available at http://www.healthleadersmedia.com/content/311323/topic/WS_HLM2_HEP/Narrow-Networks-Enjoying-a-Resurgence.html, Dec. 16, 2014.

[9] Christopher Cheney, *Rules to Rein in HIX Narrow Networks Could Drive Away Payers*, HealthLeaders Media, *available at* http://www.healthleadersmedia.com/content/HEP-301790/Rules-to-Rein-in-HIX-Narrow-Networks-Could-Drive-Away-Payers, Mar. 11, 2014.

[10] Jonathon Gruber & Robin McKnight, *Controlling Health Care Costs Through Limited Network Insurance Plans: Evidence from Massachusetts State Employees*, *available at* http://www.nber.org/papers/w20462, Sept. 2014.

[11] *Id.* at 4.

insureds saved money overall because of the reduction in more costly specialist and hospital care.[12] Some economists have speculated that networks that are particularly restrictive on primary care access may fare less well than networks that impose only downstream restrictions on specialty and institutional services.[13]

LIMITED CHOICE?

Critics counter that narrower networks limit consumer choice and disrupt patient-doctor relationships. Some consumers who are willing to pay extra for a broader network may not be able to access it in a reasonable fashion because they live in rural areas with fewer plan options. Critics also argue that if the insurer imposes overly strict limitations on the choice of provider, the overall quality of care is likely to decline. To obtain out-of-network care, consumers may be forced to pay significant out-of-pocket costs if the insurer concludes that an in-network provider is appropriate. For this reason, narrow network plans also may discourage sicker individuals from enrolling. In particular, new members (or members whose established plans' networks are modified by the issuer) may not realize that their regular health care provider is now out-of-network or from a less-preferred tier until after they enroll in the plan. This confusion is exacerbated if the plan's provider directory is inaccurate, as discussed further below.

LOWER QUALITY OF CARE?

Historically, successful challenges to the adequacy of plan networks or the termination of individual providers from networks rested in part on express or implied assertions that equated dropping physicians or hospitals from insurance plans, or altering patients' access to specialists by terminating plan contracts with those specialists, with lower quality care and/or irreparable harm offensive to the public interest.[14]

As courts take note of the efforts to reform the nation's health care delivery system, however, opinions in some recent unsuccessful challenges to narrower networks have not referred to "quality of care" at all, and have approved even apparently inadequate provider networks as not barring government health care contracts, provided that there is reason to believe that a network may ultimately prove to be adequate after all of the provider contracts are in place.[15]

TRANSPARENCY VERSUS CONFUSION?

Consumer confusion can result when providers participating in an insurer's network for its off-exchange products do not also participate in that insurer's exchange products. Finding an accurate source of information is difficult for consumers. Few exchange websites offer provider listings; most link to the carriers' websites. Consumers have experienced difficulty in determining which insurer's directory corresponds to a particular exchange plan because the network names listed on the insurer's website do not always match the plan names listed on the exchange website, and an insurer can have different networks that apply to different plans.[16]

There have also been error-filled provider directories. For example, Covered California, the California exchange, has had to take down its provider list multiple times because of consumer complaints that the list was inaccurate.[17] A 2014 study performed by the Mental Health Association of Maryland to assess the accuracy of the information in the provider directory linked from the Maryland Health Connection website found that only 43 percent of the listed psychiatrists could be reached.[18] The study found that less than 40 percent of the providers listed in the directory were

[12] *Id.* at 21.

[13] *Id.* at 4.

[14] *See, e.g., Harper v. Healthsource New Hampshire, Inc.*, 674 A.2d 962, 966, 140 N.H. 770, 776-77 (1996); *Potvin v. Metropolitan Life Ins. Co.*, 997 P.2d 1153, 1159-60, 22 Cal. 4th 1060, 1071 (2000); *Barron v. Vision Serv. Plan*, 575 F. Supp. 2d 825, 835-36 (N.D. Ohio 2008); *Fairfield County Medical Association v. United HealthCare of New England*, 2013 U.S. Dist. LEXIS 172930 *21 (D. Conn. 2013).

[15] *G. v. Hawaii, Dept. of Human Servs.*, 703 F. Supp. 2d 1078. 1091 (2010); *Columbia United Providers, Inc. v. State of Washington, Health Care Authority*, 2012 U.S. Dist. LEXIS 58015 *16 (W.D. Wash. 2012).

[16] Linda J. Blumberg, *et al.*, *Physician Network Transparency: How Easy Is It for Consumers to Know What They Are Buying?*, Urban Institute, Aug. 2014, at 6.

[17] Covered California ultimately determined that it was not able to provide consumers with reliable and accurate information and decided to link to each health insurance company's online provider directory instead. The exchange will reassess its opportunity to launch an accurate, combined provider directory. Covered California, *Covered California Open Enrollment 2013-2014: Lessons Learned*, Oct. 2014, at 29–30 Oct. 2014.

