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## Narrow Networks, the Very Sick, and the Patient Protection and Affordable Care Act: Recalling the Purpose of Health Insurance and Reform

Valarie Blake

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# Narrow Networks, the Very Sick, and the Patient Protection and Affordable Care Act: Recalling the Purpose of Health Insurance and Reform

Valarie Blake\*

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## I. INTRODUCTION

Rebekah Blankers took her five-month-old daughter to the hospital after observing that her head looked misshapen.<sup>1</sup> Rebekah’s fears were confirmed when a computerized tomography (CT) scan of Gabriella’s head showed craniosynostosis, a rare genetic defect where the skull bones fuse prematurely, leaving no room for the infant’s brain to grow.<sup>2</sup> Without treatment, intracranial pressure can build and

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1. Caroline Chen, *Insurers Slash Specialty Hospitals to Keep Premiums Low*, BLOOMBERG (Feb. 6, 2014, 7:04 AM), <http://www.bloomberg.com/news/2014-02-06/insurers-slash-specialty-hospitals-to-keep-premiums-low.html>.

2. *Id.*; Press Release, Seattle Children’s Hospital, Seattle Children’s Hospital Treats 125 Patients in January Who Lost Contracted Access Through

cause blindness, seizures, brain damage, and death.<sup>3</sup> Long-lasting facial deformities can obstruct breathing, permanently deform the head, and pose speech and language challenges.<sup>4</sup> Craniosynostosis may also signal underlying genetic conditions that can lead to heart problems, feet deformities, and developmental delays.<sup>5</sup>

Rebekah's family was covered by a Premera health insurance plan that she had purchased on Washington State's Health Benefit Exchange during the 2014 open enrollment.<sup>6</sup> Yet, Premera initially declined to reimburse the hospital for the CT scan.<sup>7</sup> The hospital, Seattle Children's Hospital, was out-of-network and the Premera plan only covered "unique" care at Seattle Children's, that is, care that could not be performed by an in-network provider.<sup>8</sup> For example, a CT scan or blood work might not be reimbursed if provided at Seattle Children's while a specialized surgery not capable of being performed elsewhere might.<sup>9</sup> Premera later agreed to cover all Seattle Children's care for two months for Gabriella, but then only cover unique services.<sup>10</sup> Because it was still open enrollment period on the exchange, Rebekah transferred Gabriella to a more expensive health insurance plan that covered Seattle Children's in-network, while keeping the remainder of the family on the cheaper Premera plan.<sup>11</sup> Rebekah did not feel that Premera's plan could provide appropriate health care for Gabriella "[u]nless [she] went out of state, out of network, or out of pocket."<sup>12</sup>

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Washington's Health Benefit Exchange (Jan. 30, 2014), *available at* <http://www.seattlechildrens.org/media/press-detail.aspx?id=523620>.

3. *Craniosynostosis*, MAYO CLINIC (Sept. 30, 2013), <http://www.mayoclinic.org/diseases-conditions/craniosynostosis/basics/complications/con-20032917>.

4. *Id.*

5. *Id.*

6. Chen, *supra* note 1.

7. *Id.*

8. *Id.* I use provider in the broadest possible sense to encompass a hospital, health system, physician, or other health care professional unless otherwise specified.

9. *See id.*

10. *Id.*

11. *Id.*

12. *Id.*

Seattle Children's provides a number of unique services not available in other area hospitals (like cancer and transplant care) and also handles most tertiary and acute care for the state.<sup>13</sup> How would a plan that did not cover such a hospital serve Gabriella who might require frequent hospitalizations and heart, neurology, vision, rehabilitation, and genetics specialists all coordinating her care? Without Seattle Children's being in-network, Rebekah and Gabriella's doctors would have to continuously justify why any given procedure was unique and unavailable elsewhere or, alternatively, Rebekah might need to take her daughter to a number of different institutions for her care, some perhaps hours away.<sup>14</sup> Arguing that such fracturing of care might lead to coordination, quality, and safety issues, particularly for patients who require tertiary care, Seattle Children's has challenged the state agency approving Premera's plan for a review of whether it offers its enrollees adequate care.<sup>15</sup>

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13. *Id.* For purposes of this Article, I will often refer to care based on its level of complexity. For this Article, I adopt the following definitions. Primary care is "[b]asic or general health care traditionally provided by doctors trained in: family practice, pediatrics, internal medicine, and occasionally gynecology." Secondary care is "the medical care provided by a physician who acts as a consultant at the request of the primary physician." Tertiary care is "[s]pecialized consultative care, usually on referral from primary or secondary medical care personnel, by specialists working in a center that has personnel and facilities for special investigation and treatment." *Tertiary Care Definition*, JOHNS HOPKINS MED., [http://www.hopkinsmedicine.org/patient\\_care/pay\\_bill/insurance\\_footnotes.html](http://www.hopkinsmedicine.org/patient_care/pay_bill/insurance_footnotes.html) (last visited July 17, 2014). Acute care is "all promotive, preventive, curative, rehabilitative or palliative actions, whether oriented towards individuals or populations, whose primary purpose is to improve health and whose effectiveness largely depends on time-sensitive and, frequently, rapid intervention." Jon Mark Hirshon et al., *Health Systems and Services: The Role of Acute Care*, 91 BULL. WORLD HEALTH ORG. 386 (2013), available at <http://www.who.int/bulletin/volumes/91/5/12-112664.pdf>.

14. See Chen, *supra* note 1 ("Unless I went out of state, out of network, or out of pocket.") (internal quotation marks omitted).

15. Press Release, *supra* note 2. In the first month of the exchanges being operational, Seattle Children's reported that it treated approximately 125 former patients who had lost coverage as a result of purchasing insurance on the exchange. *Id.* On behalf of these 125 patients, Seattle Children's filed over 200 exceptions with insurance companies for which it was out-of-network seeking coverage for the care the hospital provided them. *Id.* As of January 2014, the majority of the requests were outstanding, twelve had been paid for, and eight had been denied. Denials included Gabriella's case (later temporarily overturned), "[a] 2-year-old with a neck mass that could have been a dangerous infection or a tumor," and "[a] teenager suffering from mitochondrial disease, a rare disorder that requires treatment from a variety

At the close of the first enrollment in the Patient Protection and Affordable Care Act (PPACA) health insurance exchanges, it is increasingly clear that the Blanker family's experience may not be unique.<sup>16</sup>

Consumers<sup>17</sup> purchasing health insurance on both state- and federally-run exchanges are finding that affordable premiums may come at the cost of restricted provider choice.<sup>18</sup> So-called narrow networks are increasingly popular in individual, small group, and large group insurance markets as a means for insurers to curb premiums and compete for business.<sup>19</sup> As PPACA regulations limit medical underwriting and homogenize insurance offerings, insurers are agreeing to

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of specialists." *Id.* All of these cases raise concerns about how to coordinate the care of a patient requiring a variety of different specialists, when the care is not being provided in a single health care system or hospital. The Vice President of Medical Affairs at Seattle Children's tells of a two-year-old who required hernia surgery, had the surgery scheduled at Seattle Children's, and then later had it cancelled because Children's was out of network. Their referral to an in-network hospital failed, however, when the in-network hospital informed them that they do not perform surgeries on two-year-olds. Mark Del Beccaro, Vice President Med. Affairs, Seattle Children's Hosp., Address to the NAIC Network Adequacy Model Review (B) Subgroups' Regarding Revisions to the Network Adequacy Model Act 3 (June 5, 2014), available at [http://www.naic.org/documents/committees\\_b\\_rftf\\_namr\\_sg\\_140605\\_seattle\\_childrens\\_hospital\\_testimony.pdf](http://www.naic.org/documents/committees_b_rftf_namr_sg_140605_seattle_childrens_hospital_testimony.pdf). These stories will become increasingly familiar, we will discuss, as insurers compete for cheaper providers that may not be able to fulfill the needs of tertiary care patients.

16. See Press Release, *supra* note 2.

17. Throughout this Article I will use terms like enrollees, insureds, consumers, or patients. As Kinney notes, such terms are meant to encompass the broad swath of the public that is intimately concerned with health care. These terms are meant to demarcate where the individual is currently at in the process. I use enrollee, consumer, or insured when speaking about the time of insurance purchase or use of insurance, and patient when speaking about the individual's role in a patient-physician relationship. ELEANOR DEARMAN KINNEY, PROTECTING AMERICAN HEALTH CARE CONSUMERS 9–10 (2002). Many scholars have argued that these terms can alter public perceptions about individual's claims to health care sometimes in harmful ways. For a summary, see Wendy K. Mariner, *Can Consumer-Choice Plans Satisfy Patients?: Problems with Theory and Practice in Health Insurance Contracts*, 69 BROOK. L. REV. 485, 491–92 (2004).

18. Robert Pear, *Lower Health Insurance Premiums to Come at Cost of Fewer Choices*, N.Y. TIMES (Sept. 22, 2013), <http://www.nytimes.com/2013/09/23/health/lower-health-insurance-premiums-to-come-at-cost-of-fewer-choices.html?pagewanted=all&r=0>.

19. Reed Abelson, *More Insured, but the Choices Are Narrowing*, N.Y. TIMES (May 12, 2014), <http://www.nytimes.com/2014/05/13/business/more-insured-but-the-choices-are-narrowing.html>.

nudge their patients to a narrow selection of providers in exchange for better reimbursement rates and lower premiums.<sup>20</sup> This may mean wider availability of health insurance for the public, increased enrollment for insurers, and cost-savings across the health care system.<sup>21</sup>

In exchange for lower costs, narrow networks might mean compromised choice and access issues for some patients.<sup>22</sup> Seattle Children's is just one example of how academic medical centers are being frequently left out of narrow networks.<sup>23</sup> Typically higher in cost, academic medical centers provide important social functions like medical education, research, and tertiary, acute, and other specialized medical care, which are not traditionally performed at other types of institutions.<sup>24</sup> The majority of consumers seem happy to trade extensive provider choice in favor of lower costs.<sup>25</sup> But, to the extent that narrow networks compromise access to certain types of medical care, are they appropriate and, if so, for whom?

Cases like Gabriella's illustrate the ethical dilemma. As insurance becomes more affordable and mandated for purchase, consumers are drawn to the best bargain.<sup>26</sup> Yet, for the unlucky few with a serious illness, narrow networks may challenge their ability to access medically necessary, and even

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20. See *id.*; see also Pear, *supra* note 18.

21. SABRINA CORLETTE & JOANN VOLK, NARROW PROVIDER NETWORKS IN NEW HEALTH PLANS: BALANCING AFFORDABILITY WITH ACCESS TO QUALITY CARE 10 (2014), available at [http://www.rwjf.org/content/dam/farm/reports/issue\\_briefs/2014/rwjf413643](http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2014/rwjf413643).

22. Pear, *supra* note 18.

23. See PRICEWATERHOUSECOOPER HEALTH RESEARCH INST., HEALTH SYSTEMS DEVELOPING STRATEGIES TO CAPTURE NEWLY-INSURED 5–6 (2013) [hereinafter PRICEWATERHOUSECOOPER], available at [http://www.pwc.com/en\\_US/us/health-industries/health-insurance-exchanges/assets/pwc-provider-health-exchanges-09-18-13.pdf](http://www.pwc.com/en_US/us/health-industries/health-insurance-exchanges/assets/pwc-provider-health-exchanges-09-18-13.pdf).

24. Tertiary care by its very definition presumes a single health care system will be performing the care, because of the heightened need for coordination and technology. Chapin White et al., *Understanding Differences Between High- and Low-Price Hospitals: Implications for Efforts to Rein in Costs*, 33 HEALTH AFF. 324, 325 (2014); see also Press Release, *supra* note 2 (“But Dr. Melzer said the real concern is the potential lack of coordinated care . . . . Studies have shown that such fragmenting of health care services can negatively impact outcomes and increase cost.”).

25. LIZ HAMEL ET AL., KAISER FAMILY FOUND., KAISER HEALTH TRACKING POLL: FEBRUARY 2014 17 (2014), available at <http://kff.org/health-reform/poll-finding/kaiser-health-tracking-poll-february-2014/>.

26. *Id.*

life-saving, care.<sup>27</sup> Is it a just outcome if Gabriella's family must pay significantly more for health insurance? If not, then who foots the bill? And what if there are no plans offered on the exchanges that contract with the tertiary providers most appropriate for her condition?

Given their popularity and potential for cost-savings, narrow networks may be here to stay.<sup>28</sup> The PPACA and the states regulate narrow networks through network adequacy provisions, which require plans to provide reasonable access to covered benefits through provider-to-patient ratios, geographic limits, and other criteria.<sup>29</sup> The federal government creates a baseline upon which the states can build more stringent and locally relevant guidelines that reflect their unique health care markets and level of competition.<sup>30</sup> With increased public scrutiny and various legal challenges, state legislatures and the federal government are examining their laws to see whether more safeguards are warranted.<sup>31</sup> Any regulation must strike a balance between network innovation that could curb rising premiums and a level of network adequacy that delivers promised benefits.<sup>32</sup>

In this Article, I argue that narrow networks, in their most extreme, create the very same access issues that the PPACA attempts to eliminate. By sorting the population (and insurance premiums) according to healthy and sick, they pose distributive justice challenges, strain the goals of social health insurance, and create barriers to care for those who most need health insurance (the very sick who access tertiary care); particularly if narrow networks continue to exclude academic medical centers, as this first year on the exchanges has foreshadowed.<sup>33</sup> Narrow networks have the potential to create two streams of health insurance: plans that are affordable, narrow, and ideal for those with few health care needs, and plans that are more expensive yet cover the types of providers

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27. See Press Release, *supra* note 2.

28. See Abelson, *supra* note 19.

29. See SABRINA CORLETTE ET AL., IMPLEMENTATION OF THE AFFORDABLE CARE ACT: CROSS-CUTTING ISSUES 5–6 (2014), available at <http://www.rwjf.org/content/dam/farm/reports/reports/2014/rwjf415649>.

30. See *id.*

31. But see *id.* at 7–8.

32. See *id.* at 8–9.

33. See *infra* Parts V, VI.



that very sick people need.<sup>34</sup> Whether this is an ethically supportable prospect depends on the role we expect health insurance, post-PPACA, to play in society. While a true account of all of the ethical challenges narrow networks raise is beyond the scope of any single manuscript, my purpose is to highlight that network adequacy poses a distributive justice problem that is not currently adequately addressed in the law.

This Article presents an early examination of developing network adequacy issues as they have unfolded on the exchanges, with an eye toward establishing a minimum threshold for access to tertiary care to inform state and federal policymaking. Section II describes how PPACA provisions have led to narrow networks as a new form of insurance competition. In Section III, current data on narrow networks are discussed. Current legal controversies and federal and state law will be summarized in Section IV. In Section V, I argue that current regulatory efforts do not reach to the full breadth of issues that narrow networks create, particularly access to tertiary care and questions of quality and coordination of health care services. I raise two primary ethical issues which must be addressed: (1) what counts as sufficient access, and (2) who is responsible for paying for the health care costs associated with that access? Lastly, in Section VI, I propose a number of practical, regulatory, and policy considerations for legislatures and courts that are attempting to balance the cost and access issues raised by narrow networks.

## II. ALTERED HEALTH INSURANCE COMPETITION DRIVEN BY THE PPACA

The PPACA aims to improve access to health care, make health insurance more affordable, strengthen social safety nets, and enhance consumer rights and protections.<sup>35</sup> It broadly regulates the U.S. health care system, including public and private health care financing and delivery.<sup>36</sup> Of most relevance to this Article are individual and small group market reforms that alter competition among insurers.

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34. *See infra* Part III.

35. *See Health Care that Works for Americans*, WHITE HOUSE, <http://www.whitehouse.gov/healthreform/healthcare-overview> (last visited Oct. 11, 2014).

36. *See id.*

A. BUSINESS AS USUAL: MARKET COMPETITION LEFT UNREGULATED

Health insurance was originally intended as a safety net and a form of mutual aid for those individuals who encountered devastating medical conditions.<sup>37</sup> For a small and predictable cost, larger and unforeseeable costs could be avoided.<sup>38</sup> Social and economic changes, and technological advances, drove medicine out of the home and into the hospital where health care was increasingly safer, more effective, and more valued.<sup>39</sup> Today, health insurance occupies two primary roles: (1) a safety net for significant and unpredictable health care costs like cancer treatments or organ transplantation, and (2) promotion of individual and population health by paying for preventive services like check-ups (which may now also be too expensive to be paid for out-of-pocket).<sup>40</sup> Insurance is a cost spreader, spreading the cost of risk across the individual's lifetime and across society from families that have incurred the risk to those that have not.<sup>41</sup>

But if the purpose of health insurance is to insulate members of society from ruinous health care costs, unregulated health insurance markets are maladaptive because they seek to avoid the very people who need health insurance: the very

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37. See Tom Baker, *Containing the Promise of Insurance: Adverse Selection and Risk Classification*, 9 CONN. INS. L.J. 371, 372–73 (2003); John V. Jacobi, *The Ends of Health Insurance*, 30 U.C. DAVIS L. REV. 311, 312–19 (1997); Wendy K. Mariner, *The Affordable Care Act and Health Promotion: The Role of Insurance in Defining Responsibility for Health Risks and Costs*, 50 DUQ. L. REV. 271, 279 (2012); Deborah A. Stone, *The Struggle for the Soul of Health Insurance*, 18 J. HEALTH POL. POL'Y & L. 287 (1993).

38. See Baker, *supra* note 37, at 372.

39. See generally Christian Nordqvist, *What Is Modern Medicine?* MED. NEWS TODAY (Aug. 9, 2012), <http://www.medicalnewstoday.com/info/medicine/modern-medicine.php> (providing a historical timeline of changes throughout medical history).

40. Wendy K. Mariner, *Health Reform: What's Insurance Got to Do with It? Recognizing Health Insurance as a Separate Species of Insurance*, 36 AM. J.L. & MED. 436, 441 (2010) [hereinafter *Health Reform*]; Wendy K. Mariner, *Social Solidarity and Personal Responsibility in Health Reform*, 14 CONN. INS. L.J. 199, 200 (2008).