[18] Mental Health Association of Maryland, *Access to Psychiatrists in 2014 Qualified Health Plans: A Study of Network Accuracy and Adequacy Performed from June 2014 – November 2014*, available at http://mhamd.org/wp-content/uploads/2014/01/2014-QHP-Psychiatric-Network-Adequacy-Report.pdf, Jan. 26, 2015. The study reported that most of the 1,154 listed psychiatrists were unreachable because of nonworking numbers or because the psychiatrist no longer practiced at the listed location. Id.

psychiatrists who had actually confirmed that they accepted the insurance that they were listed as accepting.[19]

In response to concerns about network transparency, CMS will require issuers offering QHPs on the exchanges in 2016 to make updated, accurate and complete provider network directories available to the exchange for publication online.[20] The listed information must include whether the provider is accepting new patients, as well as the provider's location, contact information, specialty, medical group and any institutional affiliations.[21] All health insurance issuers are required to make it easy for consumers to determine which providers participate in particular networks and plans.[22] For QHPs offered through the FFM,[23] issuers must publish and update their directories monthly on their public websites so that consumers may access the information without signing up for an account.[24]

Regulatory, Legislative and Litigatious Responses to Narrower Networks Across the Nation

Across the country, consumers have been filing class action lawsuits challenging narrower networks (often with the assistance of consumer advocate groups). Among the lawsuits are a number of class actions alleging that consumers were billed for out-of-network care even though the insurer's website indicated that the specific provider was in-network. In response to the litigation and complaints from consumers and providers, state insurance regulators are increasing their scrutiny of narrower networks. Some state legislators are considering new "any willing provider" legislation designed to restrict plans' ability to limit their networks.

THE CALIFORNIA MARKETPLACE: A MAJOR BATTLEGROUND OVER NARROWER NETWORKS

In California, insurers claim that their sharp new limits on the number of doctors and hospitals accessible to patients through the California Health Insurance Exchange (Covered California) are successfully reducing the rate of increase in premiums.[25] In 2013, Health Net Inc., which had secured about 19 percent of the Covered California market, sold products at the lowest rates (with monthly premiums up to $100 less than the closest competitor in some cases) but offered the fewest doctors (less than half the number offered by some of its competitors).[26] For 2015, Health Net has transitioned its Covered California PPO plan to a closed network Exclusive Provider Organization (EPO) plan with a 9 percent rate increase.[27] Health Net says that it is maintaining its Covered California HMO network rates but has added about 4,000 doctors to its network.[28]

Meanwhile, Blue Shield has cut physicians by 4 percent in its two Covered California plans offered in 2015.[29] Anthem, which added almost 7,000 doctors in 2014, will maintain its network sizes in 2015.[30] The issuers note that Californians

[19] *Id* at 6.

[20] 45 C.F.R. 156.230(b); Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016; Final Rule, 79 Fed. Reg. 10750, 10830 (Feb. 27, 2015); Center for Consumer Information and Insurance Oversight (CCIIO), Final 2016 Letter to Issuers in the Federally-facilitated Marketplaces, 24 (Feb. 20, 2015).

[21] *Id*.

[22] *Id.*

[23] In 2015, 37 states use the FFM's Healthcare.gov platform: (i) the seven partnership exchange states (Arkansas, Delaware, Illinois, Iowa, Michigan, New Hampshire and West Virginia); (ii) the 27 states whose exchanges will be run fully by the FFM in 2015 (Alabama, Alaska, Arizona, Florida, Georgia, Indiana, Kansas, Louisiana, Maine, Mississippi, Missouri, Montana, Nebraska, New Jersey, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Wisconsin and Wyoming); and (iii) the three states whose state-based exchanges will use the FFM's website platform for 2015 (Nevada, New Mexico and Oregon). Office of the Assistant Secretary for Planning and Evaluation Issue Brief: Health Insurance Marketplace 2015 Open Enrollment Period: January Enrollment Report for the Period: Nov. 15, 2014 – Jan. 16, 2015, 25–26 (Dep't Health & Human Serv. Jan. 27, 2015) [hereinafter HHS Report].

[24] Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016; Final Rule, 79 Fed. Reg. 10750, 10830 (Feb. 27, 2015); Center for Consumer Information and Insurance Oversight (CCIIO), Final 2016 Letter to Issuers in the Federally-facilitated Marketplaces, 24 (Feb. 20, 2015).

[25] Chad Therhune, *Insurers Limiting Doctors, Hospitals in Health Insurance*, Market, L.A. Times, Sep. 14, 2013.

[26] *Id*.

[27] Chad Therhune, *et al*., *Obamacare doctor networks to stay limited in 2015*, L.A. Times, Sept. 28, 2014.

[28] *Id*.

[29] *Id*.

[30] *Id*.

insured by products purchased through Covered California saw their premium 2015 rates rise only about 4 percent.[31] On the other hand, some providers and consumer advocates counter that narrower networks may keep provider reimbursement rates low, but a substantial portion of those savings are not being passed on to the insureds in the form of premium rate reductions.

Concerns about timely access to mental health care have drawn California regulators to investigate Kaiser Permanente.[32] In 2013, Kaiser agreed to pay a $4 million fine levied by the California Department of Managed Health Care (DMHC), based upon survey results that indicated members had to wait excessively long periods between therapy appointments, and that they were effectively dissuaded from seeking individual treatment.[33] As an HMO, Kaiser relies almost solely upon its own network of in-house providers and facilities to provide care to patients. Although Kaiser has made progress by increasing its number of therapists, a follow-up survey by the DMHC found that some members continue to wait weeks to see psychiatrists and therapists.[34] Moreover, the DMHC also found cases of providers giving members inaccurate information about the extent of their mental health care benefits.[35]

The drive to lower costs has also affected where carriers decide to sell exchange plans. Although 10 insurers offer Covered California plans for 2015, few sell state-wide. In some rural areas, there may be only one choice of carrier.[36] For instance, Blue Shield had to stop selling individual plans in certain rural areas because it could not find enough health care providers willing to accept a level of payment that would maintain premiums at affordable levels.[37]

Multiple lawsuits were brought against California insurers in 2014 alleging that insurers did not offer adequate provider networks, misled enrollees about network size and presented inaccurate directories of participating providers. In May 2014, consumers filed a class action lawsuit in state court claiming that Blue Shield of California misrepresented that its PPO plans purchased on Covered California would cover the full provider network advertised on the company's website.[38] The consumers representing the class alleged that they received medical treatment with providers found through the insurance company's website and that their claims for payment were later rejected. Two subsequent class action suits accuse CIGNA and Blue Shield of concealing their reduced provider networks during the Open Enrollment Period to increase their sales of health care service plans and lock members into reduced network plans until the next open enrollment period.[39] The claims against CIGNA, which was not part of Covered California, also allege that the insurer misled consumers by selling its plans as if they were regulated and overseen by the state exchange.[40]

In July 2014, consumers filed a similar class action lawsuit in state court against Anthem Blue Cross of California, claiming that the insurer misrepresented that they were signing up for PPO plans (which provide out-of-network coverage and benefits), when in fact they were signing up for EPO plans (which have far greater restrictions on the number of providers considered in-network and do not provide any out-of-network coverage and benefits).[41] The complaint alleges that the insurer concealed its reduced network and the actual amounts for out-of-network deductible payments.[42] Anthem has acknowledged that some inaccuracies existed in its provider database, but maintains that the vast majority of the listings were correct.[43] Two additional cases claim Anthem Blue Cross improperly

[31] *Id*.

[32] Stuart Pfiefer and Chad Therhune, *California again slams Kaiser for delays in mental health treatment*, L.A. Times, Feb. 24, 2015.

[33] Id.

[34] Department of Managed Health Care Help Center, Division of Plan Surveys, *Routine Survey Follow-Up Report of Kaiser Foundation Health Plan, Inc. Behavioral Health Services*, *available at* http://www.dmhc.ca.gov/desktopmodules/dmhc/medsurveys/surveys/055bhfu022415.pdf, Feb. 24, 2015.

[35] *Id*.

[36] Pauline Bartolone, *Limited Insurance Choices Frustrate Some Patients In California*, Kaiser Health News, Jan. 15, 2015.

[37] Pauline Bartolone, *Insurance Choices Dwindle In Rural California As Blue Shield Pulls Back*, Kaiser Health News, Jan. 30, 2015.

[38] *Harrington et al. v. Blue Shield of California et al*., No. 14-539283 (Cal. Super. Ct. May 14, 2014).

[39] Compl. *Davidson v. Cigna Health and Life Insurance Company*, No. BC558566, ¶ 9 (Cal. Super. Ct. Sept. 24, 2014); Compl. *McCarthy v. Blue Shield of California*, No. BC55849, ¶ 10 (Cal. Super. Ct. Sept. 23, 2014).

[40] Compl. *Davidson*, ¶ 6.

[41] Compl. *Felser v. Blue Cross of California*, No. BC550739, ¶ 1 (Cal. Super. Ct. Jul. 8, 2014).

[42] *Id.* ¶¶ 43, 57.

[43] Chad Therhune, *California probes Obamacare doctor networks at Anthem and Blue Shield*, L.A. Times, Jun. 20, 2014.

shifted members from PPO to EPO plans and intentionally concealed the change to increase profits.[44]

In response to health insurers reducing their network size and/or shifting consumers to narrowed networks, California passed legislation requiring HMO-type health care plans, which are regulated by the DMHC, to provide annual reports to the DMHC regarding the adequacy of their provider networks, with the agency's assessment of that data to be posted on its website.[45] Meanwhile, California insurance regulators are pressing insurers to add more providers to their networks, and plan to revise the regulatory standards to increase oversight for insurers' health networks. California Insurance Commissioner Dave Jones issued an emergency regulation, effective February 2, 2015, strengthening requirements for non-HMO insurance companies to publish and maintain accurate in-network provider lists.[46] During 2015, more than 80,000 medical providers and almost 90 percent of active licensed physicians are expected to participate in Covered California.[47]

WASHINGTON: HOSPITAL COMPLAINTS PROMPT INCREASED REGULATORY OVERSIGHT OF NETWORKS

In Washington, the Office of the Insurance Commissioner (OIC) initially decided not to permit five health insurers to participate in the Washington Health Benefit Exchange for the 2014 benefit year because of their inability to meet state and federal network adequacy standards.[48] However, after several carriers appealed, the OIC approved their applications to offer exchange coverage in fall 2013.[49] In October 2013, Seattle Children's Hospital, which had been excluded from most of the plans offered on the exchange, sued the OIC to reverse two of these approvals, alleging that the agency failed to ensure adequate network coverage in several exchange plans.[50] These two insurance carriers subsequently agreed to add the hospital to their network plans for 2015, and the lawsuit was dismissed.[51] Parallel to the civil suit, the hospital also filed an administrative appeal asking the OIC to reverse its decision to approve certain exchange plans.[52] After reaching agreements with those insurers that originally excluded it, the hospital withdrew its administrative appeal in September 2014.[53]

Prompted by consumer complaints about narrower networks, and overriding the complaints of certain insurers and hospitals regarding the speed of the implementation, in late April 2014 the OIC finalized new network adequacy rules applicable to individual or small-group health plans (both on and off Washington's Health Benefit Exchange) sold in 2015.[54] These rules set specific standards for network adequacy to ensure "timely" service, access to certain specialists, adequate mental health treatment and preventive care programs.[55] The rules limit so-called "spot contracting" to fill holes or gaps in the network.[56] Moreover, the rules will require plans to provide detailed reports on where the doctors and hospitals in their networks are located, including provider directories and a more

[44] Compl. *Brown v. Blue Cross of California*, No. BC554949, ¶ 5 (Cal. Super. Ct. Aug. 19, 2014); Compl. *Cowart v. Blue Cross of California*, No. BC549438, ¶ 1 (Cal. Super. Ct. Jun. 20, 2014).