41. Michael J. Graetz & Jerry L. Mashaw, *Constitutional Uncertainty and the Design of Social Insurance: Reflections on the Obamacare Case*, 7 HARV. L. & POL'Y REV. 343, 353 (2013).

sick.<sup>42</sup> Insurers have to offset a number of market imperfections like adverse selection (where individuals avoid the cost of health insurance until they need it) and moral hazard (where individuals seem to need and use insurance more once they have it).<sup>43</sup> Like team captains in gym class, insurers try to stack the deck, picking the best players to offset those few weak ones that they would never recruit purposefully. In health insurance, this practice of allocating health insurance premiums according to actuarial fairness is done through medical underwriting.<sup>44</sup> Healthy individuals are wooed to market with low premiums and the sick are charged higher premiums to offset their anticipated claims.<sup>45</sup> Historically, insurers have used a variety of techniques to do this: denying sick people coverage altogether; imposing pre-existing condition, annual, or lifetime coverage limits; heightening cost-sharing; and refusing to cover certain procedures.<sup>46</sup> This effect was felt most strongly in individual and small group markets, where no pool was large enough to spread the risk.<sup>47</sup> Because health insurance may often mean access to health care, health reform often attempts to mitigate these behaviors.

## B. PPACA REFORMS ALTER INSURANCE COMPETITION

The PPACA fundamentally alters insurance competition by combatting the insurers' desire to dodge risk.<sup>48</sup> The law

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42. Cf. *Health Reform*, *supra* note 40, at 440 (explaining that conventional insurance relies on risk classification, a discriminatory process, to exclude bad risks).

43. Baker, *supra* note 37, at 375; Thomas L. Greaney, *Regulating to Promote Competition in Designing Health Insurance Exchanges*, 20 KAN. J.L. & PUB. POL'Y 237, 242–43 (2011); Jacobi, *supra* note 37, at 371–72; Deborah A. Stone, *Beyond Moral Hazard: Insurance as Moral Opportunity*, 6 CONN. INS. L.J. 11, 13 (1999).

44. Stone, *supra* note 37, at 287, 290.

45. See Baker, *supra* note 37, at 378. Baker analogizes the practice to insurers picking peaches and avoiding lemons. *Id.* at 387 n.36; see also Tom Baker, *Health Insurance, Risk, and Responsibility After the Patient Protection and Affordable Care Act*, 159 U. PA. L. REV. 1577, 1609–10 (2011) [hereinafter *Health Insurance, Risk, and Responsibility*].

46. See *Health Care that Works for Americans*, *supra* note 35.

47. See *id.*

48. For a synopsis of primary insurance reforms, see SABRINA CORLETTE & KEVIN LUCIA, *THE LAUNCH OF THE AFFORDABLE CARE ACT IN SELECTED STATES: REFORMING INSURANCE MARKETS AND PROTECTING CONSUMERS*

promotes access by prohibiting individual and group health plans from discriminating on the basis of preexisting conditions.<sup>49</sup> Insurers cannot refuse coverage based on health status, medical condition (both physical and mental), claims experience (the number of claims per patient), receipt of health care, medical history, genetic information, evidence of insurability (including domestic abuse), disability, and any other health related factor determined appropriate by the Secretary of Health and Human Services.<sup>50</sup> Insurance must be guaranteed issue<sup>51</sup> and guaranteed renewable,<sup>52</sup> and waiting periods for coverage cannot exceed ninety days.<sup>53</sup> By virtue of these changes, the cost that individuals pay for health insurance will now “depend more on their ability to pay than on the amount of health care services consumed, and more on current choices than on inherited or previously determined health risks.”<sup>54</sup> To offset the extension of coverage for those individuals with higher health care costs and to minimize risk avoidance by insurers, the PPACA mandates that most legal residents purchase health insurance or pay a penalty.<sup>55</sup> The

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(2014), *available at* <http://www.urban.org/UploadedPDF/413041-The-Launch-of-the-Affordable-Care-Act-in-Eight-States-Reforming-Insurance-Markets-and-Protecting-Consumers.pdf>.

49. Patient Protection and Affordable Care Act § 2704, 42 U.S.C. § 300gg-3 (2012).

50. 42 U.S.C. § 300gg-4.

51. *Id.* § 300gg-1.

52. *Id.* § 300gg-2.

53. *Id.* § 300gg-7.

54. *Health Insurance, Risk, and Responsibility*, *supra* note 45, at 1597.

55. Patient Protection and Affordable Care Act § 1501, 26 U.S.C. § 5000A (2012). This PPACA section describes a number of religious-based, poverty-based, and other exemptions. Many found the mandate necessary to ensure the viability of the exchange markets. By eliminating bans on pre-existing conditions and annual and lifetime caps on coverage, costs increase and those with higher health risks can view insurance as a bargain while those with lower-risk may view the insurance as high-priced and of marginal value. Low-risk individuals withdraw from the market and premiums must be raised to account for it, leading to the dreaded “death spiral” of much renown with the PPACA. To offset this potential flight from the market, the PPACA’s insurance mandate sets up a financial disincentive. For a detailed discussion of the death spiral potential of the PPACA, see Seth Chandler, *CBO Implies Obama Regulation Shoveled \$8 Billion to Insurers*, ACA DEATH SPIRAL (Apr. 17, 2014), <http://acadeathspiral.org/>. For death spirals generally, see Jacobi, *supra* note 37.

purchase of insurance must occur during an open enrollment period unless there is a qualifying event.<sup>56</sup>

To address affordability, the PPACA limits premium variation in individual and small group markets.<sup>57</sup> It substantially reduces premiums for income-qualified individuals and restricts cost sharing by enrollees, including deductibles.<sup>58</sup> Maximum out-of-pocket limits, however, do not apply to balance billing, the costs that are paid out-of-pocket by the enrollee for out-of-network care.<sup>59</sup> Insurers are limited in their profit-making abilities and must spend 80%–85% of the premiums they collect on the delivery of medical care to enrollees, only keeping 15%–20% of premiums as profit.<sup>60</sup>

Lastly, to ensure that benefits are adequate, the PPACA requires all individual or small group markets to offer minimum essential health benefits.<sup>61</sup> Plans must be worth at least 60% actuarial value and must fall into one of four categories that signal their value (and thus potential out-of-

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56. 26 U.S.C. § 5000A(e). This is to discourage “free riders” from signing up only when they believe they need coverage. *See id.*

57. Rates may only vary based on family size, geographic area, age (cannot vary more than 3-to-1 for adults), and tobacco use (cannot vary more than 1.5-to-1). 42 U.S.C. § 300gg.

58. Patient Protection and Affordable Care Act § 1302(c)(1), 42 U.S.C. § 18022(c) (2012). No cost sharing is permitted for any essential health benefits.

59. Balance billing for out-of-network care is explicitly excluded from the definition of cost sharing and thus some out-of-network care may not be considered in out-of-pocket maximums, actuarial values, etc. 42 U.S.C. § 18022(c)(3)(B). The PPACA does note that essential benefits provided out-of-network must have the same coinsurance rate as in-network benefits, but as a percentage rate, this could still mean a higher amount for individuals if the total sum of the care is greater. Moreover, it is still unclear in the essential benefits context if these out-of-network charges count in the overall out-of-pocket maximum, actuarial value, etc.

60. *Id.* § 18003; *see* 42 U.S.C. § 300gg-18(b).

61. 42 U.S.C. § 18022. Essential health benefits are defined by the Secretary but include at least the following items and services in these general areas: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use services including behavioral health, prescription drugs, rehabilitative services, laboratory services, preventative and wellness services and chronic disease management, and pediatric services (including oral and visual care). *Id.* The Secretary conducts a review to ensure that the essential benefits mirror a typical employer plan and will periodically monitor to assure and address any gaps in coverage. *Id.*

pocket costs) to the consumer.<sup>62</sup> The PPACA also allows the sale of catastrophic plans (high-deductible, low premium plans) on the exchanges but only for individuals below the age of thirty.<sup>63</sup>

In the face of a mandate to cover everyone regardless of health status, the PPACA also discourages risk avoidance on the part of insurers through risk adjustment,<sup>64</sup> risk corridors,<sup>65</sup> and reinsurance.<sup>66</sup> The “three R’s” are designed to maintain true competition in the health insurance market by promoting “consumer value in the form of covered benefits, quality of care, and cost efficiency” rather than how well an insurance company avoids risk.<sup>67</sup> Risk corridor and reinsurance programs

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62. Actuarial values attempt to reflect the cost paid by the insurer versus the enrollee. For example, with a 60% value, an average person can expect the plan to cover 60% of all annual health costs while the patient will pay 40% through deductibles, copays, and coinsurance. LARRY LEVITT & GARY CLAXTON, KAISER FAMILY FOUND., *WHAT THE ACTUARIAL VALUES IN THE AFFORDABLE CARE ACT MEAN* (2011), available at <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8177.pdf>. The four metal categories include bronze plans (60% actuarial value), silver plans (70% actuarial value), gold plans (80% actuarial value) and platinum plans (90% actuarial value). 42 U.S.C. § 18022(d).

63. 42 U.S.C. § 18022(e).

64. 42 U.S.C. § 18063. Risk adjustment concentrates on the health of the insurer’s enrollees, shifting money from plans with “lower than average risk enrollees” to plans who insure enrollees with “higher than average risk.” Timothy Jost, *Implementing Health Reform: Health Insurance Exchanges (Part 3)*, HEALTHAFFAIRS BLOG (July 13, 2011), <http://healthaffairs.org/blog/2011/07/13/implementing-health-reform-health-insurance-exchanges-part-3/>. For thoughts on improving risk adjustment, see MARK A. HALL, COMMONWEALTH FUND, *RISK ADJUSTMENT UNDER THE AFFORDABLE CARE ACT: A GUIDE FOR FEDERAL AND STATE REGULATORS 6–9* (2011), available at [http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2011/May/1501\\_Hall\\_risk\\_adjustment\\_ACA\\_guide\\_for\\_regulators\\_ib\\_v2.pdf](http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2011/May/1501_Hall_risk_adjustment_ACA_guide_for_regulators_ib_v2.pdf).

65. 42 U.S.C. § 18062 (2012). Risk corridors focus on the insurers’ predicted performance, shifting from those who had better experience than anticipated to those who had worse experience. See Jost, *supra* note 64.

66. 42 U.S.C. § 18061. Reinsurance is a form of subsidy to support those plans that cover high-risk individuals. See Jost, *supra* note 64; see also John V. Jacobi, *The Present and Future of Government-Funded Reinsurance*, 51 ST. LOUIS U. L.J. 369, 383–84 (2007).

67. Mark A. Hall, *Risk Adjustment Under the Affordable Care Act: Issues and Options*, 20 KAN. J.L. & PUB. POL’Y 222, 227 (2011) (noting that risk selection can be by chance or by design and can be accomplished by the insurer or by the insured’s selection). For example, insureds with predictable health problems tend to select out of the networks that do not cover their medical care or that require higher cost sharing, while healthier enrollees tend to favor greater cost sharing. HALL, *supra* note 64. For thoughts on

are only in place for the first three years of PPACA implementation to help soften the blows from an unpredictable market, but risk adjustment is a long-term aspect of the law and was a fixture in regulating competition in the Medicare Advantage and Part D markets.<sup>68</sup> If risk adjustment works, it strips from insurers the incentive to cherry-pick the healthiest enrollees, as insurers will essentially lose those gains to poorer-performing insurers.<sup>69</sup> However, insurers will avoid cherry-picking only to the extent that they believe that risk adjustment will be accurate and properly calculated.<sup>70</sup> At least until insurers trust these mechanisms to account for their losses, insurers may continue to avoid risk and favor healthy enrollees to the extent that they are able to under the new reforms.

What are the implications of new insurance competition for the types of products being offered on the exchanges? The next section will discuss narrow networks, the primary new model of competition in the health exchanges.

### III. NARROW NETWORKS AS A NEW MODEL FOR INSURANCE COMPETITION

Success for an insurance company used to mean being the best at avoiding risk.<sup>71</sup> The PPACA alters competition through disincentives to risk-select.<sup>72</sup> But while insurers remain for-profit creatures, they must find new ways to compete.<sup>73</sup> Insurers skeptical of the precision of risk adjustment might

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improving risk adjustment, see ERIC SCHONE & RANDALL S. BROWN, ROBERT WOOD JOHNSON FOUND., *RISK ADJUSTMENT: WHAT IS THE CURRENT STATE OF THE ART, AND HOW CAN IT BE IMPROVED* 18–23 (2013), available at <http://www.rwjf.org/content/dam/farm/reports/reports/2013/rwjf407046>.

68. NAT'L ASS'N OF INS. COMM'RS, *ADVERSE SELECTION ISSUES AND HEALTH INSURANCE EXCHANGES UNDER THE AFFORDABLE CARE ACT* 1, 4–5 (2011), available at <http://www.naic.org/store/free/ASE-OP.pdf>; see also Joseph P. Newhouse et al., *Steps to Reduce Favorable Risk Selection in Medicare Advantage Largely Succeeded, Boding Well for Health Insurance Exchanges*, 31 HEALTH AFF. 2618, 2618–20 (2012) (highlighting the role of risk adjustment in the Medicare Advantage and Part D markets).

69. Newhouse et al., *supra* note 68, at 2618.

70. See *id.* at 2618–19 (“The less effective risk adjustment is, the greater the incentive for competing insurers to select good risks . . .”).

71. *Id.*

72. *Id.*

73. NAT'L ASS'N OF INS. COMM'RS, *supra* note 68, at 3.

continue to simply favor healthy enrollees.<sup>74</sup> Direct advertisement that is intended to draw in the healthy and repel the sick is forbidden,<sup>75</sup> but plans might achieve the same results by offering the cheapest plan with the most minimal benefits permitted by law or by offering high-deductible, low-premium plans.

Insurers might try to attract larger pools of enrollees with lower monthly premiums.<sup>76</sup> As Jost explains, insurers “can’t compete on benefits and cost-sharing, so you compete on your prices and your network and your quality of services.”<sup>77</sup> If the insurer can offer the cheapest or the best value plan, they might attract a larger pool of enrollees overall and secure more profits. And, as early data on the exchange suggests, a primary way to compete via cost is through narrow networks.<sup>78</sup>

#### A. THE RATIONALE FOR NARROW NETWORKS

Many insurance companies are narrowing their networks, increasing their ability to compete for better rates by agreeing to contract only with a narrow group of providers.<sup>79</sup> In return for the insurer’s full market share of patients, providers drop their reimbursement rates and the savings trickle down to the enrollees as lower premiums.<sup>80</sup> While a narrow network may

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74. *Id.* at 1–5.

75. See Patient Protection and Affordable Care Act § 1311(c)(1)(A), 42 U.S.C. § 18031 (2012) (requiring that insurance packages being offered on the exchanges “meet marketing requirements, and not employ marketing practices or benefit designs that have the effect of discouraging the enrollment in such plan by individuals with significant health needs”).

76. While medical loss ratios require the insurer to keep only a percentage of their premiums for profits when compared with medical care, the requirement is a percentage-based return, thus not discouraging insurers from collecting larger pools of premiums overall. See *supra* notes 58–61 and accompanying text.

77. Patrick Connole, *Providers Turn to Courts, Regulators for Relief as Insurers Favor Narrower Networks*, HEALTH PLAN WK. (AIS HEALTH) (Oct. 21, 2013), available at <http://aishealth.com/archive/nhpw102113-02> (quoting Timothy Jost). Jost reminds us of the history behind such regulated competition based on the works of economist Alain Enthoven. See Timothy Stoltzfus Jost, *The Health Insurance Exchange and Competing Visions of Justice*, LAHEY CLINIC J. MED. ETHICS, Fall 2010, at 4, 4.

78. See Connole, *supra* note 77 (discussing competition among insurers through the use of narrow networks).

79. *Id.*

80. Joseph Burns, *Narrow Networks Found to Yield Substantial Savings*, MANAGED CARE (Feb. 2012), <http://www.managedcaremag.com/archives>



seem unattractive compared to broader choice, narrow networks may introduce cost-savings that other models cannot.<sup>81</sup> Narrow networks come in multiple forms. Tiered physician networks are less restrictive, assigning physicians into preferred and non-preferred networks where the patient has a choice to go to either tier, but cost sharing is less when visiting a preferred provider.<sup>82</sup> In the more restrictive narrow network, patients are only allowed to see providers that are in-network and care provided outside of the network will not be reimbursed.<sup>83</sup> Recall that balance billing is not prohibited by the PPACA when a patient goes out-of-network and only a handful of states prohibit out-of-network balance billing.<sup>84</sup>

The concept of a narrow network bears a resemblance to managed care plans which rose in popularity in the 1980s and 1990s largely in response to rising health care costs.<sup>85</sup> Controlling costs through limited networks was a hallmark of managed care, like narrow networks, but managed care also used administrative processes to review and restrict care.<sup>86</sup>

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/1202/1202.narrow\_networks.html; see also CORLETTE ET AL., *supra* note 29; Abelson, *supra* note 19; Tracy Jan, *With Health Law, Less-Easy Access in N.H.*, BOS. GLOBE (Jan. 20, 2014), <http://www.bostonglobe.com/news/nation/2014/01/20/narrow-hospital-networks-new-hampshire-spark-outrage-political-attacks/j2ufuNSf9J2sdEQBpgIVqL/story.html>; Pear, *supra* note 18.

81. Promedica Health Systems, Inc., Trade Reg. Rep. (CCH) ¶ 16,700 (F.T.C. Jan. 5, 2012); Connole, *supra* note 77.

82. AM. MED. ASS'N, TIERED AND NARROW PHYSICIAN NETWORKS 1, 2 (2006), available at [http://www.wsma.org.asp1-3.dfw1-1.websitetestlink.com/Media/PRC-pdfs-Operations/PO\\_P4P\\_AMA\\_Tiered%20Narrow\\_Networks\\_0606.pdf](http://www.wsma.org.asp1-3.dfw1-1.websitetestlink.com/Media/PRC-pdfs-Operations/PO_P4P_AMA_Tiered%20Narrow_Networks_0606.pdf).