[45] SB-964 (approved Sept. 25, 2014) codified at Health and Safety Code §§ 1367.03(f), 1367.035 (2015).

[46] 10 Cal. Code Reg. 2240 (2015); Cal. Dept. Ins. *Press Release: Commissioner Dave Jones issues emergency regulation at his inauguration requiring health insurers to have sufficient medical providers to provide patients timely access to care, available at* https://www.insurance.ca.gov/0400-news/0100-press-releases/2015/release001-15.cfm, Jan. 5, 2015; Cal. Dept. Ins. *Press Release: Emergency regulation requiring health insurers to have sufficient medical providers goes into effect immediately*, http://www.insurance.ca.gov/0400-news/0100-press-releases/2015/release012-15.cfm, Feb. 2, 2015. The California Department of Insurance regulates non-HMO plans whereas the DMHC regulates California's HMO-type health care plans.

[47] Chad Therhune, *et al.*, *Obamacare doctor networks to stay limited in 2015*, L.A. Times, Sept. 28, 2014.

[48] Wash. State Ins. Commissioner Update: An open letter from Mike Kreidler about insurance plans filed for Washington's exchange, *available at* http://wainsurance.blogspot.com/2013_08_22_archive.html, Aug. 22, 2013.

[49] Wash. State Ins. Commissioner News Release No. 13-25: Kreidler approves Coordinated Care's three exchange plans, *available at* http://www.insurance.wa.gov/about-oic/news-media/news-releases/2013/9-5-2013.html, Sept. 5, 2013; Wash. State Ins. Commissioner News Release No. 13-24: Kreidler settles with Molina – approves two more exchange plans for King, Pierce, and Spokane counties, *available at* http://www.insurance.wa.gov/about-oic/news-media/news-releases/2013/9-4-2013.html, Sept. 4, 2013; Wash. State Ins. Commissioner News Release No. 13-23: Kreidler achieves settlement with two health insurers – approves 10 additional exchange options for consumers, *available at* http://www.insurance.wa.gov/about-oic/news-media/news-releases/2013/8-30-2013.html, Aug. 30, 2013.

[50] *Seattle Children's Hospital v. Office of the Insurance Commissioner of the State of Washington*, (Wash. Sup. Ct. 2014).

[51] Greg Lamm, *Legal wrangling pays off: Seattle Children's, Premera make nice*, Puget Sound Business Journal, Aug. 18, 2014.

[52] Letter from Seattle Children's Hospital to Mike Kreidler, Office of the Insurance Commissioner re: Demand for hearing, dated Oct. 22, 2013.

[53] Not. and Mot. To Withdraw *In re Seattle Children's Hospital Appeal of OIC's Approvals of HBE Plan Filings*, No. 13.0293 (Wash. Ins. Comm'n Sept. 5, 2014).

[54] WSR 14-10-017.

[55] WAC § 284-43-200.

[56] *Id.*

transparent process for the building and monthly maintenance of provider networks.[57]

MASSACHUSETTS: LEGISLATIVE RATE CONTROL OF TIERED AND LIMITED NETWORKS

In 2010, Massachusetts recognized the cost-savings of limited networks by amending its health care reform laws to require that plans develop tiered and limited networks.[58] Carriers have been required to reduce the premiums for tiered or limited network products by at least 14 percent as compared to the equivalent full network products.[59] Massachusetts also requires (i) marketing materials to include certain language and (ii) the provider director to alert members that the network is limited.[60]

MAINE: LEGISLATORS AND REGULATORS URGE PAYOR TRANSPARENCY AND CONSUMER VIGILANCE

Anthem was the only Maine for-profit insurer offering products for sale through the FFM in 2014. After Anthem's 2013 partnership with MaineHealth (parent to Maine Medical Center in Portland), the Maine Bureau of Insurance ultimately approved Anthem's proposed exchange plans' provider network despite competitor hospitals' complaints that they were being actively excluded from Anthem's exchange network.[61] However, the Bureau rejected Anthem's proposal to migrate many existing policyholders with non-grandfathered individual coverage (nonexchange plans that were to be discontinued for the 2014 benefit year) to plans using the same narrow provider networks offered through Anthem's exchange plans.[62] Although Anthem asserted that its narrow networks reduced premiums for Mainers by 8 percent, the Bureau expressed its concern that policyholders might not truly understand the effects of a default replacement of their plans to narrow networks (rather than an affirmative choice by the consumer to switch to a narrower network) until they actually seek or receive health care.[63] The Bureau emphasized that it was not restricting Anthem's ability to encourage policyholders to affirmatively purchase its narrow network exchange plans.[64]

Continuing this emphasis on increasing transparency to consumers of narrow networks, in April 2014 the Maine Legislature enacted a law requiring the issuer to make certain disclosures about its network offerings to the Bureau, and to disclose to a provider, upon request, the reason for the issuer's decision not to offer the provider the opportunity to participate in the network.[65] For 2015, 40 QHPs are available to Mainers on the FFM from three insurers (Anthem, Harvard Pilgrim Health Care and the not-for-profit Maine Community Health Options). As open enrollment drew to a close in February 2015, Maine Insurance Superintendent Eric Cioppa urged state residents enrolling in an exchange plan to call the insurance company and their providers of choice to verify network status before finalizing their purchase.[66]

NEW YORK: COMPREHENSIVE LEGISLATION TO INCREASE NETWORK TRANSPARENCY

In response to consumer complaints about receiving low reimbursement for out-of-network services, New York enacted comprehensive legislation effective March 31, 2015, (i) limiting the charges to consumers who receive emergency services to their usual in-network out-of-pocket costs, regardless of the provider's network status, and (ii) imposing the same limitation to out-of-network nonemergency services if there were no in-network providers available or the member did not receive the disclosures mandated by the new law.[67] The law also imposes network adequacy rules, which previously only applied to HMOs, on plans offering PPO and EPO networks as well.[68] Health plans must publish their provider

[57] *Id.* § 284-43-203, -204.

[58] Mass. Gen. Laws ch. 176O § 9A; 176J § 11.

[59] *Id.* 176J § 11.

[60] *Id.* 176J § 15; 211 CMR 152.00 (2011).

[61] *In re: Anthem Blue Cross and Blue Shield Request for Approval of Access Plans*, No. INS-13-801, Decision and Order, (Me. Dep't of Prof. and Financial Regulation Bureau of Ins. Jul. 25, 2013); Lindsay Tice, *Maine health insurance companies say they have won final approval for upcoming marketplace,* Bangor Daily News, Sept. 17, 2013.

[62] *In re: Anthem Blue Cross and Blue Shield Request to Discontinue Individual Health Plans*, No. INS-13-803, Decision and Order, (Me. Dep't of Prof. and Financial Regulation Bureau of Ins. Oct. 4, 2013).

[63] *Id.* at 13–14, n.7.

[64] *Id.* at 22.

[65] 24-A Me. Rev. Stat. §§ 4303 sub-§19; 4303-B.

[66] Bureau of Insurance Reminds Mainers about End of Open Enrollment and Urges Consumers to Check Doctors, Hospitals and Other Health Providers in Plans Before Making a Selection, Feb. 12, 2015, http://www.maine.gov/tools/whatsnew/index.php?topic=INS-PressReleases&id=637744&v=Default

[67] N.Y. Ins. Law § 3241(c) (2015); Article 6 of the N.Y. Fin. Servs. Law §§ 601–608.

[68] N.Y. Ins. Law § 3241(a); *see also* Dep't of Fin. Servs., *Network Adequacy Standards and Guidance, available at* http://www.dfs.ny.gov/insurance/health/Network_Adeq_standards_guidance.pdf (last visited Apr. 1, 2015).

directories on their websites and update the listing within 15 days of the addition or termination of a provider from the insurer's network or a change in a physician's hospital affiliation.[69]

New York insurers, providers and hospitals also face new disclosure requirements related to provider networks and charges. When pre-authorizing services, insurers must inform their members regarding the network status of the providers and the level of reimbursement, and are also required to compare that amount to the usual, customary and reasonable fee.[70] Insurers must give members examples of the level of reimbursement for out-of-network services and compare that amount to typical in-network charges.[71] Before providing nonemergency services, providers are obligated to disclose their anticipated charges for the procedure.[72] When making appointments, providers must indicate their network participation status, and must also provide their network and hospital affiliations to patients in writing or online.[73] Hospitals also are required to disclose the health care plans in which they participate, a schedule of charges for various services, and information enabling patients to determine the network affiliations of their physician employees and contracted practice groups (*e.g.*, radiology, anesthesiology and pathology).[74]

NEW HAMPSHIRE: COMPETITION EXPANDS NETWORK OPTIONS

In New Hampshire, following pressure from consumers, regulators and legislators, the number of insurers offering FFM plans for 2015 increased from one to five.[75] All 26 hospitals in New Hampshire accept coverage from at least two of those five carriers.[76] Compared to 2014, New Hampshire residents have more plans and broader network options for 2015.[77]

Anthem Blue Cross and Blue Shield, which was the only insurer offering coverage to New Hampshire residents through the FFM in 2014, did not contract with 10 hospitals for the 2014 benefit year.[78] Anthem claimed that this reduced premiums by 25 percent, keeping New Hampshire residents' premiums comparable to those in states with multiple carriers.[79] Nonetheless, Frisbie Memorial Hospital and an individual patient filed a legal protest challenging Anthem's decision not to include Frisbie and other hospitals in its network.[80] The New Hampshire Insurance Department refused to force Anthem to negotiate with Frisbie regarding rates and maintained that it had no authority to force Anthem to contract with Frisbie.[81] Although the Department denied Frisbie's request to reconsider its decision to approve Anthem's application, it held a discretionary public hearing in February 2014 to explain its process.[82] After Frisbie and the patient filed a request for rehearing challenging the adequacy of Anthem's network, the Department held an adjudicative hearing.[83] In September 2014, the Department denied the petition based upon a finding that the petitioners failed to show that the exclusion of Frisbie rendered Anthem's exchange network inadequate under state law.[84] Anthem maintained that its 2014 provider network—which included 16 hospitals, 78 percent of the

[69] N.Y. Ins. Law §§ 3217-a(a)(17); 4324(a)(17); N.Y. Pub. Health Law § 4408(r); *see also* Dep't of Fin. Servs., Out-of-Network Law (OON) Guidance (Part H of Chapter 60 of the Laws of 2014), *available at* http://www.dfs.ny.gov/insurance/health/OON_guidance.pdf (last visited Apr. 1, 2015).