83. *Id.* This is limited in some regards. For example, most states prohibit balance billing in the context of emergency care. *State Restriction Against Providers Balance Billing Managed Care Enrollees*, KAISER FAM. FOUND. (2013), <http://kff.org/private-insurance/state-indicator/state-restriction-against-providers-balance-billing-managed-care-enrollees/>.

84. Forty-nine states prohibit balance billing for health maintenance organization (HMO) enrollees with in-network expenses; however, only thirteen states prohibit the same for out-of-network balance billing. Twenty-seven states have a ban on balance billing for in-network care through preferred provider organizations (PPOs), with nine states forbidding out-of-network balance billing in that context. *State Restriction Against Providers Balance Billing Managed Care Enrollees*, *supra* note 83.

85. Vickie Yates Brown & Barbara Reid Hartung, *Managed Care at the Crossroads: Can Managed Care Organizations Survive Government Regulation?*, 7 ANNALS HEALTH L. 25, 25-27 (1998).

86. Eleanor Kinney outlines four major areas of reform in response to managed care that were meant to protect patients: (1) limits on networks that might challenge patient access, (2) restrictions on utilization reviews, (3)

Both models present similar policy challenges around how to handle population-based health care while accounting for the interests of individuals,<sup>87</sup> and both face(d) similar backlash around limited provider choice, the implications of this limited choice for quality, consumer skepticism about whether their medical care is being determined based on medical appropriateness or cost,<sup>88</sup> and a pushback by patients whose long-term physicians were no longer covered in their networks.<sup>89</sup>

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restrictions on management measures that involve strict coverage determinations, and (4) restrictions on financial incentives to limit care. As this shows, managed care presented a number of broad access issues that go beyond those raised by narrow networks, but the network concern remains. KINNEY, *supra* note 17, at 11. For a summary of legal responses to managed care at both federal and state levels, see generally *id.*

87. William M. Sage, *Judicial Opinions Involving Health Insurance Coverage: Trompe L'Oeil or Window on the World?*, 31 IND. L. REV. 49, 51 (1998) (presenting the legal and ethical challenges of managed care).

88. For an interesting argument about how managed care can support patient trust in health care, see generally Bradford H. Gray, *Trust and Trustworthy Care in the Managed Care Era*, 16 HEALTH AFF. 34 (1997).

89. For a discussion of some of the challenges faced by managed care with respect to small networks, see Karen A. Jordan, *Managed Competition and Limited Choice of Providers: Countering Negative Perceptions Through a Responsibility to Select Quality Network Physicians*, 27 ARIZ. ST. L.J. 875, 900–01 (1995) (arguing for imposing legal standards on managed care to enforce quality in their recruitment of providers). Although it is beyond the scope of this Article, both managed care and narrow networks implicate antitrust laws and whether insurers can exercise their market power in bargaining for the best rates with hospitals. *Ball Mem'l Hosp., Inc. v. Mut. Hosp. Ins., Inc.*, 784 F.2d 1325, 1331 (7th Cir. 1986). In *Ball*, hospitals tried to sue Blue Cross Blue Shield for excluding them from a newly developed PPO program. *Id.* Judge Easterbrook held that exclusion of these hospitals was not in violation of the Sherman Act because even monopolies can drive hard bargains and use their market power to create good deals for themselves, so long as they came by that power lawfully. *Id.* at 1331, 1337–39. Judge Easterbrook looked to Indiana law, which required plans to “not discriminate unreasonably against or among providers” where differences in price among individual negotiations with hospitals or price differentials due to geography or specialty did not constitute discrimination. *Id.* at 1341. Judge Easterbrook noted that if an “insurer could not cut out of its system the high-price providers . . . there would be no reason for hospitals to bid against one another for inclusion.” *Id.* at 1343. In a similar case where Blue Cross used its market power to barter for lower premiums for its customers, the court found no Sherman Act violation because “Blue Cross has done no more than conduct its business as every rational enterprise does, i.e., get the best deal possible” which it then passes down in savings to its customers. *Travelers Ins. Co. v. Blue Cross of W. Pa.*, 481 F.2d 80, 84 (3d Cir. 1973). Though the use of market share in this way may pose a challenge to other commercial insurers, the goal

Managed care fell out of fashion either in response to increased state and federal regulation or employer preferences.<sup>90</sup> Broader networks brought increased premiums (around an 11% increase per year) until the concept was reintroduced with the PPACA regulatory environment and another pushback against rising health care costs.<sup>91</sup>

Narrow networks may be a response to local market conditions as well as predicted market instabilities driven by the PPACA and the challenge of predicting the risk of the previously uninsured.<sup>92</sup> Some narrow networks may simply be trying to offset hospitals' increasing ability to raise reimbursement rates, as their market control increases with employed physicians and expanded practices.<sup>93</sup>

Understanding the insurer's rationale for contracting with only some providers, as well as which providers they select and why, is critical. Some health insurers may only contract with "efficient" providers, sorting providers based on the resources they use per episode of care, demographics, and diagnoses.<sup>94</sup> Such measurement might favor physicians who use fewer

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of antitrust is to protect competition, not particular competitors. Jack A. Rovner, *Monopsony Power in Health Care Markets: Must the Big Buyer Beware Hard Bargaining?*, 18 LOY. U. CHI. L.J. 857, 860–63 (1987). Similar arguments and conclusions would likely apply to any similar claims brought against narrow networks.

90. Sage describes the frustration consumers felt with managed care narrow networks, which were "selected for unrevealed but presumably economic reasons." William M. Sage, *Relational Duties, Regulatory Duties, and the Widening Gap Between Individual Health Law and Collective Health Policy*, 96 GEO. L.J. 497, 516 (2008).

91. See CORLETTE ET AL., *supra* note 29, at 2.

92. For example, a study found several market conditions that promote narrow networks include "higher excess bed capacity, greater provider or payor fragmentation, and more significant potential for growth from the uninsured than from people who previously had coverage." MCKINSEY CTR. FOR U.S. HEALTH SYS. REFORM, HOSPITAL NETWORKS: UPDATED NATIONAL VIEW OF CONFIGURATIONS ON THE EXCHANGES 1, 3 (2014), available at [http://healthcare.mckinsey.com/sites/default/files/McK%20Reform%20Center%20-%20Hospital%20networks%20national%20update%20%28June%202014%29\\_0.pdf](http://healthcare.mckinsey.com/sites/default/files/McK%20Reform%20Center%20-%20Hospital%20networks%20national%20update%20%28June%202014%29_0.pdf).

93. This is contrasted with public insurance, which typically establishes a set rate that the provider takes or leaves. For example, differences between payments for Medicare and private payment for the same hospital average 40% more, but can rise as high as 600%. CORLETTE ET AL., *supra* note 29, at 3.

94. See AM. MED. ASS'N, *supra* note 82, at 2–4.

resources for their patients, for better or for worse.<sup>95</sup> Alternatively, insurers might simply select the cheapest providers possible, raising quality issues.<sup>96</sup>

Alternately, some insurers may positively use their market power to promote high-quality, cost-conscious care.<sup>97</sup> For instance, some insurers allow enrollees to go out-of-network (and even out-of-state) to providers that have cost conscious, value-driven clinical results.<sup>98</sup> Lowe's Home Improvement, for example, has contracted with the Cleveland Clinic to provide cardiac surgery for all of its employees or dependents and, given their large national market share, their rate is still about the same for a local procedure despite paying for travel, hotel, and meals.<sup>99</sup>

Narrow networks vary by intentionality, as well. Some insurers consciously impose a narrow network design while other insurers simply establish a lower reimbursement rate, which not all providers are willing to accept.<sup>100</sup>

Theoretically, narrow networks could be used as a tool by insurers to continue to avoid risk (even in the face of PPACA prohibitions) if healthy enrollees are naturally drawn to narrow networks and the sick are not.<sup>101</sup> While risk adjustment evens out the playing field so that everybody carries some burden for covering the sick, it does not adjust for those insurers who

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95. Moreover, episode groupers are critiqued for failing to consider comorbidities of patients, socioeconomic status of patients, patient adherence, and inaccurate or incomplete descriptions of an episode of care partly due to limitations of accuracy and specificity of medical claim systems. *Id.* at 3–5. We expect physicians to monitor and be prudent with health care resources yet we do not want physicians to undercut patient care solely in the name of saving money. AM. MED. ASS'N, CODE OF MEDICAL ETHICS: OPINION 9.0652 - PHYSICIAN STEWARDSHIP OF HEALTH CARE RESOURCES (2012), *available at* <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion90652.page>.

96. *See* AM. MED. ASS'N, *supra* note 82, at 4.

97. CORLETTE ET AL., *supra* note 29, at 3.

98. *Id.*

99. PepsiCo has a similar arrangement for its employees' cardiac and joint surgeries with Johns Hopkins. Burns, *supra* note 80.

100. CORLETTE ET AL., *supra* note 29.

101. *See* Newhouse et al., *supra* note 68, at 2624–26. This certainly makes intuitive sense if an individual with a known serious health condition has to choose a broader network to have their specialist or specialists covered or their higher cost health care systems covered. *See* CORLETTE ET AL., *supra* note 29, at 3–5.

simply recruit larger pools of enrollees.<sup>102</sup> In other words, if narrow networks draw in large crowds of healthy enrollees, the insurer might have to redistribute their premium dollars to poorer performing insurers who attracted sicker enrollees, but not the premium dollars they earned for recruiting more enrollees overall. Thus, insurers are incentivized to craft the plan that attracts the biggest pool of enrollees.<sup>103</sup> If many people are more interested in the cheapest plan than the one that offers broader coverage (like tertiary care) then we might see such plans pervade the market, and the enrollees who do need broader coverage may be too small to make a difference in the market.<sup>104</sup> As the next section describes, this is exactly what early data on narrow networks shows.

## B. EARLY DATA ON NARROW NETWORKS

About three-quarters of all insurance companies planned to and did offer a narrow network on the exchange in 2014, compared with about half of plans before the exchange.<sup>105</sup> Narrow networks are increasingly popular in employer plans, as well.<sup>106</sup>

Nationwide for 2014, most consumers had a choice between either a broad or narrow network on the exchange.<sup>107</sup> But narrow networks made up almost half of all plans offered on the exchange, and 60% of urban markets.<sup>108</sup> The current 2014

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102. See *supra* notes 77–80 and accompanying text.

103. See *supra* notes 76–78 and accompanying text.

104. See CORLETTE ET AL., *supra* note 29, at 8.

105. Of insurers polled, 69% predicted they would offer narrow network plans on the exchanges in 2014. See PRICEWATERHOUSECOOPER, *supra* note 23, at 1–3. Of fourteen state exchanges studied during the first operational year, 78% of new individual insurers had some narrow network offering (compared with only 42% of plans offering narrow networks prior to the exchanges). MCKINSEY CTR. FOR U.S. HEALTH SYS. REFORM, EMERGING EXCHANGE DYNAMICS: TEMPORARY TURBULENCE OR SUSTAINABLE MARKET DISRUPTION? 1, 6 (2013), available at [http://healthcare.mckinsey.com/sites/default/files/Emerging\\_Exchange\\_Dynamics\\_September\\_2013\\_FINAL.pdf](http://healthcare.mckinsey.com/sites/default/files/Emerging_Exchange_Dynamics_September_2013_FINAL.pdf).

106. Narrow networks rose in the employer market from 15% in 2007 to 23% in 2012. CORLETTE ET AL., *supra* note 29.

107. Broader networks were available on the exchanges to nearly 90% of the U.S. population while narrow networks were available to about 92%. See MCKINSEY CTR., *supra* note 92, at 2.

108. Of the 48% that were narrow network plans, 22% of plans were narrow, 19% were ultra-narrow, and 7% were tiered. *Id.* at 4. The study defines a broad network as 70% or more of hospital participation within the

exchange market reflected some reluctance among large insurers to enter the exchange market but also a wealth of new individual market entrants.<sup>109</sup> Levels of competition in the market varied across the states, with some states having only one insurer on the exchange and others having a multitude.<sup>110</sup>

Premiums are predicted to be between 13% and 17% cheaper in most narrow networks, which could mean twenty-nine to fifty-nine dollars in premiums saved “per member per month.”<sup>111</sup> Premium savings vary across markets, though, with some predicting modest 4% savings and others predicting savings as great as 53%.<sup>112</sup>

In return, narrow networks limit hospital choice.<sup>113</sup> The majority of narrow networks excluded at least one hospital from their plan, and about half excluded a hospital from each

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area, a narrow network as 31 to 70% participation, and an ultra-narrow network as 30% or less participation. *Id.*

109. Approximately one-third of the insurers who previously operated on the individual market chose not to participate in the exchanges for 2014, while new individual insurers made up about 26% of the overall individual market for 2014. MCKINSEY CTR., *supra* note 105, at 4.

110. The average number of competitors in any given market was 3.9 for the 395 rating areas across the thirty-four states that used a federally facilitated exchange. *Gruber and Colleagues Call for More Research on Health Plan Competition*, PHYSICIANS FOR NAT'L HEALTH PROGRAM (May 20, 2014), <http://www.pnhp.org/news/2014/may/gruber-and-colleagues-call-for-more-research-on-health-plan-competition>. For example, in 2010, more than half of the states had over half of their market dominated by a single insurer. KAISER FAMILY FOUND., HOW COMPETITIVE ARE STATE INSURANCE MARKETS? 1, 5 (2011), available at <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8242.pdf>. There is significant variation in this regard. For example, on the higher competition side, states like Colorado, Missouri, Pennsylvania, New York, and Wisconsin have large insurers only accounting for 21 to 34% of individual markets while Alabama and Indiana's large insurers dominate 84 to 86% of the individual market. *Id.* at 7–8. The small group reflects similar competition dynamics across the country. *Id.*

111. MCKINSEY CTR., *supra* note 92, at 7.

112. Aetna projects 1% to 4% lower premiums for its employer-based narrow plans, compared with traditional plans, while Health Net of Arizona predicts 10% to 20% cheaper rates and Blue Shield of California will have prices 10% to 15% lower than standard plans. Burns, *supra* note 80. New York State's Blue Cross and Blue Shield Plans projected that, if it were forced to provide out-of-network coverage for exchange products, premiums would rise nearly 30% as a result. Connoles, *supra* note 77.

113. MCKINSEY CTR., *supra* note 92, at 12–13.

system they contracted with.<sup>114</sup> Meanwhile, New Hampshire had only one insurer on the exchange, which excluded ten of the state's twenty-six hospitals.<sup>115</sup> This may suggest challenges for enrollees if they are looking for coverage for a particular hospital (whether tertiary or community) that is not participating in any narrow networks. Also, while early data suggests there may be no overall quality difference between the care delivered in broad and narrow networks based on Centers for Medicare and Medicaid Services (CMS) hospital metrics,<sup>116</sup> the types of hospitals included in broad versus narrow networks differ markedly. Only 14% of acute hospitals participated in ultra-narrow networks and these networks only included academic medical centers in less than half of their plans.<sup>117</sup> Networks that included academic medical centers had 9% higher premiums.<sup>118</sup> For example, "[i]nsurers passed over major medical centers in Chicago, Indiana, Kentucky, Los Angeles, [and] Tennessee."<sup>119</sup> While BlueShield of California included 53% of state providers in its broadest commercial network, the network excluded all five medical centers of University of California as well as Cedars-Sinai in Beverly Hills.<sup>120</sup>

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114. Three quarters of narrow, silver plans excluded at least one hospital from their network; 44% excluded at least one hospital from each participating system. *Id.* The premium savings for such plans seemed to be around 13%. *Id.*

115. Jan, *supra* note 80.

116. Specifically, the researchers used available data of the following four outcomes: thirty-day mortality rate for heart failure, patient experience rating, clinical scores for surgery patient antibiotics delivery, and hospital value-based purchasing score. MCKINSEY CTR., *supra* note 92, at 9. The value-based purchasing (VBP) score is a composite score where 70% is earned through twelve clinical measures and 30% is earned through eight patient surveys. *Id.* While this is a good early detection of any relevant similarities or differences, the authors admit that different researchers might use different measurements and that differences might emerge through the use of such different measurements. *Id.* For example, arguably antibiotics delivery and myocardial infarction do not reach to the concerns I will raise about tertiary care and persons with a broad variety of complex chronic conditions.

117. 96% of broad networks included an academic medical center, "compared with 40% of the ultra-narrow networks." *Id.* at 10.

118. *Id.*

119. PRICEWATERHOUSECOOPER, *supra* note 23, at 5.

120. The Executive Vice President of California's BlueShield suggested that many insured or lower income individuals who would be purchasing lower premium plans on the exchange do not live in Beverly Hills where Cedars-Sinai is located. Pear, *supra* note 18.

The sorting of academic medical centers and acute care into broader networks with more expensive premiums may have important implications for patient care, particularly patients who require access to highly specialized and coordinated medical care. A recent RAND study found that these hospitals, in exchange for higher rates, “were more likely to be engaged in medical education; offer specialized, expensive services typically associated with tertiary care hospitals; and serve a higher percentage of low-income (and poorly reimbursed) patients.”<sup>121</sup> But these same high-price hospitals also used their size, market share, and inclusion in large health systems to minimize insurers’ ability to negotiate for lower rates.<sup>122</sup> Overall, while higher-price hospitals performed better on reputation-based quality measures like U.S. News and World Report rankings, their performance on outcome-based quality measures were generally not better than lower-price hospitals and, sometimes, worse.<sup>123</sup> However, these quality measures may not account for the sicker patients that high-price hospitals more often see, or may reflect poorer performance on routine care while good outcomes in the tertiary services that make them unique.<sup>124</sup>

### C. IMPLICATIONS OF NARROW NETWORKS FOR PATIENT CARE

According to a recent Kaiser poll, half of patients prefer a broader network with higher premiums and more provider choice, while about one-third prefer a narrow network.<sup>125</sup> The preference for broader networks increases with age, higher income, and access to employer-sponsored insurance.<sup>126</sup> Lower

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121. White et al., *supra* note 24, at 330. The RAND study involved a comparison study of hospital price calculations for a set group of retired autoworkers involving 24,187 inpatient hospital stays at 110 hospitals. *Id.* at 325. The resulting price indexes were then sorted into low-price hospitals (with a price index of 0.77, amounting to thirty hospitals), medium-price hospitals (index of 0.97, amounting to fifty hospitals) and high-price hospitals (index of 1.30, amounting to thirty hospitals). *Id.* at 325–26.

122. *Id.* at 330.

123. *Id.* at 327–29.

124. *Id.* at 330. Another possibility is that high-price hospitals enjoy good reputations among physicians, which are undeserved.

125. The remaining 12% were either undecided or would prefer something else. HAMEL ET AL., *supra* note 25.

126. Only 47% of eighteen- to twenty-nine-year-olds preferred the broader network, compared with 54% of the sixty-five and over crowd. Households making less than \$40,000 preferred broad networks only 44% of the time,



income individuals without employer support for insurance and the uninsured tend to favor narrow networks.<sup>127</sup> Interestingly, preferences for broad networks were malleable.<sup>128</sup> When those who preferred broad networks were told that they could cut their premiums by 25%, preference for broad networks dropped from 51% to 37%.<sup>129</sup> With such findings, it is not surprising that narrow networks are common on the exchanges, particularly given their appeal to the uninsured and purchasers of individual coverage. And given the correlation between higher premiums and coverage of academic medical centers, it is also unsurprising that they are the prime service cut from plans.<sup>130</sup>

While narrow networks are clearly favored, consumer recognition of narrow networks may be problematic, especially among the newly insured. Almost half of persons reported purchasing a narrow network option on the exchanges, but a quarter of all persons purchasing on the exchange did not understand it to be a narrow network when they purchased it.<sup>131</sup> Of these individuals who were unaware of their narrow network, half of them were individuals who had previously been uninsured.<sup>132</sup> Overall, 40% of individuals purchasing any type of plan on the exchanges would have preferred more information about providers available in each network.<sup>133</sup>

Consumer understanding of the consequences of narrow networks is key. The use of narrow networks, while saving on premiums, “may also lead to higher out-of-pocket expenses, especially if a patient has a complex medical problem that’s being treated at a hospital that has been excluded from their

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compared with households making \$90,000 or more who preferred them 62% of the time. The preference for broader networks was also heavily apparent in those covered by employer insurance (55% favored), as opposed to the insured or purchasers of individual coverage, who preferred it only 35% of the time. *Id.*

127. See CORLETTE ET AL., *supra* note 29, at 6–8 (pointing out that evidence suggests such individuals “are more accepting of narrow network when choosing a plan than those with employer-based coverage”).

128. HAMEL ET AL., *supra* note 25.

129. In the same scenario, the preference for broad networks among the uninsured dropped from 35% to only 22%. *Id.*

130. See *supra* notes 117–22 and accompanying text.

131. Individuals unaware of the breadth of their network were also more than twice as likely to have been previously uninsured. MCKINSEY CTR., *supra* note 92, at 14.

132. *Id.*

133. *Id.* at 15.

health plan.”<sup>134</sup> One study projects that as many as three million patients will experience unexpected medical costs for going out-of-network each year.<sup>135</sup> The study found that most plans do not have an out-of-pocket maximum when a patient goes out-of-network.<sup>136</sup> With a risk of balance billing, some patients may forgo necessary care because it is out-of-network and consequently harm their health or require more costly care later, while others might seek care with an out-of-network provider and be subjected to bills and possible medical bankruptcies.<sup>137</sup> The patient may not even realize he or she is going out-of-network, for example, if the in-network hospital has out-of-network physicians delivering care.<sup>138</sup>

Narrow networks are a growing trend which may mean lower premiums overall but higher premiums or out-of-pocket costs for those who know they need access to academic medical centers.<sup>139</sup> Narrow networks are regulated for their availability of providers but, as the next section will describe, the laws do

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134. PRICEWATERHOUSECOOPER, *supra* note 23, at 6.

135. Kelly A. Kyanko et al., *Out-of-Network Physicians: How Prevalent Are Involuntary Use and Cost Transparency?*, 48 HEALTH SERVICES RES. 1154, 1166 (2013). Out of 566 polled patients, 27% cited experience with a previously known physician as their primary reason while 20% cited a recommendation by family, other physician, or friend. *Id.* at 1164. 19% went out-of-network because of a physician’s skill, 9% needed care right away, 4% had no in-network physician available, 4% cited convenient location, 2% knew the service or specialty was not covered by their insurance, 2% stated that they could schedule an appointment sooner with the out-of-network provider, 1% sought a second opinion, and 14% gave “other” as their primary reason. *Id.* at 1164.

136. *Id.* at 1167.

137. CORLETTE & VOLK, *supra* note 21, at 1.

138. *Id.* at 3–4. *See also supra* notes 83–85 and accompanying text. Hospitals may sometimes have a hard time coordinating patient care to guarantee that all providers are in-network. Hospitals and health plans make exclusive contracts with providers for a variety of reasons, both limiting the ability of the provider to be available to multiple hospitals or plans, and potentially limiting the ability of the plan or the hospital to use other providers for its services. Likewise, within the hospital, providers accept varying types of plans. Coordinating a patient’s care to only include in-network providers may be impossible if the hospital does not have a given provider in-network for that type of care and/or based on scheduling, among other reasons. TEX. DEP’T. OF INS., REPORT OF THE HEALTH NETWORK ADEQUACY ADVISORY COMMITTEE, S. 1731-11, 80th Sess., at 15–17 (2009).

139. CORLETTE ET AL., *supra* note 29, at 2–4.

not consider the issue of tertiary access—the primary provider being left out of narrow networks.<sup>140</sup>

#### IV. REGULATION OF NARROW NETWORKS FOR NETWORK ADEQUACY

The Secretary of Health and Human Services establishes “criteria for certification of health plans as qualified health plans (QHP),” before they can be offered on the exchanges (whether federal, state, or jointly-run).<sup>141</sup> Narrow networks are regulated for network adequacy to ensure a sufficient pool of providers for enrollees.<sup>142</sup> The PPACA provides minimum federal regulations for federally-run exchanges, while state-run exchanges have the freedom to follow federal guidance or add additional requirements.<sup>143</sup>

The following section details relevant federal and state guidance, the challenges of applying these standards in practice, and their shortcomings with respect to tertiary care, as evidenced by current legislative and administrative efforts.

##### A. FEDERAL REGULATIONS

The PPACA regulates network adequacy through two main provisions: network adequacy and essential community provider (ECP) rules.<sup>144</sup> Both have roots in earlier federal regulations and national standards.<sup>145</sup>

##### 1. Network Adequacy

To be certified as a QHP, a plan must “ensure a sufficient choice of providers . . . and provide information to enrollees and prospective enrollees on the availability of in-network and out-of-network providers.”<sup>146</sup> The Department of Health and

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140. *See infra* Part IV.

141. Patient Protection and Affordable Care Act § 1311(c)(1), 42 U.S.C. § 18031 (2012).

142. *Id.* § 1311(c)(1)(B).

143. *Id.* § 1311(d)(4).

144. *Id.* § 1311(c)(1)(B)–(C).

145. *Id.*

146. *Id.* § 1311(c)(1)(B). The rule elaborates that the network adequacy standards must be consistent with § 2702(c) of the Public Health Services Act, which allows the plan to limit enrollment to those who live, work, or reside within the area of the network’s plan and may, if too occupied by its responsibilities to current enrollees, deny enrollment of new enrollees so long

Human Services (DHHS) elaborated in 45 C.F.R. § 156.230, saying that networks must be “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.”<sup>147</sup> The regulation does not specify whether sufficient choice can be established by in-network providers or also by out-of-network providers.<sup>148</sup> Notably, network adequacy is about an appropriate *diversity* of providers, not the *services* they cover; the latter is a question of essential health benefits.<sup>149</sup> But, in essence, the rules can be read together to suggest that a plan needs sufficient providers to deliver its essential benefits or any additional ones promised to the beneficiary.

In the preamble to the final rule, DHHS acknowledged that the network adequacy standard is intentionally broad to allow exchanges “significant flexibility to apply this standard to QHPs in a manner appropriate to the State’s existing patterns of care” given “that network adequacy standards should be appropriate to States’ particular geography, demographics, local patterns of care, and market conditions.”<sup>150</sup> DHHS feared that too strict of a federal standard could misalign standards inside and outside of the exchanges and threaten their viability.<sup>151</sup> A minimum standard could provide some baseline and consistent nationwide protection for consumers.<sup>152</sup>

More comprehensive language such as “reasonable proximity of providers to enrollees’ homes or workplaces, ongoing monitoring process, and out-of-network care at no additional cost when in-network care is unavailable,” was rejected after public comment to better align with state

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as this is done without respect to claims experience or health status. Patient Protection and Affordable Care Act § 2704, 42 U.S.C. § 300gg-1(c) (2012).

147. 45 C.F.R. § 156.230(a)(2) (2013).

148. This issue is presented below in the Seattle Children’s case. *See infra* Part VI.C.1.

149. *See* 45 C.F.R. § 156.235(a)(3) (2013) (“Nothing in this requirement shall be construed to require any QHP to provide coverage for any specific medical procedure provided by the essential community provider.”).

150. Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans, 76 Fed. Reg. 41,866, 41,893 (proposed July 15, 2011) (to be codified at 45 C.F.R. pts. 155–56).

151. *Id.*

152. *Id.* at 41,893–94.

regulation.<sup>153</sup> States tend to provide more detailed and varying standards, as will be discussed in the next section.<sup>154</sup>

The National Association of Insurance Commissioners' (NAIC) Managed Care Plan Network Adequacy Model Act of 1996<sup>155</sup> and the 1997 Consumer Bill of Rights and Responsibilities<sup>156</sup> clearly informed the federal standards. They provided more detailed and stringent requirements than the current federal rules.<sup>157</sup> For example, the NAIC provides more food for thought on how network adequacy might be measured.<sup>158</sup> It requires that out-of-network care be made available at no additional cost to the enrollees where in-network providers are insufficient or unavailable to provide a covered benefit<sup>159</sup>—a standard that enjoyed strong support in the public comments to DHHS final rules but was removed to allow more state flexibility.<sup>160</sup> NAIC standards also encouraged insurers to publish information for enrollees about the providers available in the network, procedures for making referrals within and outside of the networks, efforts to monitor adequacy, plans for continuity of care in the event of a contract termination with a provider, and other administrative

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153. Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers, 77 Fed. Reg. 18,310, 18,419 (proposed Mar. 27, 2012) (to be codified at 45 C.F.R. pts. 155–57).

154. *See infra* Part IV.B.

155. NAT'L ASS'N OF INS. COMM'RS, NAIC MODEL LAWS, REGULATIONS AND GUIDELINES: MANAGED CARE PLAN NETWORK ADEQUACY MODEL ACT 74-1, 74-4 (1996) [hereinafter NAIC MODEL ACT], available at [http://www.naic.org/documents/committees\\_models\\_table\\_of\\_contents.pdf](http://www.naic.org/documents/committees_models_table_of_contents.pdf) (“A health carrier providing a managed care plan shall maintain a network that is sufficient in numbers and types of providers to assure that all services to covered persons will be accessible without unreasonable delay.”).

156. PRESIDENT'S ADVISORY COMM'N ON CONSUMER PROT. & QUALITY IN THE HEALTH CARE INDUS., U.S. DEPT OF HEALTH & HUMAN SERVS., CONSUMER BILL OF RIGHTS AND RESPONSIBILITIES (1998) [hereinafter CONSUMER BILL OF RIGHTS], available at [http://archive.ahrq.gov/hcqual/final/append\\_a.html](http://archive.ahrq.gov/hcqual/final/append_a.html).

157. *See supra* notes 155–56.

158. *See* NAIC MODEL ACT, *supra* note 155, at 74-4.

159. *Id.*

160. Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers, 77 Fed. Reg. 18,310, 18,418–19 (proposed Mar. 27, 2012) (to be codified at 45 C.F.R. pt. 155–57).

information related to network adequacy.<sup>161</sup> The NAIC Model Act requires that standards be established for the selection of in-network primary and specialty care providers.<sup>162</sup> Importantly, the selection criteria must not “allow a health carrier to avoid high-risk populations by excluding providers because they are located in geographic areas . . . [with] higher than average claims . . . or health services utilizations.”<sup>163</sup> Even more on point, they must not “*exclude providers because they treat or specialize in treating populations presenting a risk of higher than average claims, losses or health services utilization.*”<sup>164</sup>

Similarly, the Consumer Bill of Rights provided that “[i]f a health plan has an insufficient number or type of providers to provide a covered benefit with the *appropriate degree of specialization*, the plan should ensure that the consumer obtains the benefit *outside the network at no greater cost* than if the benefit were obtained from participating providers.”<sup>165</sup> More specifically, “[c]onsumers with complex or serious medical conditions who require frequent specialty care should have direct access to a qualified specialist of their choice within a plan’s network of providers. Authorizations, when required, should be for an adequate number of direct access visits under an approved treatment plan.”<sup>166</sup> The Consumer Bill of Rights was particularly intended to protect persons from the damages of catastrophic illness, especially vulnerable groups like individuals with mental or physical disabilities, children, and low-income patients.<sup>167</sup> As the language of these latter documents shows, special health care needs have been considered in prior policymaking but were omitted from federal rules to allow room for the states to regulate.

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161. NAIC MODEL ACT, *supra* note 155, at 74-4 to 74-5.

162. *Id.* at 74-6.

163. *Id.* at 74-7.

164. *Id.* (emphasis added). The NAIC Model Act goes on to explain that this provision prevents plans from weeding out enrollees on the basis of disease and cost; if plans to exclude providers in this way were allowed, such plans could ultimately avoid high-cost patients who are receiving ongoing care and who will not select a plan that fails to cover their current specialty providers for that condition. *Id.*

165. CONSUMER BILL OF RIGHTS, *supra* note 156, at ch. 2 (emphasis added).

166. *Id.* at ch. 2.

167. *Id.* at pmbl.

## 2. Essential Community Providers

The second standard related to network adequacy deals with the inclusion of ECPs in the plan.<sup>168</sup> The concept of ECPs arose during Clinton-era health reform.<sup>169</sup> It responded to a concern that insurers would avoid serving geographic areas where the poor or their physicians were located.<sup>170</sup> Similar concerns were raised with Medicaid managed care later in the 1990s.<sup>171</sup> As Jacobi explains, the need to carve out protections for ECPs stems from historical efforts by managed care to avoid covering a patient population that is typically expensive to treat.<sup>172</sup>

The PPACA requires plans offered on the exchanges to include *within* their networks “essential community providers, where available, that serve predominately low-income, medically-underserved individuals.”<sup>173</sup> The PPACA refers to certain safety net and community hospitals, noting that the law does not require insurers to cover specific services, but rather to contract with the providers.<sup>174</sup> The plan must have “a sufficient number and geographic distribution of essential

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168. Patient Protection and Affordable Care Act, § 1311(c)(1)(C), 42 U.S.C. § 18031 (2012).

169. SALLY MCCARTY & MAX FARRIS, GEORGETOWN UNIV. HEALTH POLICY INST., *ACA IMPLICATIONS FOR STATE NETWORK ADEQUACY STANDARDS* (2013), available at [http://www.rwjf.org/content/dam/farm/reports/issue\\_briefs/2013/rwjf407486](http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2013/rwjf407486).

170. *Id.* at 2.

171. *Id.*

172. John V. Jacobi, *Mission and Market in Health Care: Protecting Essential Community Providers for the Poor*, 75 WASH. U. L.Q. 1431, 1446 (1997). While managed care “value[s] efficiency, practice methods that reduce utilization of high-cost modalities of care, well-developed quality measurement systems, and integration with broad delivery systems,” traditional providers of the poor have often measured badly in these areas, given a complex patient population with serious health and socioeconomic challenges. *Id.*

173. § 1311(c)(1)(C). Note that plans are required to contract with ECPs but not other types of providers per § 1311(c)(1)(C). ECPs may include: federally qualified health centers, certain entities receiving grants under the Public Health Services Act including family planning and outpatient early intervention for HIV, AIDS drug purchasers, black lung clinics, hemophilia clinics, certain community hospitals, certain children’s hospitals, certain cancer clinics, rural referral centers, and some critical access hospitals. Public Health Services Act § 340B(a)(4)(A)–(O), 42 U.S.C. §256b(a)(4) (2012). Also included are some safety net hospitals, nonprofit hospitals, and hospitals providing care to students. Social Security Act §1927(c)(1)(D)(i)(IV), 42 U.S.C. § 1396r-8(c)(1)(D)(i)(IV) (2012).

174. § 1311(c)(1)(C).

community providers, where available, to ensure reasonable and timely access to a broad range of such providers for low-income, medically underserved individuals in the QHP's service area."<sup>175</sup> ECPs are circularly defined as "providers that serve predominantly low-income, medically underserved individuals."<sup>176</sup> QHPs need not contract with an ECP that "refuses to accept the generally applicable payment rates of such issuer."<sup>177</sup>

### 3. Other Relevant Federal Guidance

To help with transparency, a plan must share its provider directory for online publication and provide a directory to potential enrollees upon request, which notifies whether any providers are not currently accepting new patients.<sup>178</sup> There is no requirement for how often directories must be updated.<sup>179</sup>

Similar to safeguards put in place during managed care, QHPs must have an effective appeals process for coverage disputes and must notify enrollees about available internal and external appeals, state ombudsman, and other consumer assistance for insurance appeal issues.<sup>180</sup> The exchanges must implement quality improvement strategies and oversee enrollee satisfaction surveys, assessment and ratings of health care quality and outcomes, and information disclosures.<sup>181</sup> Satisfaction surveys may be a way of highlighting, retroactively, if a network has an adequacy problem.

QHPs can be decertified on a federally facilitated exchange if the issuer substantially fails to meet network adequacy or ECP standards,<sup>182</sup> and can appeal this decision through an administrative hearing process.<sup>183</sup>

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175. 45 C.F.R. § 156.235(a) (2013).