[70] N.Y. Ins. Law § 4903(b); N.Y. Ins. Law §§ 3217-a.

[71] *Id*.

[72] N.Y. Pub. Health Law § 24.

[73] *Id*.

[74] *Id*.

[75] Network Adequacy: Public Information Release Marketplace Issuer Networks for the 2015 Plan Year, N.H. Ins. Dep't, *available at* http://www.nh.gov/insurance/consumers/documents/pres_updated_network11.12.14.pdf, Nov. 14, 2014.

[76] NH Health Insurance Individual Marketplace and Small Business Health Options Program (SHOP) Networks, N.H. Ins. Dep't, *available at* http://www.nh.gov/insurance/consumers/documents/networks2015.pdf, (rev. Mar. 20, 2015). Initial projections by the Department of Insurance had expected three carriers to include all 26 hospitals. Network Adequacy: Public Information Release Marketplace Issuer Networks for the 2015 Plan Year, N.H. Ins. Dep't, *available at* http://www.nh.gov/ insurance/consumers/documents/pres_updated_network11.12.14.pdf, Nov. 14, 2014.

[77] Network Adequacy: Public Information Release Marketplace Issuer Networks for the 2015 Plan Year, N.H. Ins. Dep't, *available at* http://www.nh.gov/insurance/consumers/documents/pres_updated_network11.12.14.pdf, Nov. 14, 2014.

[78] Todd Bookman, *Senator Pushes For Public Hearings On ACA Insurance Plans*, New Hampshire Public Radio, *available at* http://nhpr.org/post/senator-pushes-public-hearings-aca-insurance-plans, Feb. 4, 2014.

[79] *Id*.

[80] Order, *In re: Frisbie Memorial Hospital, et al.*, No. 13-038-AR (N.H. Ins. Dep't Dec. 11, 2013).

[81] *Id.* at 8.

[82] *Id*. at 8–9; Sarah Palermo, *Anthem's narrow network, N.H. insurance regulators criticized at hearing*, Concord Monitor, Feb. 11, 2014.

[83] Order and Notice of Hearing, *In re: Petition of Margaret McCarthy*, No. 13-038-AR (N.H. Ins. Dep't Mar. 28, 2014).

[84] Final Order, *In re Petition of Margaret McCarthy*, No. INS. 13-038-AP, (N.H. Ins. Dep't Sept. 2, 2014).

state's primary care providers and 87 percent of specialists—met or exceeded all state adequacy standards.[85] Anthem will continue to offer narrower network plans for 2015, which include 17 hospitals. [86]

Although some legislators criticized the narrower provider network offered in 2014, the House of Representatives rejected proposed legislation that sought to require insurers on the FFM to negotiate with any willing provider.[87] The Department has created an informal working group to review network adequacy standards and propose changes to the legislature, which aims to have new standards in place for plans sold in 2017.[88]

MISSISSIPPI: "ANY WILLING PROVIDER" BILL FAILS AS THE MARKET SLOWLY CHANGES

In Mississippi, a bill that sought to allow any health care provider who agrees to a health insurance company's terms to be included in the carrier's network died in the legislature in March 2014.[89] Sponsors had introduced the "any willing provider" bill in the wake of a dispute between Blue Cross Blue Shield of Mississippi (which did not participate in the FFM in 2014) and hospital system Health Management Associates (HMA).[90] In 2013, the two companies settled the dispute surrounding Blue Cross' decision to exclude HMA hospitals from its network when all 10 HMA hospitals were re-admitted to Blue Cross' network.[91] Although Blue Cross opted not to sell any products through the FFM for 2015, the number of insurers offering QHPs on the FFM increased from two to three (Humana, Magnolia and new entrant United).[92] Two carriers offer QHPs in 62 of Mississippi's 82 counties, and all three carriers compete in 15 counties. [93] However, Mississippians living in five counties near or along the Gulf Coast have only one option for exchange coverage in 2015.[94]

SOUTH DAKOTA: VOTERS APPROVE "ANY WILLING PROVIDER" BILL

After "any willing provider" legislation was rejected in 2013 by the South Dakota Senate, South Dakota voters approved a measure requiring insurers to include and list any provider that accepts the insurer's terms.[95]

PENNSYLVANIA: TRYING THE REVERSE APPROACH – "ANY WILLING INSURER" BILL FAILS

Taking the opposite approach, in 2013 the Pennsylvania House of Representatives proposed legislation that would have required all hospitals and physicians practicing in the state as part of an integrated health care system to contract with "any willing insurer."[96] That legislation, which ultimately died in committee, was introduced in an effort to force a large health care system (University of Pittsburgh Medical Center) to contract with a large commercial insurer (Highmark Blue Cross Blue Shield) in western Pennsylvania.[97] Although the bills were reintroduced in 2014, they died in committee again.[98]

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[85] Second Supplemental Brief by Anthem Blue Cross and Blue Shield re: Aggrievement, *In re: Frisbie Memorial Hospital, et al.*, No. 13-038-AR (filed Mar. 12, 2014).

[86] Bob Sanders, *Evaluating N.H.'s expanded health plan options*, New Hampshire Business Review, Oct. 31, 2014.

[87] NH HB 1294 marked inexpedient to legislature on March 5, 2014.

[88] N.H. Ins. Dep't Press Release: NH Insurance Department Announces New Model for Network Adequacy Standards, Jul. 24, 2014; N.H. Ins. Dep't Press Release: NH Insurance Department's Network Adequacy Working Group to Meet December 9, Nov. 17, 2014.

[89] Miss. HB 553 (2014) died on calendar on February 13, 2014.