176. 45 C.F.R. § 156.235(c).

177. 45 C.F.R. § 156.235(d).

178. 45 C.F.R. § 156.230(b).

179. *See id.* "[R]ather, the rule suggests that Exchanges consider balancing consumer choice with the issuer's regulatory burden to comply." MCCARTY & FARRIS, *supra* note 169.

180. Patient Protection and Affordable Care Act § 2719(a), 42 U.S.C. 300gg-19 (2012).

181. Patient Protection and Affordable Care Act §§ 1311(c)(1), (c)(3), (c)(4), 42 U.S.C. § 18031 (2012).

182. 45 C.F.R. § 156.810(a)(8).

183. 45 C.F.R. § 156.810(e).



#### 4. Centers for Medicare and Medicaid Services Implementing the Law

CMS has issued guidance for federally facilitated exchanges to inform implementation of the PPACA.<sup>184</sup> This guidance is instructive for state-run exchanges but not required, unlike the PPACA rules themselves.<sup>185</sup> For 2014, CMS used state reviews as well as commercial or Medicaid accreditation and consumer complaints to monitor network adequacy.<sup>186</sup> Plans fell within a “safe harbor” if they could show inclusion of at least 20% of ECPs in the network’s region, as well as offer contracts to all available providers of Indian health care in the area and “at least one ECP in each category . . . in each county.”<sup>187</sup> For 2015, CMS reacted to strong public criticism of narrow networks by increasing the

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184. Letter from Ctr. for Consumer Info. & Ins. Oversight & Ctrs. for Medicare & Medicaid Servs., Dep’t of Health & Human Servs., to Issuers on Federally-Facilitated & State Partnership Exchanges 1 (Apr. 5, 2013), available at [http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2014\\_letter\\_to\\_issuers\\_04052013.pdf](http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2014_letter_to_issuers_04052013.pdf).

185. *Id.*

186. *Id.* at 6.

187. *Id.* at 7. The categories of required ECPs include Federally Qualified Health Centers (FQHC) and FQHC “Look-Alike” Clinics, “Ryan White HIV/AIDS providers,” family planning providers, Indian health providers, Hospitals (including Disproportionate Share Hospitals, “Children’s Hospitals, Rural Referral Centers, Sole Community Hospitals, Free-standing Cancer Centers,” and Critical Access Hospitals), and other ECP providers (STD and TB clinics, “Hemophilia Treatment Centers, Black Lung Centers, and other centers serving medically underserved and low income patients”). *Id.* at 8–9. There was an exception to the requirement to contract with at least one category per county if the plan met the 20% threshold and submitted “a supplemental response describing how the applicant’s provider networks provide access to a broad range of ECP types.” Or. Ins. Div., *ECP Supporting Documentation Instructions and Supplemental Response Form*, OR. DEP’T CONSUMER & BUS. SERVICES, [http://www.oregon.gov/DCBS/insurance/insurers/rates-forms/Documents/3-ECP\\_Supplemental\\_Response\\_Form.pdf](http://www.oregon.gov/DCBS/insurance/insurers/rates-forms/Documents/3-ECP_Supplemental_Response_Form.pdf) (last visited Oct. 14, 2014). Plans that met at least 10% of ECPs in that area met the “minimum expectation” if the plan provides “as part of its application a satisfactory narrative justification describing how the issuer’s provider network(s), as currently designed and after taking into account new 2014 enrollment, provides an adequate level of service for low-income and medically underserved enrollees.” Letter to Issuers, *supra* note 184, at 7. A plan that did not meet the 10% or 20% threshold needed to justify why their current proposal was adequate for low-income and medically underserved patients and how they would promote ECP participation in future. *Id.* at 8. Different standards apply, like in the PPACA, for plans that primarily employ providers. *Id.*

stringency of its review.<sup>188</sup> CMS is using a “reasonable access” standard to determine network adequacy for federally facilitated exchanges (states are free to use the same standard).<sup>189</sup> Special attention will be paid to providers that have historically raised network adequacy concerns, including hospital systems, mental health providers, oncology providers, and primary care providers, though nothing explicitly addresses tertiary care providers.<sup>190</sup> CMS will monitor consumer complaints and will be considering the best methods to collect provider network information in the future.<sup>191</sup> It may consider a time or distance standard for future rules, like the states.<sup>192</sup> The 2015 plans are held to a higher standard for ECPs, having to contract with at least 30% of ECPs in the network’s region (up from 20% in 2014).<sup>193</sup>

While more stringent with 2015 guidance, the federal regulation is still meant to be a floor that cedes power to the states to regulate according to their own particular needs.<sup>194</sup>

## B. STATE REGULATIONS

State regulation began in response to managed care after consumers became concerned about keeping their own

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188. Letter from Ctr. for Consumer Info. & Ins. Oversight & Ctrs. for Medicare & Medicaid Servs., Dep’t of Health & Human Servs., to Issuers on Federally-Facilitated Marketplaces 1, 14 (Mar. 14, 2014), *available at* <http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2015-final-issuer-letter-3-14-2014.pdf>.

189. *Id.* at 18.

190. *Id.*

191. *Id.* at 43.

192. *Id.* at 18.

193. *Id.* at 19. The 2015 plan includes a good faith effort to contract with at least one ECP in every category and all Indian health providers. *Id.* If the 30% threshold is not met, the plan must provide a narrative explaining how the plan provides an adequate level of service for “low-income and medically underserved enrollees.” *Id.* at 20. Plans that only met the minimum threshold in 2014 may be recertified if they satisfy the narrative justification. *Id.* CMS projects little problems on this account, given that only one plan reported not meeting the 20% standard in 2014. *Id.* Plans can satisfy this threshold by good faith efforts to contract even if they do not meet the articulated percentage. Good faith means “terms that a willing, similarly-situated, non-ECP provider would accept or has accepted.” *Id.* at 19.

194. Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers, 77 Fed. Reg. 18,310 (proposed Mar. 27, 2012) (to be codified at 45 C.F.R. pts. 155–57).

preferred doctors and having an adequate supply of physicians that were selected based on quality and not cost-savings.<sup>195</sup> State law is more descriptive, and often quantitative, in its network adequacy regulations.<sup>196</sup> Provider-to-patient ratio has been a primary focus; the state designates a certain number of primary or specialty care providers that must be in-network per a set number of enrollees.<sup>197</sup> States also regulate distance to travel between recipients' homes and provider offices<sup>198</sup> or a

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195. *E.g.*, Brown & Hartung, *supra* note 85, at 31–33.

196. Network adequacy provisions for offerings on the exchanges are to be distinguished from purchasing of insurance across state lines, a possibility never permitted before but now being considered both at federal and state levels.

197. For example, Illinois requires one primary care provider per every 1000 patients in Illinois, and one general surgeon per 5000 patients. *Illinois State Partnership Exchange Blueprint Application*, HEALTH CARE REFORM IN ILL.—WHAT IT MEANS TO YOU 7, <http://www2.illinois.gov/gov/healthcarereform/documents/health%20benefits%20exchange/11%2016%2012%20blueprint%20application%20-%20final%20draft.pdf> (last visited Sept. 30, 2014).

198. For 2015, Arkansas has thirty-mile requirements for enrollees with respect to primary care providers, ECPs, and mental health/substance abuse providers, and sixty-mile requirements for specialists. Letter from Ark. Ins. Dep't, to All Licensed Insurers, Health Maintenance Organizations, Fraternal Benefit Societies, Farmers' Mutual Aid Associations or Companies, Hospital Medical Service Corporations, Nat'l Ass'n of Ins. Comm'rs, Producer and Company Trade Associations, and Other Interested Parties 21–23 (Apr. 11, 2014), available at <http://www.insurance.arkansas.gov/Legal/Bulletins/9-2014.pdf>. Delaware has specific provisions that build on the federal standard, e.g., ensuring that every enrollee has access to a primary care provider “whose office is located within 20 miles and no more than 30 minutes driving time.” *Delaware State-Specific Qualified Health Plan (QHP) Standards for Plan Year 2015*, DEL. DEP'T INS., <http://www.delawareinsurance.gov/health-reform/DE-QHP-Standards-PY2015-May2014-v1.pdf> (last visited July 18, 2014). Providers must also meet the state's Medicaid standards for timely access to care for certain types of care including general, specialty, maternity, and behavioral health care. *Id.* Illinois follows the general federal standard but builds upon it with very specific time and distance and provider ratio standards for a variety of general and specialty care. *Illinois State Partnership Exchange Blueprint Application*, *supra* note 197, at 6–7. Minnesota poses some interesting additional language beyond the federal floor and the typical language about provider ratios and time and distance standards. It requires the plan to have appropriate privileged doctors across the hospital systems to allow for timely admitting of patients and also “ha[ve] available, either directly or through arrangements, appropriate and sufficient personnel, physical resources, and equipment to meet the projected needs of enrollees.” MINN. STAT. § 62K.10(subdiv.4)(6) (2013). New Hampshire has been active in the network adequacy realm after a single major insurer offered plans on the exchange excluding ten of the state's hospitals from its network for 2014. *Health*

particular number of providers to choose from within a given geographic area.<sup>199</sup> Some states rely heavily on retrospective consumer complaints and reporting to identify any network weaknesses.<sup>200</sup>

Some states have adopted the NAIC's Model Act with which NAIC encouraged compliance in a 2012 white paper as a way for states to be in compliance with PPACA standards.<sup>201</sup>

Some states look to the federal regulation as a temporary standard while others intend to use it (or some other national standard) in the long-term.<sup>202</sup> For example, the District of Columbia has followed the federal rules with intentions to have its own guidelines by 2016.<sup>203</sup> States vary with respect to how

*Insurance Marketplace Plan Management: 2015 QHP Application Process*, N.H. INS. DEP'T (Mar. 18, 2014), [http://www.nh.gov/insurance/consumers/documents/nhid\\_qhp2015app.pdf](http://www.nh.gov/insurance/consumers/documents/nhid_qhp2015app.pdf). For 2015, New Hampshire is following a mix of federal standards and additional state expectations (e.g., time and distance standards) but has been reviewing its process through the state legislature. *Id.*

199. New York follows the general federal standard with comprehensive additional state standards—provider ratio, time and distance, and the inclusion of certain types of specialists. *Invitation and Requirements for Insurer Certification and Recertification for Participation in 2015*, N.Y. ST. HEALTH 22–23 (Apr. 25, 2014), <http://info.nystateofhealth.ny.gov/sites/default/files/2015%20Invitation%20to%20Participate%20in%20NYSOH.pdf>. A plan must include a choice of three primary care doctors, and a choice of two of each required specialist doctors for each county. *Id.*

200. Kentucky focuses on reporting, which may expose problematic network adequacy issues over time. *State Marketplace Profiles: Kentucky*, KAISER FAM. FOUND., <http://kff.org/health-reform/state-profile/state-exchange-profiles-kentucky/> (last updated Nov. 11, 2013) (“Issuers must submit information on enrollment, denied claims, rating practices, cost-sharing, and payments for out-of-network coverage to the KHBE, DOI, and HHS and provide public access to the data. Issuers are also required to establish and report on quality improvement strategies.”).

201. The white paper recommended additional factors states might consider in determining an adequate network including “geographic distribution of providers” in the area, “population density,” “time and/or distance to access providers,” and “location of low-income, medically underserved [] populations,” while noting that the PPACA affords states considerable flexibility in crafting standards that are best appropriate to their interests. NAT'L ASS'N OF INS. COMM'RS, PLAN MANAGEMENT FUNCTION: NETWORK ADEQUACY WHITE PAPER 1, 6 (June 27, 2012), *available at* [http://www.naic.org/documents/committees\\_b\\_related\\_wp\\_network\\_adequacy.pdf](http://www.naic.org/documents/committees_b_related_wp_network_adequacy.pdf).

202. *E.g., State Marketplace Profiles: District of Columbia*, KAISER FAM. FOUND., <http://kff.org/health-reform/state-profile/state-exchange-profiles-district-of-columbia/> (last updated Oct. 1, 2013).

203. *Id.*

they monitor network adequacy from an administrative perspective.<sup>204</sup>

Meanwhile, in many states, any willing provider (AWP) statutes still stand,<sup>205</sup> impacting network adequacy laws. A number of states passed AWP laws in the 1990s and 2000s in response to managed care.<sup>206</sup> These laws require that the health plan contract with any provider willing to accept the terms of the plan.<sup>207</sup> This typically comes down to whether the provider is willing and able to accept the payment and patient load of the plan.<sup>208</sup> AWP laws may broaden patient choice of providers but may weaken a plan's market share and

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204. A 1999 study related to network adequacy among Medicaid managed care systems found that states had a variety of methods, some more hands-on and some less, for dealing with network adequacy. Mary R. Anderlik & Wendy J. Wilkinson, *The Americans with Disabilities Act and Managed Care*, 37 HOUS. L. REV. 1163, 1202–06 (2000). More paper-oriented approaches relied on on-site or desk reviews of provider directories, networks contracts, contracting process, and related paperwork. *Id.* at 1202–03. Others reviewed member complaints, which was critiqued as being only reactionary. *Id.* at 1203. More pro-active approaches include on-site reviews and tracking requests for services with available contractors. *Id.* at 1203–04. States also have differing agencies responsible for and capable of performing various aspects of the network adequacy and/or plan certification process. For example, Illinois parcels the role of network adequacy review between the Department of Public Health and the Office of Insurance. *Illinois State Partnership Exchange Blueprint Application*, *supra* note 197, at 14–15.

205. See Ashley Noble, *Any Willing or Authorized Providers*, NAT'L CONF. ST. LEGISLATURES (Nov. 5, 2014), <http://www.ncsl.org/research/health/any-willing-or-authorized-providers.aspx>.

206. *Managed Care State Laws and Regulations, Including Consumer and Provider Protections*, NAT'L CONF. ST. LEGISLATURES, <http://www.ncsl.org/research/health/managed-care-state-laws.aspx> (last updated Sept. 2011).

207. Fred J. Hellinger, *Any-Willing-Provider and Freedom-of-Choice Laws: An Economic Assessment*, 14 HEALTH AFF. 297, 297 (1995) (“AWP laws require managed care plans to accept any qualified provider who is willing to accept the terms and conditions of a managed care plan.”).

208. AWP laws are to be distinguished from mandated provider laws, where an insurer that will pay a physician for a particular service must also pay any other provider for that same service (for example insurers that reimburse orthopedic surgeons for lower back treatment must also reimburse chiropractors for treatment of that same condition). James W. Childs, *You May Be Willing but Are You Able? A Critical Analysis of “Any Willing Provider” Legislation*, 27 CUMB. L. REV. 199, 199–201, 227 n.148 (1997); J. Peter Rich & Susan M. Nash, *An Overview of Insurance Payment for Health Care Services and Employee Welfare Benefit Plans*, in 2 HEALTH LAW PRACTICE GUIDE § 18:7 (2014) (differentiating between mandated benefit laws, mandated provider laws, and AWP laws).

bargaining power and, in turn, may increase premiums.<sup>209</sup> AWP laws can be contrasted with freedom of choice laws, where a patient can receive care from providers that have not even signed contracts with the plan.<sup>210</sup> States may also have a good faith contracting requirement which may require plans to contract with a certain number or type of hospitals,<sup>211</sup> or to

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209. Naturally, hospitals excluded from managed care contracts have advocated for these regulations while managed care companies have opposed them, calling for freedom to contract with whichever providers they choose. AWP laws are hotly contested, typically supported by health care providers, and protested by insurers, employers, and trade advocates. See Thomas C. Fox et al., *State “Any Willing Provider” Laws: State Developments*, in HEALTH CARE FIN. TRANSACTIONS MANUAL § 11.35 (2014). Advocates of AWP also argue that such regulation ensures the highest quality of providers and preserves patient choice of provider. Yet opponents counter that by maintaining the ability to contract with only select providers, they retain the market control and can thus better assure quality. The ability of managed care companies to control cost through narrow markets may be overestimated. The only way AWP could completely neutralize the insurers bidding war would be if physicians all banded together to agree upon bottom rates—an activity which is, of course, illegal because of antitrust regulations over price-fixing. Without the ability to band together, some physicians will still worry about being excluded from the market and will be ready to barter for lower reimbursement rates. See also William J. Bahr, *Although Offering More Freedom to Choose, “Any Willing Provider” Legislation Is the Wrong Choice*, 45 U. KAN. L. REV. 557 (1997) (“Any willing provider statutes undermine the incentive of the managed care organizations to set competitive prices so their network will be the choice picked by employers. Without the competition, the managed care organizations lose their ability to control costs. Thus, a state that adopts any willing provider statutes will have less competition among the managed care organizations.”); Childs, *supra* note 208. Disputes related to AWP laws are in the purview of the states, as the ERISA “savings clause” saves them from federal preemption. *E.g.*, *Ky. Ass’n of Health Plans, Inc. v. Miller*, 538 U.S. 329 (2003). Administrative costs may also increase with AWP laws. One study suggests as much as by anywhere from 34 to 52%, but scholars debate the certainty of this data. Sharon Reece, *Puncturing the Funnel—Saving the “Any Willing Provider” Statutes from ERISA Preemption*, 27 U. ARK. LITTLE ROCK L. REV. 407, 418–19 (2005).

210. Twenty-five states have some version of a freedom of choice law which still runs the risk of exposing patients to high out-of-pocket costs, as the laws only guarantee access to care, not reimbursement for it. These regulations are only targeted at managed care typically and tend to carve out specific types of providers, for example, pharmacies in Virginia. VA. CODE ANN. §§ 38.2-3407, -4209.1, -4312.1 (West 2010); Rich & Nash, *supra* note 208.

211. *Illinois State Partnership Exchange Blueprint Application*, *supra* note 197. Whereas in New York each plan must contract with at least one hospital in each county and some counties require more than one hospital, based on population density. *Invitation and Requirements for Insurer Certification and Recertification for Participation in 2015*, *supra* note 199. Delaware requires plans to contract with all federally qualified health centers. *Delaware State-*

offer at least one plan on the exchange that includes their broadest network of providers.<sup>212</sup> This latter provision could be important for tertiary care access, to ensure that at least one plan is available for patients who need it, though it may not ensure that such plans are affordable.

The process of defining network adequacy has been an active one in the state legislatures as states race to catch up to insurance innovation.<sup>213</sup> Public and professional testimony on network adequacy at state legislature and insurance commissioner hearings has perhaps provided some of the more interesting insights.<sup>214</sup>

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*Specific Qualified Health Plan (QHP) Standards for Plan Year 2015, supra note 198.*

212. Massachusetts is requiring insurers to offer plans on the exchange plans in each of the four metallic tiers that include access to their broadest network. Sarah Bushold, Senior Manager of External Affairs & Plan Mgmt., Mass. Health Connector & Ashley Hague, Deputy Exec. Dir. of Strategy & External Affairs, Mass. Health Connector, Address at the Board of Directors Meeting: 2015 Qualified Health and Dental Plan Seal of Approval (Mar. 27, 2013), *available at* [https://www.mahealthconnector.org/HomePortal/content/conn/UCM/path/Contribution%20Folders/Content%20Folders%20for%20Connector/About/Leadership/Board\\_Meetings/2014/2014-03-27/2015\\_SoA\\_Board\\_Presentation\\_032714.pdf](https://www.mahealthconnector.org/HomePortal/content/conn/UCM/path/Contribution%20Folders/Content%20Folders%20for%20Connector/About/Leadership/Board_Meetings/2014/2014-03-27/2015_SoA_Board_Presentation_032714.pdf).

213. Connoles, *supra* note 77 (“[T]he health reform statute and implementing regulations only broadly define network adequacy and plans’ need to offer ‘essential community providers.’ That basically leaves the determination of network adequacy up to the states. And not only do states’ standards differ, but they also are evolving.”).

214. Maryland mainly follows the federal standard but has received interesting comments from carriers about these and other standards including that adequacy standards should focus less on mechanical time and distance standards and more on “access to appropriate, high-quality care,” quality metrics, and patient satisfaction. Carolyn A. Quattrochi, Interim Exec. Dir., Md. Health Connection, Address at the Maryland Health Benefit Exchange Board Meeting: 2015 Plan Certification Standards (Mar. 18, 2014), *available at* <http://marylandhbe.com/wp-content/uploads/2014/03/2015-Plan-Certification-Standards.MHBE-Board.3.18.14pptx.pdf>. A bill is moving through the Connecticut state legislature concerning network adequacy. *See* INS. & REAL ESTATE COMM., JOINT FAVORABLE REPORT: AN ACT CONCERNING HEALTH CARE PROVIDER NETWORK ADEQUACY, S.B. 392, 2014 Sess. (Conn. 2014), *available at* <http://www.cga.ct.gov/2014/JFR/S/2014SB-00392-ROOINS-JFR.htm>. Among a variety of requirements, the bill gives enrollees a choice of at least five different primary care providers in their geographic region, requires and monitors for good faith contracting efforts among both insurers and providers, and requires special attention for the needs of individuals with disabilities. *Id.* Testimony in favor of and against the bill is illuminating. Benefits of the bill included protecting patients who face ever-lengthening commutes to healthcare, maintaining long-term doctor-patient relationships, preserving choice among providers, promoting patient access to trusted

### C. CURRENT CONTROVERSIES IN COURTS AND LEGISLATURES

In addition to state and federal laws setting the standard for what makes a network adequate,<sup>215</sup> state insurance courts are tasked with the challenge of using those laws to approve or disapprove plans for listing on the exchange.<sup>216</sup> In this context, patients who are unsatisfied with their purchased plans and providers who have been excluded from plans<sup>217</sup> are creating a flurry of activity in state legislatures and courts.<sup>218</sup> These cases unveil aspects of network adequacy that are important in practice but not amply met by current network adequacy laws, such as the issue of access to tertiary care as presented by Seattle Children's.

#### 1. Seattle Children's Hospital

Gabriella's story is part of a much larger controversy that occurred at Seattle Children's, a 250-bed nonprofit children's hospital providing tertiary and quaternary care to neonatal and pediatric populations, in the first year of the insurance

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providers, ensuring both timely and clinically appropriate care, promoting transparency of networks for patients, and the process of contracting. *Id.* Concerns raised included disrupting innovation in network delivery, limiting available provider networks and plans, adding administrative burden to state agencies, and the harms of regulatory uncertainty for the insurance industry. *Id.*

215. See Ashley Noble, *Insurance Carriers and Access to Healthcare Providers: Network Adequacy*, NAT'L CONF. ST. LEGISLATURES (June 27, 2014), [http://www.ncsl.org/research/health/insurance-carriers-and-access-to-health-care-providers-network-adequacy.aspx#State\\_Laws](http://www.ncsl.org/research/health/insurance-carriers-and-access-to-health-care-providers-network-adequacy.aspx#State_Laws).

216. Louise Radnofsky, *States Try to Protect Health Exchanges from Court Ruling*, WALL ST. J. (July 25, 2014, 6:51 PM), <http://online.wsj.com/articles/states-try-to-protect-health-exchanges-from-court-ruling-1406328692>.

217. Terry Baynes, *California Consumers Say Duped by Blue Shield's Limited Obamacare Plans*, REUTERS (May 15, 2014, 3:41 PM), <http://www.reuters.com/article/2014/05/15/us-usa-healthcare-blueshield-idUSBREA4E0VN20140515>; Sandhya Somashekhar & Ariana Eunjung Cha, *Insurers Restricting Choice of Doctors and Hospitals to Keep Costs Down*, WASH. POST (Nov. 20, 2013), [http://www.washingtonpost.com/national/health-science/insurers-restricting-choice-of-doctors-and-hospitals-to-keep-costs-down/2013/11/20/98c84e20-4bb4-11e3-ac54-aa84301ced81\\_story.html](http://www.washingtonpost.com/national/health-science/insurers-restricting-choice-of-doctors-and-hospitals-to-keep-costs-down/2013/11/20/98c84e20-4bb4-11e3-ac54-aa84301ced81_story.html); see also Jan, *supra* note 80 (discussing dissatisfaction among newly insured New Hampshire residents).

218. *E.g.*, Somashekhar & Cha, *supra* note 217 (citing the Seattle Children's lawsuit as an example).



exchanges.<sup>219</sup> Seattle Children's petitioned the Office of Insurance Commissioner of the State of Washington (OIC) for a review of its own determination that two health plans excluding Seattle Children's from network (BridgeSpan Health Company<sup>220</sup> and Premera Blue Cross<sup>221</sup>) are adequate.<sup>222</sup> According to representatives from the OIC and relevant insurers, the Premera plan was the only plan being offered on the exchange for a number of Washington counties in 2014.<sup>223</sup>

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219. *Seattle Children's Hospital*, U.S. NEWS & WORLD REP., <http://health.usnews.com/best-hospitals/area/wa/seattle-childrens-hospital-6910560> (last visited Oct. 18, 2014).

220. *About Us*, BRIDGESPAN, [https://www.bridgespanhealth.com/web/bridgespan\\_individual/about-us](https://www.bridgespanhealth.com/web/bridgespan_individual/about-us) (last visited Oct. 7, 2014). BridgeSpan is an exchange-based health insurer offering insurance in Idaho, Oregon, Utah, and Washington. *Id.*

221. *Fast Facts*, PREMERA BLUE CROSS, <https://www.premera.com/wa/visitor/about-premera/fact-sheet/> (last visited Oct. 7, 2014). Premera Blue Cross is a nonprofit Blue Cross Blue Shield health care provider and one of the largest in the Pacific Northwest, servicing 1.8 million people in Washington and Alaska. *Id.*

222. *Seattle Children's Hospital*, No. 13-0293 (Wash. State Office of the Ins. Comm'r Oct. 22, 2013) (demand for hearing) [hereinafter Demand for Hearing], available at <http://www.insurance.wa.gov/laws-rules/administrative-hearings/judicial-proceedings/documents/13-0293-sch-demand.pdf>. A third plan, Coordinated Care, was part of the original suit but has since contracted with Seattle Children's. Coordinated Care specifically designed its network as a low-cost gap insurance for those thousands of individuals or families who "churn off and on Medicaid" as their income changes. It was the lowest priced package on Washington's exchange for 2014. See *Seattle Children's Hospital*, No. 13-0293 (Wash. State Office of the Ins. Comm'r Jan. 17, 2014) (declaration of Jay Fathi), available at <http://www.insurance.wa.gov/laws-rules/administrative-hearings/judicial-proceedings/documents/13-0293-int-msj-fathi-declaration.pdf>. A fourth health insurer, Molina Healthcare of Washington, Inc., later contracted with Seattle Children's after Seattle Children's demanded a hearing, and thus their network adequacy is moot. See Beth Kutscher, *Seattle Children's Settles Differences with Molina Healthcare*, MODERN HEALTHCARE (Oct. 23, 2013), <http://www.modernhealthcare.com/article/20131023/BLOG/310239996>.

223. *Seattle Children's Hospital*, No. 13-0293 (Wash. State Office of the Ins. Comm'r Dec. 2, 2013) (declaration of Christopher Blanton), available at <http://www.insurance.wa.gov/laws-rules/administrative-hearings/judicial-proceedings/documents/13-0293-bridgespan-intervene.pdf>; *Seattle Children's Hospital*, No. 13-0293 (Wash. State Office of the Ins. Comm'r Jan. 17, 2014) (declaration of Jay Fathi), available at <http://www.insurance.wa.gov/laws-rules/administrative-hearings/judicial-proceedings/documents/13-0293-int-msj-fathi-declaration.pdf>; *Seattle Children's Hospital*, No. 13-0293 (Wash. State Office of the Ins. Comm'r Jan. 15, 2014) (declaration of Molly Nollette), available at <http://www.insurance.wa.gov/laws-rules/administrative-hearings/judicial-proceedings/documents/13-0293-oic-dismiss-nollette-dec-1.pdf>.

Only one plan covered Seattle Cancer Care Alliance in 2014 on the exchange, while at the time only three plans covered Seattle Children's.<sup>224</sup> The cheapest plans offered on the exchanges were the ones that typically excluded Seattle Children's from the network.<sup>225</sup>

Seattle Children's argued that many patients, when sick, will still present to their hospital regardless of network status (and perhaps more acutely ill and in need of more expensive services than if they had regular access to the hospital).<sup>226</sup> Seattle Children's may be unable to transfer such patients if care is needed imminently, or may simply find referral inappropriate if the in-network providers are not used to the volume or severity of the cases.<sup>227</sup> Seattle Children's may have no way to receive compensation for its services and, while charity care can address this, it will mean fewer resources for others in the community without insurance.<sup>228</sup> The OIC

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Premera has a contract with Seattle Children's but Seattle Children's disputes the applicability of that contract to insurance plans offered on the exchange. See Seattle Children's Hospital, No. 13-0293 (Wash. State Office of the Ins. Comm'r Jan. 15, 2014) (OIC staff's motion to dismiss demand for hearing and to terminate adjudicative proceeding), *available at* <http://www.insurance.wa.gov/laws-rules/administrative-hearings/judicial-proceedings/documents/13-0293-oic-dismiss-motion.pdf>.

224. Carol Ostrom, *Obamacare Implementation in Seattle Draws Fire for Excluding Seattle Children's Hospital from Network*, MEDCITY NEWS (Apr. 24, 2014, 6:00 AM), <http://medcitynews.com/2014/04/obamacare-implementation-in-seattle-draws-fire-for-excluding-seattle-childrens-hospital-from-network/>.

225. See Amy Snow Landa, *Children's Hospital Sues State Over Exclusion from Exchange Plan Networks*, SEATTLE TIMES (Oct. 4, 2013, 3:50 PM), <http://blogs.seattletimes.com/healthcarecheckup/2013/10/04/childrens-hospital-sues-state-over-exclusion-from-exchange-plan-networks/>; Carol M. Ostrom & Amy Snow Landa, *Many Health-Exchange Plans Exclude Top Hospitals from Coverage*, SEATTLE TIMES (Mar. 19, 2014, 10:41 AM), [http://seattletimes.com/html/localnews/2022371201\\_exchangenetworksxml.html](http://seattletimes.com/html/localnews/2022371201_exchangenetworksxml.html).

226. Demand for Hearing, *supra* note 222 ("Many patients enrolled in these exchange plans who require services available only at SCH are likely to present for services at SCH, regardless of its network status, more acutely ill and require more services, and more complex services when they present for care.").

227. See Press Release, *supra* note 2.

228. Demand for Hearing, *supra* note 222 ("These patients will consume more resources, thereby reducing resources available for other SCH patients and impairing the ability of SCH to serve the pediatric healthcare needs of the region. SCH will, in addition, not be fairly compensated for these services because of its exclusion from these exchange plan networks.").

reviewed for network adequacy using the federal regulations as well as two state laws.<sup>229</sup>

In an earlier case, the OIC had initially disapproved a third plan, Coordinated Care, for not being adequate because it had not contracted with pediatric hospitals and level 1 burn units and was planning to spot contract (providing individual agreements for services on an as-needed basis) instead.<sup>230</sup> Coordinated Care appealed.<sup>231</sup> Applying only state law, the Chief Presiding Officer found the plan adequate because state laws do not explicitly require that an insurer contract with all burn units or pediatric hospitals in the area.<sup>232</sup> In fact there is

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229. WASH. ADMIN. CODE § 284-43-200 (2014) requires a health carrier to “maintain each provider network for each health plan in a manner that is sufficient in numbers and types of providers and facilities to assure that . . . all health plan services provided to enrollees will be accessible” without unreasonable delay as well as “adequate choice among [each type of] health care provider[.]” The statute allows sufficiency and adequacy of choice to be established by a number of criteria including, “provider-covered person ratios by specialty; primary care covered person ratios; geographic accessibility; waiting times for appointments with participating providers; hours of operation; and the volume of technology and specialty services available to serve the needs of covered persons requiring technologically advanced or specialty care.” NAIC MODEL ACT, *supra* note 155, at 74-4. State agency standards like that of Medicaid can be used to demonstrate network sufficiency. WASH. REV. CODE ANN. § 48.46.030 (West 2013) requires, for certification of health maintenance organizations, that they demonstrate that their “facilities and personnel are reasonably adequate to provide comprehensive health care services to enrolled participants . . . .”

230. Coordinated Care Corp., No. 13-0232 (Wash. State Office of the Ins. Comm’r Sept. 3, 2013) (findings of fact, conclusions of law and final order) at 16–17 [hereinafter Findings of Fact, Conclusions of Law and Final Order], *available at* <http://www.insurance.wa.gov/laws-rules/administrative-hearings/judicial-proceedings/documents/13-0293-oic-dismiss-nollette-dec-2.pdf> (“[T]he OIC advised that its remaining concerns about [the network adequacy] issue are 1) the Company has no massage therapists in its provider network; 2) the Company has no Level 1 Burn Unit or pediatric specialty hospitals in its network; and 3) the Company is not allowed to use ‘spot contracts’ or ‘single payer agreements’ to complete its network of providers because, e.g., the Providers under the Company’s plan are prohibited from balance billing the consumer (which those ‘spot contract’ providers would do).”).

231. *Id.*

232. Likewise, the statute allowed for similarity to a Medicaid plan to be evidence of network sufficiency, and this plan was almost identical to the already-approved Medicaid plan. *See id.*; Coordinated Care Corp., No. 13-0232 (Wash. State Office of the Ins. Comm’r Nov. 15, 2013) (order on OIC’s motion for reconsideration) [hereinafter Order on OIC’s Motion], *available at* <http://www.insurance.wa.gov/laws-rules/administrative-hearings/judicial-proceedings/documents/13-0232-reconsideration-order.pdf>.

no requirement that these types of facilities must be included in-network at all, so long as the care is ultimately accessible to the patient.<sup>233</sup> Coordinated Care presented testimony that 99% of all services could be covered in-network, while “unique” services could be offered through spot contracts.<sup>234</sup> Spot contracts were ultimately permitted, so long as patients were informed that they are protected from balance billing in the event of a spot contract.<sup>235</sup> This “unique” care standard is what could lead a patient like Gabriella to require care from a variety of different providers without coordination.

In the present case, Seattle Children’s argued that BridgeSpan’s and Premera’s networks are inadequate according to both federal and state standards because the plans have failed to include sufficient ECPs and have failed to provide essential health benefits including pediatric services.<sup>236</sup> The OIC admitted that Seattle Children’s is an ECP, as the only pediatric hospital in King County and as the provider of services that are unique in the state and the Northwest region.<sup>237</sup> In terms of uniqueness, Seattle Children’s claims to have provided the following for the state of Washington in 2012: 100% of kidney and liver transplants, 81.7% of all age zero to fourteen pediatric inpatient discharges within a thirty

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233. Order on OIC’s Motion, *supra* note 232 (“[O]n cross examination the OIC agreed, correctly, that these rules do not specifically require the Company to include Pediatric Specialty Hospitals and Level I Burn Units in its network [Testimony of Kreitler] but that WAC 284-43-200(1) requires that the Company maintain each plan network in a manner that is sufficient in numbers and types of providers and facilities to assure all health plan services to covered persons will be accessible without unreasonable delay.”).

234. *See id.*

235. Coordinated Care pointed to other established network contracts that had been permitted to use “spot contracts” in the past via OIC. Findings of Fact, Conclusions of Law and Final Order, *supra* note 230. It also pointed to language in WASH. REV. CODE ANN. § 48.46.030 (West 2013), which explicitly permits the use of out-of-network providers so long as the consumer is not placed in a worse position. *Id.*

236. *See* Seattle Children’s Hospital, No. 13-0293 (Wash. State Office of the Ins. Comm’r Jan. 17, 2014) (motion for partial summary judgment), *available at* <http://www.insurance.wa.gov/laws-rules/administrative-hearings/judicial-proceedings/documents/13-0293-sch-msj-motion.pdf>.