[90] Emily Wagster Pettus, *Miss. lawmakers hear about BlueCross-HMA dispute*, The Associated Press, Sept. 17, 2013.

[91] Geoff Pender, *BCBS-HMA reach agreement to return hospitals to network*, The Clarion-Ledger, Dec. 20, 2013.

[92] Bobby Harrison, *More health exchange options coming*, Northeast Mississippi Daily Journal, Sept. 27, 2014.

[93] *3 insurers selling health plans on Mississippi exchange, but only 1 in coastal counties*, The Associated Press, Nov. 15, 2014.

[94] *Id*.

[95] South Dakota Insurance Provider Measure, Initiated Measure 17 (Approved Nov. 4, 2014) *available at* http://electionresults.sd.gov/resultsSW.aspx?type=BQ&map=CTY.

[96] Pennsylvania House Bills Nos. 1621 and 1622 did not progress beyond their referral to the Health Committee for the Pennsylvania General Assembly, although a hearing was held on December 18, 2013. Matt Fair, *Pa. Hospital Access Bills Hurt Competition, Lawmakers Hear*, Law360, Dec. 18, 2013.

[97] Bill Toland, *Feds might object to any state law forcing a insurer, hospital into contract*, Pittsburgh Post-Gazette, Dec. 24, 2013.

[98] Pennsylvania Senate Bills 1647 and 1648 did not progress beyond their referral to the Banking and Insurance Committee for the Pennsylvania General Assembly in March 2014; Bill Toland, Battle continues between UPMC, Highmark, Pittsburgh Post-Gazette, Mar. 1, 2014.

THE FEDERALLY FACILITATED MARKETPLACE: WILL CMS DEVELOP FEDERAL MINIMUM STANDARDS FOR FFM PROVIDER NETWORKS?

The provider networks of issuers offering QHPs through the FFM have become subject to more direct federal oversight since the 2014 benefit year. During the 2014 benefit year, CMS largely relied on state regulators and third-party organizations to review networks. Beginning in benefit year 2015, CMS has required QHPs to include a significantly larger share (30 percent) than previously required (20 percent) of "essential community providers," which are "safety-net" hospitals, clinics and other providers often used by lower-income consumers.[99] Issuers offering QHPs through the FFM for the 2016 benefit year must submit to CMS a full list of providers in their network before their plans are approved for listing in the FFM.[100] CMS has said that it expects to continue "reasonable access standards" through 2016.[101] In the future, CMS plans to develop federal standards for the required number of providers, but the agency will wait for the National Association of Insurance Commissioners (NAIC) to complete its work on a network adequacy model act before proposing significant changes.[102]

Judicial and CMS Consideration of Narrower Networks for Medicare Advantage

Providers are also challenging narrower MA networks in the courts. In November 2013, two professional organizations brought a complaint in federal court in Connecticut on behalf of 2,000 providers terminated from United's MA network.[103] United cited the ACA's rate reductions to MA plans as the primary rationale to trim its provider network by almost 20 percent.[104] In December 2013, U.S. District Court Judge Stefan R. Underhill granted a temporary restraining order blocking the terminations based upon a finding that the doctors would suffer irreparable reputational harm as well as disruption to patient-doctor trust relationships.[105] Judge Underhill held that the plaintiffs demonstrated a likelihood of success on the merits given that the contract language did not support that United had a unilateral right to terminate the doctors without cause by amendment, and that the MA regulations (42 C.F.R. § 422.202(d)) and the contract instead mandated at least 90 days notification of termination. United immediately appealed the decision.[106] In February 2014, the U.S. Court of Appeals for the Second Circuit summarily affirmed the lower court, giving the terminated providers 30 days to challenge their removal by initiating arbitration proceedings.[107]

CMS WEIGHS IN

Concerned about the timing of "no cause" provider terminations by MA Organizations, the American Medical Association requested that CMS instruct MA Organizations to delay the effective date of their contract terminations for the 2014 contract year.[108] CMS responded that it did not have authority to hold terminations in abeyance outside of notice and comment rulemaking, but indicated that the agency would carefully oversee network changes and require MA Organizations to make adjustments as needed.[109] In 2015, CMS will require MA Organizations to notify CMS when "significant" provider network changes are planned.[110] The definition of "significant" is left to the MA Organizations, but CMS has said that it expects MA Organizations to take a "conservative approach" to determining whether a network change is significant and notify CMS if there is any doubt as to whether planned contract terminations represent significant change to the

[99] Center for Consumer Information and Insurance Oversight (CCIIO), Final 2016 Letter to Issuers in the Federally-facilitated Marketplaces, 22–24 (Feb. 20, 2015); Center for Consumer Information and Insurance Oversight (CCIIO), 2015 Letter to Issuers in the Federally-facilitated Marketplaces, 18–24 (Mar. 14, 2014).

[100] Center for Consumer Information and Insurance Oversight (CCIIO), Final 2016 Letter to Issuers in the Federally-facilitated Marketplaces, 22–24 (Feb. 20, 2015).

[101] *Id.*

[102] *Id.*; Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016; Proposed Rule, 79 Fed. Reg. 70674, 70726 (Nov. 26, 2014).

[103] *Fairfield Cnty. Med. Ass'n v. United Healthcare of New England, Inc.*, 985 F. Supp. 2d 262, 265–66 (D. Conn. 2013)

[104] Matthew Sturdevant, *UnitedHealthcare Cuts Doctors From Medicare Advantage Network*, The Hartford Courant, Oct. 9, 2013.