237. *Id.* (“There is no dispute here that SCH is an essential community provider; the OIC has admitted this . . . There also can be no dispute here that SCH, the only pediatric hospital in King County, providing multiple services that are unique in the state and Northwest, is providing essential health benefits.”) (citation omitted).

mile radius, 90% of all pediatric ECMO procedures, 90% of pediatric bone marrow transplants, 70% of all pediatric heart surgeries in the state, 75% of all pediatric psychiatry inpatients, 81% of all pediatric inpatients generally, and 90% of all high acuity inpatients in a thirty mile radius.<sup>238</sup> Notably, Seattle Children's uniqueness is about the quantity, as well as range, of its services.

Seattle Children's challenged the use of spot contracts for the over 50,000 patients that are being covered by these plans.<sup>239</sup> They pointed to data suggesting a very low rate of actual use of spot contracts, insinuating that health plans may not be as generous at covering unique services as they now indicate.<sup>240</sup> Seattle Children's argued the lack of in-network status has already caused harm to patients and administrative burden for Seattle Children's.<sup>241</sup> The OIC and insurance plans countered that neither the federal nor state regulations on network adequacy require "inclusion of a specific provider, regardless of their preeminence or sympathetic patient base" or their level of experience.<sup>242</sup> The plans argued that, according to

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238. *See id.*; Seattle Children's Hospital, No. 13-0293 (Wash. State Office of the Ins. Comm'r Jan. 17, 2014) (declaration of Michael Madden), *available at* <http://www.insurance.wa.gov/laws-rules/administrative-hearings/judicial-proceedings/documents/13-0293-sch-msj-madden-declaration.pdf>.

239. Seattle Children's Hospital, No. 13-0293 (Wash. State Office of the Ins. Comm'r Jan. 29, 2014) (opposition to intervenors' joint motion for summary judgment), *available at* <http://www.insurance.wa.gov/laws-rules/administrative-hearings/judicial-proceedings/documents/13-0293-int-msj-sch-opposition.pdf>.

240. In 2012, spot contracts occurred in only 67 cases out of 351,147 patient encounters (a rate of 0.02%) and in other years spot contracts have been in the single digits. *See id.*

241. In January 2014, Seattle Children's had to add three full time employees to process paperwork with Premera and has already made 200 requests for spot contract coverage for patients, compared with four spot contracts in the past. Seattle Children's Hospital, No. 13-0293 (Wash. State Office of the Ins. Comm'r Mar. 14, 2014) (order on motion for partial summary judgment) at 4-5, *available at* <http://www.insurance.wa.gov/laws-rules/administrative-hearings/judicial-proceedings/documents/13-0293-order-sch-msj.pdf>. Of these 200 requests, Seattle Children's says that only 21 have been approved, 8 have been denied, and the remainder have not been settled, which certainly poses a concern about the rapidity if not frequency with which such claims can or will be approved. *Id.*

242. Seattle Children's Hospital, No. 13-0293 (Wash. State Office of the Ins. Comm'r Jan. 29, 2014) (OIC's opposition to motion for partial summary judgment), *available at* <http://www.insurance.wa.gov/laws-rules>

the regulations for QHP certification, they fulfill the 20% ECP enrollment standard for 2014.<sup>243</sup>

The court ruled that there are genuine material issues of fact as to whether the OIC properly considered the uniqueness of Seattle Children's services in certifying plans for the exchange and agreed to hear oral arguments.<sup>244</sup> The primary relief that could be granted in such a case would be to deauthorize the plans for listing on the exchange or fail to reauthorize them in the future.<sup>245</sup> However, this was rendered unnecessary when, before oral arguments, both Premera and BridgeSpan agreed to cover Seattle Children's in some exchange plans, and Seattle Children's dismissed their appeal with prejudice.<sup>246</sup> Meanwhile, new plans were approved for

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/administrative-hearings/judicial-proceedings/documents/13-0293-sch-msj-opp  
osition-oic.pdf.

243. Seattle Children's Hospital, No. 13-0293 (Wash. State Office of the Ins. Comm'r Jan. 17, 2014) (intervenors' joint motion for summary judgment), *available at* <http://www.insurance.wa.gov/laws-rules/administrative-hearings/judicial-proceedings/documents/13-0293-int-msj-motion.pdf>.

244. Seattle Children's Hospital, No. 13-0293 (Wash. State Office of the Ins. Comm'r Jan. 17, 2014) (motion for partial summary judgment), *available at* <http://www.insurance.wa.gov/laws-rules/administrative-hearings/judicial-proceedings/documents/13-0293-sch-msj-motion.pdf>. Premera and BridgeSpan had argued that the issue of spot contracting has already been settled by the Coordinated Care case but summary judgment was denied since that case only applied state, and not federal, law. Likewise, the Coordinated Care case being referred to and discussed above did not expressly allow networks to use spot contracting to satisfy network adequacy. Seattle Children's Hospital, No. 13-0293 (Wash. State Office of the Ins. Comm'r Feb. 20, 2014) (order on intervenors' joint motion for summary judgment), *available at* <http://www.insurance.wa.gov/laws-rules/administrative-hearings/judicial-proceedings/documents/13-0293-order-intervenors-msj.pdf>.

245. "The Exchange may at any time decertify a health plan if the Exchange determines that the QHP issuer is no longer in compliance with the general certification criteria . . ." Decertification of QHPs, 45 C.F.R. 155.1080 (2012). The Exchanges are also responsible for establishing processes for decertification and appeal of decertification. *Id.* The Chief Presiding Officer for the OIC has declared justiciability, noting that the case is asking whether authorization of the health insurers was appropriate (not forcing insurers to contract with the hospital) and also that OIC's approval of insurance plans have legal and regulatory affects which may implicate actual legal interests of Seattle Children's. *See* Seattle Children's Hospital, No. 13-0293 (Wash. State Office of the Ins. Comm'r Feb. 20, 2014) (order on OIC's motion to dismiss), *available at* <http://www.insurance.wa.gov/laws-rules/administrative-hearings/judicial-proceedings/documents/13-0293-order-oic-motion-dismiss.pdf>.

246. Seattle Children's Hospital, No. 13-0293 (Wash. State Office of the Ins. Comm'r Sept, 5 2014) (notice of withdrawal motion), *available at* <http://www.insurance.wa.gov/laws-rules/administrative-hearings/judicial-proc>

2015 with new state network adequacy standards in Washington.<sup>247</sup> The state's insurance commissioner issued these new standards removing provider-patient ratios and time and distance standards, and adding specific types of care that plans must cover.<sup>248</sup> They require care that cannot be supplied by the covered providers to be provided out-of-network at no additional cost, and that plans have adequate staff to handle medical necessity reviews.<sup>249</sup> Lastly, the new language allows a plan to contract with facilities outside of its area if such a facility does not exist in the service area or if the plan shows a good faith effort to contract with such entity.<sup>250</sup> Spot contracts must not be used to fill gaps in service, but are permissible in unique situations where the care would typically occur out-of-network and out of the service area.<sup>251</sup>

The details of the Seattle Children's settlement are not public, but the decision by insurers to ultimately include Seattle Children's in-network might reflect consumer preference, insurer avoidance of litigation or harmful publicity, a realization that Seattle Children's services were unique and spot contracts were to be covered frequently enough to be more cost-effective if provided in-network, or a reaction to perceived strictness in the new state insurance standards. Unfortunately, without a hearing, the case provides little guidance for future litigation. Yet, the issues it presents are not unique, and Seattle Children's case raises a number of distinct questions that network adequacy law does not reach but could be raised in other exchange years. The current law is confined to questions of geographic distance and generally whether there

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eedings/documents/13-0293-order-dismissal.pdf; *Enroll with Care*, SEATTLE CHILDREN'S, <http://www.enrollwithcare.org/#plans> (last visited Sept. 30, 2014).

247. *See* WASH. STATE OFFICE OF THE INS. COMM'R, RULE-MAKING ORDER CR-103P (Apr. 25, 2014), *available at* <http://www.insurance.wa.gov/laws-rules/legislation-rules/recently-adopted-rules/documents/2013-22103P.pdf>.

248. *Id.* This includes access to primary, ancillary, specialty, and institutional services. The proposal also requires pediatric access to designated pediatric specialties, such as rheumatology, oncology, and cardiology. *Id.*

249. *See id.* The insurer must make known to the enrollees the referral and authorization practices and the possible effect of limiting access. *Id.*

250. *Id.* This applies to pediatric community hospitals, tertiary centers, specialty hospitals, transplant centers, and neonatal intensive care units. *Id.*

251. *Id.*

are enough providers to deliver promised benefits.<sup>252</sup> Seattle Children's suggests that, to the extent that narrow networks exclude tertiary and acute care providers, network adequacy is also about the availability of specialized services that some patients need, the ability of providers to coordinate that specialized care, and the quality and experience of those providers.<sup>253</sup>

## 2. Other Cases with Network Adequacy Implications

Network adequacy issues are cropping up in other states, raising different issues than Seattle Children's. One case emphasizes the likelihood that some insurers will find narrow networks so effective, they might not wish to provide broad ones.<sup>254</sup> In July 2013, Maine's Superintendent of Insurance approved two narrow networks put forth by Anthem Blue Cross and Blue Shield for offering on the exchange.<sup>255</sup> The Bureau of

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252. Anthem Blue Cross and Blue Shield Request for Approval of Access Plans, No. INS-13-801 (State of Me. Bureau of Ins. July 25, 2013) (decision and order), *available at* [http://www.maine.gov/pfr/insurance/AnthemBC-2013/PDF/Decision\\_and\\_Order.pdf](http://www.maine.gov/pfr/insurance/AnthemBC-2013/PDF/Decision_and_Order.pdf) ("In particular, Paragraph 7(A)(3) [of Insurance Rule 850, Section 7] requires a carrier's access plan to include: Written standards for providing a network that is sufficient in numbers and types of providers to assure that all services to covered persons will be reasonably accessible without unreasonable delay. Standards must be realistic for the community, the delivery system, and clinical safety. In establishing these standards, the carrier may incorporate standards published by independent standard-setting organizations and approved by the Superintendent. In addition, specific criteria on the number and geographic distribution of providers and practitioners are set forth in Rule 850(7).").

253. Seattle Children's Hospital, No. 13-0293 (Wash. State Office of the Ins. Comm'r Jan. 29, 2014) (opposition to intervenors' joint motion for summary judgment), *available at* <http://www.insurance.wa.gov/laws-rules/administrative-hearings/judicial-proceedings/documents/13-0293-int-msj-sch-opposition.pdf>.

254. *See infra* notes 255–65 and accompanying text.

255. Maine's state statute calls for a reasonable access to health care services and specifically defines provider-patient ratios to achieve this purpose. *See supra* note 252. However, while it also had a geographic access standard that specifically articulated driving distances to primary care, specialty care, and hospitals, this provision was repealed in 2011. *See* H.P. 979, 125th Leg., 1st Reg. Sess. (Me. 2011), *available at* <http://www.mainelegislature.org/legis/bills/getPDF.asp?paper=HP0979&item=1&num=125> (repealing specific mileage provisions). Nonetheless, the Superintendent indicated that even though there is no longer a statutory driving requirement, geographic considerations are still relevant in determining network adequacy. Anthem Blue Cross and Blue Shield Request for Approval of Access Plans, *supra* note 252.



Insurance's analysis of network adequacy focused on whether there were sufficient numbers of general and specialty providers given anticipated enrollment, state-defined provider-patient ratios, and the geographic disbursement of these providers.<sup>256</sup> Like the Seattle Children's case, a popular tertiary hospital was excluded from Anthem's plans.<sup>257</sup> However, the Superintendent found it was reasonable to select one of the two tertiary hospitals for the southern part of the state, given that only one exists in the north.<sup>258</sup> The Superintendent explained:

The question is not how the proposed HMO network compares to a hypothetical network including every hospital in Maine. It is whether the proposed HMO network contains enough providers over a wide enough area to provide reasonable access to health care services to members. If the access provided is reasonable, it is irrelevant that the network could be bigger or better.<sup>259</sup>

Post-certification, Anthem proposed to cease offering its broader-network plans and to migrate policyholders to narrower plans.<sup>260</sup> Anthem found that allowing its broad network to exist beside its narrow one compromised its ability to offer large enough streams of patients to negotiate lower reimbursement rates from in-network providers.<sup>261</sup> The Superintendent denied this request by applying a "best interests" standard.<sup>262</sup> With this new narrow network, the enrollees' choice of providers could be heavily restricted compared to their old plan and patients presumably might

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256. Anthem Blue Cross and Blue Shield Request for Approval of Access Plans, *supra* note 252.

257. *Id.*

258. *Id.*

259. *Id.* Note the similarity of this standard to federal ones.

260. Anthem Blue Cross and Blue Shield Request to Discontinue Individual Health Plans, No. INS-13-803 (State of Me. Bureau of Ins. Oct. 4, 2013) (decision and order), *available at* [http://www.maine.gov/pfr/insurance/Anthem\\_INS-803\\_2013/PDF/Decision\\_and\\_Order.pdf](http://www.maine.gov/pfr/insurance/Anthem_INS-803_2013/PDF/Decision_and_Order.pdf).

261. *See id.*

262. *Id.* Of note in the decision to refuse this latest Anthem effort, the Superintendent used a best interest standard as compared to a reasonable access standard in its first Anthem analysis. The best interests standard prohibits carriers from discontinuing a guaranteed-renewable plan unless it replaces it with a plan that meets certain requirements and the Insurance Superintendent finds that the new "replacement is in the best interests of the policyholders." ME. REV. STAT. ANN. tit. 24-A, § 2850-B(3)(G)(3)(a) (2014).

have to switch providers.<sup>263</sup> While the narrow plan would be cheaper for consumers, these enrollees had already purchased broader plans and had expectations linked to that.<sup>264</sup> Nothing in the ruling, however, prevented Anthem from encouraging policyholders to purchase narrow networks plans or to not offer broad networks in the future.<sup>265</sup>

In New Hampshire, network adequacy questions were particularly pronounced, as Anthem Blue Cross and Blue Shield was the only insurer to offer plans on the exchange for 2014.<sup>266</sup> Anthem's network included sixteen of the state's twenty-six hospitals, leaving the remaining hospitals unavailable to those buying insurance on the exchange.<sup>267</sup> The New Hampshire Insurance Department established working groups to review network adequacy criteria in the state.<sup>268</sup> Current state law follows the federal standard, with additional time and distance, wait time, and specialty care standards.<sup>269</sup>

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263. Anthem Blue Cross and Blue Shield Request to Discontinue Individual Health Plans, *supra* note 260. Especially given that Anthem's narrow network only covers six out of twenty hospitals in Southern Maine. *Id.* at 11.

264. *Id.*

265. *See id.*

266. Jan, *supra* note 80.

267. *Id.* Anthem representatives state the plan is adequate within the regulations, as specialists are within a one-hour drive for 90% of enrollees. *Id.* The network also covers 77% of the state's primary care doctors and 87% of its specialists. *Id.* Because of the narrower network, premiums are 30% cheaper. *Id.* At least one county does not have a hospital in-network and several of the hospitals excluded from the network claim that Anthem never approached them or tried to contract with them and that they would have accepted Anthem's rates if they had. *Id.*

268. N.H. INS. DEP'T, NETWORK ADEQUACY: BALANCING COST AND ACCESS (2014), available at [http://www.nh.gov/insurance/consumers/documents/netw\\_adeq\\_hrngslds.pdf](http://www.nh.gov/insurance/consumers/documents/netw_adeq_hrngslds.pdf).

269. New Hampshire law dictates that a "managed care plan shall maintain a network of primary care providers, specialists, institutional providers, and other ancillary health care personnel that is sufficient in numbers, types and geographic location of providers to ensure that all covered health care services are accessible to covered persons without unreasonable delay." N.H. CODE ADMIN. R. ANN. INS. 2701.04 (2014). The law specifies time and distance standards of two primary care providers within fifteen miles of 90% of the enrollees or access to specialists within forty-five miles for 90% of enrollees. *Id.* at 2701.06. The law also requires availability of certain specialists, for example allergists, cardiologists, general surgeons, neurologists, obstetrician/gynecologists, oncologists, ophthalmologists, orthopedists, otolaryngologists, psychiatrists, and urologists. *Id.* Other specialties like plastic surgery are also required but can be further

The New Hampshire Insurance Department stresses that what its laws do not do is either: (1) force a plan to contract with “any particular provider” or (2) guarantee access to any particular provider for any particular patient.<sup>270</sup> Its underlying goal is to preserve the ability of plans to compete via networks within government constraints.<sup>271</sup>

The issue of narrow networks is also indirectly implicated in *Fairfield County Medical Ass’n v. United Healthcare of New England*, where associations representing Medicare physicians sued Medicare Advantage insurers for terminating physician positions allegedly without substantive and procedural due process protections afforded by Medicare.<sup>272</sup> America’s Health Insurance Plans (AHIP), the national trade association representing insurance companies, has filed an amicus brief arguing for the right of insurance companies to establish narrow networks and the right of patients to seek more affordable premiums.<sup>273</sup> They suggest the need to compete for customers will ensure that narrow networks do not compromise access to necessary care.<sup>274</sup>

Network adequacy laws to date appear to concentrate on safety net access for the poor and some reasonable access to primary and secondary care through provider ratios, time and distance standards, and other requirements.<sup>275</sup> But insurance courts having to apply these standards in practice are being presented with additional questions that network adequacy laws do not explicitly address. To what extent is spot contracting appropriate for tertiary and specialty care? To what extent should network adequacy consider quality and experience of the provider? And what is the appropriate standard to review network adequacy? Moving forward, both academic medical centers and the public will likely mount

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geographically. *Id.* The state requires plans to follow set standards for wait time. *Id.* at 2701.07.

270. N.H. INS. DEP’T, *supra* note 268.

271. *Id.*

272. See generally Brief of America’s Health Ins. Plans as Amicus Curiae in Support of Appellants at 15–22, *Fairfield Cnty. Med. Ass’n. v. United Healthcare of New England*, 985 F. Supp. 2d 262 (D. Conn. 2013) (No. 3:13-cv-1621) (presenting arguments in favor of Medicare Advantage insurers).

273. *Id.* at 1.

274. *Id.* at 12–14.

275. *Id.* at 8.

pressure on the states to further define the boundaries of network adequacy in the face of ongoing insurance reform.