[105] *Fairfield Cnty. Med. Ass'n*, 985 F. Supp. 2d at 272.

[106] *Id.* at 272–73.

[107] *Fairfield Cnty. Med. Ass'n v. United Healthcare of New England, Inc.*, 557 F. App'x 53 (2d Cir. 2014).

[108] Letter from Am. Med. Ass'n, *et al.*, to Marilyn B. Tavenner, Administrator of CMS, dated Nov. 6, 2013.

[109] Letter from Danielle R. Moon, Dir. of the CMS Medicare Drug & Health Plan Contract Administration Group, to Margaret Garikes, Am. Med. Ass'n Dir. of Fed. Affairs, dated Nov. 27, 2013.

[110] CMS, *Announcement of Calendar Year (CY) 2015 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter*, 102–03, Apr. 7, 2014.

network.[111] CMS warns in the 2015 Final Call Letter that it intends to take appropriate compliance action against MA Organizations that fails to notify CMS of network changes that the agency ultimately deems "significant."

Furthermore, beginning in the 2015 benefit year, CMS has required MA Organizations to notify CMS at least 90 days prior to network changes for any significant "no cause" termination.[112] However, CMS did not finalize its proposal to limit MA Organizations' ability to terminate provider contracts without cause at any time during the year by restricting terminations to certain times of the year.[113] CMS opted not to mandate that MA Organizations provide more than 60 days' prior notice to providers whose contracts are being terminated without cause based upon industry comment that such a change would need to be effectuated through notice and comment rulemaking.[114] CMS does recommend, as a "best practice," that MA Organizations provide more than 60 days' prior notice to providers whose contracts are being terminated without cause, in order to allow for a complete appeals process before beneficiaries are notified.[115]

In its 2016 Final Call Letter, CMS clarified its requirement that MA plans must update their online directories in "real time," to mean that MA Organizations are to make updates when they are notified of changes in a provider's status or when the MA Organization itself makes contracting changes to its network of providers.[116] MA Organizations are expected to communicate with providers monthly regarding their network status, contact information and whether they are accepting new patients.[117] CMS will monitor the accuracy of MA Organizations' online provider directories, and starting in mid-2015 CMS will conduct pilot audits to examine network adequacy.[118] For 2015, these audit scores will not count against the sponsor's total program audit score, be included in the final audit report or be posted to the CMS website.[119] Beginning in 2016, provider network audit scores will become a component of the total program audit score.[120] MA Organizations that fail to maintain complete and accurate directories may be subject to compliance or enforcement actions, including civil money penalties of up to $25,000 per day per beneficiary,[121] or enrollment sanctions, including bans on new enrollment or marketing.[122] CMS warns that MA plans whose network adequacy is deemed insufficient because of their failure to have a sufficient number of providers open and accepting new patients may also be subject to such sanctions.[123] Indeed, in April 2015, CMS imposed a civil monetary penalty of $1 million on Aetna because its website and customer service agents allegedly incorrectly reported that almost 7,000 pharmacies were in-network for various MA and prescription drug plans.[124] Also, CMS granted Aetna beneficiaries a special enrollment period to dis-enroll from Aetna's plan and re-enroll in another Part D plan.[125] CMS is considering requiring MA plans to provide and regularly update network information in a standardized, electronic format for eventual inclusion in a nationwide provider database, which would begin no earlier than calendar year 2017.[126] CMS indicated that it will harmonize these policies with the requirements for QHPs on the exchanges so as to provide health plans with consistent rules across programs.

Considerations for the Future

In making decisions regarding premiums, reimbursement rates and network-provider contracts, insurers increasingly should assess whether consumers and regulators are more sensitive to price or to network size. While some insurers

[111] *Id.*

[112] *Id.* at 103–04.

[113] *Id.* at 106.

[114] *Id.* at 107.

[115] *Id.*

[116] CMS, *Announcement of Calendar Year (CY) 2016 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter*, 138–40, Apr. 6, 2015.

[117] *Id.*

[118] Letter from Gerard Mulcahy, Director, CMS Medicare Parts C and D Oversight and Enforcement Group, to All Medicare Advantage Organizations and Prescription Drug Plans re: 2015 Program Audit Protocols and Process Updates dated Feb. 13, 2015, at 3.

[119] *Id.*

[120] *Id.*

[121] 42 C.F.R. § 422.760(b)(1).

[122] 42 C.F.R. § 422.750(a).

[123] CMS, *Announcement of Calendar Year (CY) 2016 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter*, 140, Apr. 6, 2015.

[124] Letter from Gerard Mulcahy, Director, CMS Medicare Parts C and D Oversight and Enforcement Group, to Francis Soistman, EVP, Government Services, Aetna Inc. dated Apr. 2, 2015.

[125] *Id.*

[126] CMS, *Announcement of Calendar Year (CY) 2016 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter*, 138–40, Apr. 6, 2015.

maintain that lower reimbursement rates for physicians and selective hospital exclusions from networks are an appropriate way to reduce the annual increases in health care costs and respond to the ACA's emphasis on affordability, and many providers have agreed to accept lower payments in return for increased patient volume, many providers remain critical of narrower networks, arguing that patients are suffering disruption, denials of care, confusion and, in many cases, higher out-of-pocket costs for their health care.

Given that federal and state regulators are increasing their scrutiny of narrower networks, there may be significant push and pull over these issue as insurers design their products in the coming years. At a minimum, it appears that health care insurers can mitigate the regulatory and litigation risks associated with narrowing networks by increasing transparency to consumers.

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