## V. ETHICAL CHALLENGES PRESENTED BY NARROW NETWORKS

Narrow networks present a number of ethical and legal challenges for patient care, especially access to tertiary care given that it is often life-saving, typically constitutes an essential health benefit, and is not currently being considered in the law despite the providers of such care being most frequently excluded from narrow networks.<sup>276</sup> Narrow networks also present a “preference” issue, a matter of wanting to keep one’s doctor despite in-network providers that are available and capable of performing the required medical service.<sup>277</sup> To the extent that “preference” issues may prevent patients from seeking or receiving sufficient medical care, they may warrant additional exploration in the future. However, this Article focuses on access to tertiary care as a more immediate and problematic issue. The need for guaranteed tertiary access, and the increased cost presumably associated

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276. See generally White et al., *supra* note 24, at 329–30 (discussing the benefits of tertiary care). Within this access group, there are the individuals with a known illness whose providers are not available through any plan on the exchange. Also, there are individuals who knowingly enrolled in a narrow network, but later require care in which a broader network would be preferred. And, presumably, there are individuals who enroll without realizing the limitations of the network (an educational issue, which requires different policy approaches). Lastly, there are individuals, like children, who do not have a say in what plan they are enrolled. Knowingly selecting a narrow network may or may not impact the individual’s right to a broader network provider from an ethical perspective. Daniels distinguishes those who wander into an unlucky path through no fault of their own as “bad brute luck” whereas those who make a bad choice have “bad ‘option luck.’” Norman Daniels, *Justice, Health, and Healthcare*, 1 AM. J. BIOETHICS 2, 4–5 (2001). While there is an argument that those who suffer misfortune through no fault of their own are worthy of aid from others while those with a choice are not, Daniels argues that gives too much centrality to our choices, which is not ideal if we want to protect the freedom to make decisions for a democratic society. *Id.* However, allowing everyone access despite not having paid for it or selected it might pose a free rider problem, where people only jump to heftier plans when they know they need it. *Id.* at 6–7. This poses a much larger ethical debate to be discussed in further research.

277. It has been a prominent complaint in the media as insurers on the exchanges failed to contract with providers whom patients and communities had long-standing relationships. CORLETTE ET AL., *supra* note 29, at 1.

with it, poses distinct ethical challenges and merits individual attention.

#### A. NARROW NETWORKS PLACE TENSIONS ON PATIENT ACCESS TO TERTIARY CARE

We will assume for the purposes of this Article that the types of care being requested in cases like Seattle Children's are covered benefits under the insurance plans.<sup>278</sup> If so, the question becomes not about covered benefits, but about the providers that provide them and whether, and how, plans must contract with these providers to satisfy benefits and network adequacy requirements.

Patients like Gabriella may be left with few choices without additional regulation.<sup>279</sup> Hopefully, a plan that contracts with the academic medical center is available on the exchange and not cost-prohibitive. If not, the experience of providing care might be very fractured and uncoordinated, posing quality, safety, and convenience concerns.<sup>280</sup> She may be forced to see a variety of specialists in many different health systems and locations, some in-network and, perhaps, some spot contracted for out-of-network, while facing uncertainty about what care is covered and what must be paid for out-of-pocket.<sup>281</sup> It would certainly be more difficult for these providers to communicate with one another, share chart notes, coordinate both short and long term care plans, and to access Gabriella's tests and records.<sup>282</sup> If Gabriella required hospitalization, her current specialists might not be part of

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278. The essential benefits standard requires coverage for hospitalization, pediatric care, rehabilitative care, mental health treatment, and other care, which may at times require tertiary or acute level care. Patient Protection and Affordable Care Act § 1302, 42 U.S.C. § 18022 (b)(1) (2012). *See generally* Press Release, *supra* note 2 (discussing the treatments denied by non-contract exchange plans).

279. Chen, *supra* note 1.

280. *See* Press Release, *supra* note 2.

281. *See id.*; Chen, *supra* note 1.

282. *See generally* Sara L. Toomey et al., *Disparities in Unmet Need for Care Coordination: The National Survey of Children's Health*, 131 PEDIATRICS 217, 217 (2013) ("A considerable proportion of parents reported unmet care coordination needs for their children, especially parents of children with special health care needs."). A 2013 Pediatrics study found that 41% of parents report that their children have needed care coordination. *Id.* at 219–20. Coordination issues were higher in children with special health care needs (41% versus 26%). *Id.* at 220.

that system and the hospital may not even have certain specialties on staff or within Gabriella's network.<sup>283</sup> The institutions may have significantly less experience with cases like Gabriella's for even non-unique care if her comorbidities make delivery of primary and secondary care more complex. And some of the institutions may not be equipped to handle a large influx of complex and comorbid patients, if they are used to major academic medical centers handling them. Meanwhile, her mother might have to drive a sick child perhaps hundreds of miles<sup>284</sup> while an experienced institution housing all of these specialties may be in her backyard.<sup>285</sup> Spot contracts for unique services could be an administrative and time burden for patients, providers, and insurers.<sup>286</sup> And the mother, who in the

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283. Chen, *supra* note 1. This is not to suggest that all hospitals would be incapable of specialty care. Individual specialists outside of major health care systems may be excellent and may see large caseloads. This is more to suggest that the vast majority of tertiary and acute care is typically provided in large health care systems, where care is more easily coordinated. *See generally* White et al., *supra* note 24, at 324–35, 330 (evaluating a study on high-priced hospitals and whether they provide significantly different care options than lower-priced hospitals).

284. In writing this I was particularly driven by my bedside ethics consultation work at the Cleveland Clinic and other Cleveland area hospitals, as well as a number of years volunteering in and observing at Children's Hospital in Pittsburgh. It was common practice for many patients, for example those with cystic fibrosis or sickle cell, to come in for "tune-ups" or periods of time where they were hospitalized to manage their chronic conditions in the hopes of avoiding larger, more dangerous, and more costly acute interventions. Often such patients would see a whole team of physicians over a period of a week or more, with that team knowing one another and the patient intimately. The value of such coordination may be difficult to quantify but it is difficult to imagine it happening outside of a tertiary or quaternary center, or the impact on many of these chronically ill patients without such coordination. *See generally* Toomey et al., *supra* note 282, at 221 (discussing the need for effective care coordination for children with special health care needs).

285. Particularly striking in the Seattle Children's case is the question of access when a top institution is in one's backyard. *See, e.g.*, Chen, *supra* note 1. It recalls the imagery of Roald Dahl's *Charlie and the Chocolate Factory*, with poor Charlie Bucket whose family could not afford to buy him candy, but where "one awful thing that tortured little Charlie, the lover of chocolate, more than anything else . . . It was the most terrible torturing thing you could imagine, and it was this: In the town itself, actually within sight of the house in which Charlie lived, there was an enormous chocolate factory!" ROALD DAHL, *CHARLIE AND THE CHOCOLATE FACTORY* 7 (Bantam Books 1984) (1964).

286. *See* Seattle Children's Hospital, No. 13-0293 (Wash. State Office of the Ins. Comm'r Jan. 29, 2014) (opposition to intervenors' joint motion for summary judgment), *available at* <http://www.insurance.wa.gov/laws-rules/ad>

immediate must decide when to take her child for care and where, is not well positioned to know what counts as unique.<sup>287</sup>

While state and federal laws discuss reasonable access to providers, they clearly do not address precisely how these plans must contract with such providers.<sup>288</sup> Certainly, nothing in the law requires that care be coordinated or that networks contract with high quality providers, high volume providers, ones with unique services, or ones with the greatest experience.<sup>289</sup> Thus, it becomes a question of whether these plans must contract with the providers clearly designed to perform these services, or whether they can piece together access through spot contracting, coverage for only “unique” services, and other mechanisms.

But are narrow networks problematic or justified if, by compromising access to academic medical centers, they increase access to affordable insurance for the population more broadly? To consider this ethical dilemma, we must look to the purposes of health insurance, our health care system, and the PPACA.

## B. AN ARGUMENT FOR EMPHASIZING TERTIARY CARE IN NETWORK ADEQUACY LAWS

Health insurance now occupies two important and somewhat distinct goals. It pays for basic care and it pools risk for larger and unanticipated costs of illness.<sup>290</sup> Whether one looks at health insurance as promoting health, protecting wealth, or compensating those that suffer bad luck, access to

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ministrative-hearings/judicial-proceedings/documents/13-0293-int-msj-sch-opposition.pdf; see also Seattle Children’s Hospital, No. 13-0293 (Wash. State Office of the Ins. Comm’r Mar. 14, 2014) (order on motion for partial summary judgment), available at <http://www.insurance.wa.gov/laws-rules/administrative-hearings/judicial-proceedings/documents/13-0293-order-sch-msj.pdf>.

287. See, e.g., Chen, *supra* note 1 (discussing Rebekah Blankers’ inability to determine where to go to get her daughter’s care needs met).

288. See generally Brief of America’s Health Ins. Plans as Amicus Curiae in Support of Appellants, *supra* note 272 (highlighting reasonable access as a common requirement for most states).

289. See generally *id.* at 8–11 (discussing federal law adequacy requirements).

290. Allison K. Hoffman, *Three Models of Health Insurance: The Conceptual Pluralism of the Patient Protection and Affordable Care Act*, 159 U. PA. L. REV. 1873, 1875–79 (2011).

high-quality tertiary care implicates all of these functions.<sup>291</sup> The chronic and/or costly interventions associated with tertiary care are the very health care costs for which even the very wealthy might not have access to without insurance.<sup>292</sup>

Network adequacy is not a debate about access to health insurance, but access to health care.<sup>293</sup> As a vehicle for paying for and delivering health care, Deborah Stone argues that success in insurance should be measured by how it treats the sick.<sup>294</sup> Sharona Hoffman favors a system where more serious and chronic illnesses take precedence over more minor conditions, in favor of a medical system that “saves lives, restores functionality, or diminishes the consequences of lasting disability.”<sup>295</sup> Norman Daniels argues that the central

291. *Id.* at 1873. Hoffman frames it as three functions: health promotion (where insurance cost-effectively promotes health), financial security (where insurance protects individuals from devastating financial loss), and brute luck (where insurance protects against chance and unavoidable risks). *Id.* She provides strong examples of how the PPACA adopts each model in its insurance reforms. *Id.* at 1874. For example, it covers preventive care to address health promotion, it limits cost sharing to address financial security, and it covers preexisting conditions for brute luck. *Id.* at 1876–79.

292. *See generally id.* at 1879–81 (discussing the expense of such care without insurance).

293. Timothy Stoltzfus Jost, *Health Care Access in the United States. Conflicting Concepts of Justice and Little Solidarity*, 27 *MED. & L.* 605, 607 (2008) (“[T]he ultimate issue here is access to health care, not insurance . . . . Just because a person is uninsured does not mean that he has no access to health care.”).

294. Deborah Stone, *Protect the Sick: Health Insurance Reform in One Easy Lesson*, 36 *J.L. MED. & ETHICS* 652, 652 (2008). In fact, Stone reminds us that in other countries health insurance is called sickness insurance, keeping the issue closer to mind. *Id.* Threaded through these debates is the larger question of health care rationing. For example, does basic access to care generate greater net benefits than tertiary care for a few? Should we preference greater net benefits or those with most medical need? In essence, it is a larger debate about basic, affordable care versus high tech, expensive care. This Article need not reach to these issues, however, as this is more an argument of some level of access to tertiary care than of which should be favored over another. *See* Norman Daniels, *Rationing Fairly: Programmatic Considerations*, 7 *BIOETHICS* 224, 224–25 (1993) (discussing rationing in health care); Leonard M. Fleck, *Last Chance Therapies: Can a Just and Caring Society Do Health Care Rationing When Life Itself Is at Stake?*, 2 *YALE J. HEALTH POL’Y L. & ETHICS* 255, 255 (2002) (examining “last chance therapy rationing” in health care).

295. Sharona Hoffman, *Unmanaged Care: Towards Moral Fairness in Health Care Coverage*, 78 *IND. L.J.* 659, 689 (2003). Hoffman also highlights a number of ways in which moral fairness might be considered, whether by ensuring equal access to resources, equal overall welfare, equal opportunity,



moral purpose of health care is maintaining normal human function because it provides people with a reasonable opportunity to meaningfully participate in society.<sup>296</sup> In a just society, he claims, this chance at opportunity should not fall disproportionately on the ill and access should not be based on ability to pay.<sup>297</sup> As so many have argued in the past, the role of health insurance and health care to our society is to restore function and ensure opportunity, and one important way to measure this is by how health insurance helps the very sick.<sup>298</sup> Within this framework, access to tertiary care (and by virtue of this, sometimes access to academic medical centers or other like providers) is imperative and no less important than access to basic care. Those in need of intensive specialty care may well be the very sickest in society, those most in need of being restored, and those who most severely lack opportunity without intervention.

Alternatively, health insurance can be viewed as a social and economic contract with a larger role of “managing risk, facilitating commerce, encouraging socially desirable activity, and protecting the public.”<sup>299</sup> In this context, what we insure and who pays for it says something about how we shape and perceive certain risks in our society.<sup>300</sup> Health insurance, through this lens, “invites moral contemplation about questions of suffering, compassion, and responsibility.”<sup>301</sup> To not

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promoting net health benefits, or ensuring adequate participation in the processes that allocate resources. *Id.*

296. Daniels, *supra* note 276, at 3.

297. *Id.* at 4.

298. *Id.* at 3; Stone, *supra* note 294, at 652. Stone argues that the very experience of unequal insurance coverage becomes an adverse event and insurance becomes a tool to remedy inequality in a just democracy. Stone, *supra* note 43, at 40.

299. Jeffrey W. Stempel, *The Insurance Policy as Social Instrument and Social Institution*, 51 WM. & MARY L. REV. 1489, 1510 (2010).

300. Mariner, *supra* note 37, at 276–79. As Stone argues, insurance creates a social norm that communities are responsible for alleviating certain defined harms for individuals and, through this, creates expectations for well-being. Stone, *supra* note 43, at 16–17; *see also* Stempel, *supra* note 299, at 1510–12 (discussing the societal values and risk of insurance policies).

301. Stone, *supra* note 43, at 16. In a different piece, Stone suggests that a lessening of social insurance and social welfare may reflect a larger culture shift in society where people and their health care, retirement plans, etc. are viewed as economic sinkholes and losses rather than investments—“The people, the nation’s citizens, are no longer a precious national asset, but voracious predators on the common weal.” Deborah Stone, *Managed Care and*

adequately ensure some level of predictable access to tertiary care seems to run counter to this notion, as tertiary care seems to harbor the very suffering for which we as a society most sympathize with and fear.

In the past there have been arguments that there are no moral claims to treatment because there were no universal statements of what anyone was owed by virtue of being insured.<sup>302</sup> Insurance was seen as a contract where the insured accepts whatever benefits the insurer agrees to, with significant variation across different plans.<sup>303</sup> Yet this was before the PPACA presumably sought to provide some meaningful level of health insurance (and health care) to everyone at some reasonable cost.<sup>304</sup>

No longer is there uncertainty about what insurers owe. Essential benefits, for example, define a benchmark for the minimal benefits that insurers owe to their insureds.<sup>305</sup> In this way, network adequacy can be seen not as a debate about what is narrow and what is broad, but about what was promised by the PPACA (and, in turn, the insurance companies) and whether it was delivered. This claim does not to extend a right to health care to all; it confines it to those who purchase health

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*the Second Great Transformation*, 24 J. HEALTH POL. POL'Y & L. 1213, 1215 (1999).

302. *E.g.*, Allen Buchanan, *Managed Care: Rationing Without Justice, but Not Unjustly*, 23 J. HEALTH POL'Y & L. 617, 618, 624 (1998) ("The lack of . . . a societal agreement on what the entitlement to health care includes . . . undercuts the very assumptions under which the current ethical debate about rationing in managed care is conducted.").

303. *Id.* at 625–26.

304. A full legislative history of the PPACA and its many-layered goals is unnecessary for the purposes of this Article, but common sense dictates that the PPACA, in name at least, intended to make care affordable but also to protect patients, through the use of a variety of insurance reforms. John Cannan, *A Legislative History of the Affordable Care Act: How Legislative Procedure Shapes Legislative History*, 105 LAW LIBR. J. 131, 133–34 (2013). One might argue whether this means ensuring affordable access to basic care for everybody or also more expensive and complex care for the few who require it. Other scholars have noted the complexity and multi-factorial legislative history of the PPACA, noting that a true examination of the goals of the law may go back to broader discussions of health reform in the George W. Bush era or even before. *Id.* at 136. See *id.* at 137–59 for a broader discussion of the challenges presented by PPACA's legislative history.

305. Patient Protection and Affordable Care Act § 1302, 42 U.S.C. §18022 (2012).

insurance.<sup>306</sup> But for those who make the purchase and trust the system, the PPACA forces the insurer to uphold the trust that the insured is making a good bet and that insurance will be useful when it is needed.<sup>307</sup>

Much of insurance reform under the PPACA (and state reforms before it) targeted exactly the insurance practices that rendered health insurance useless for the sick.<sup>308</sup> By purchasing insurance, it must now meet some basic level of benefits, at some limited amount of out-of-pocket cost.<sup>309</sup> It must be extended even to the sick, and it cannot be taken away when the individual finally needs it.<sup>310</sup> The underlying considerations here are to render insurance capable of being meaningful for the sick and to make insurance an item worth purchasing. Weak network adequacy laws that do not contemplate the care most needed by the very sick can erode that trust and threaten that willingness to pay into the system.<sup>311</sup>

Without greater regulation of network adequacy to clearly address the inclusion of tertiary care providers, insurance might naturally split into two streams: (1) smaller numbers of plans with broad access to academic medical centers (and thus tertiary and acute care) that are more costly (and perhaps cost-prohibitive), and (2) growing numbers of cheaper plans with narrow provider networks that exclude academic medical centers.<sup>312</sup> To the extent that this split compromises access to medically necessary care for the very sick, it is problematic.

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306. *Health Reform*, *supra* note 40, at 439–40.

307. Another way to look at this is with the insurer as the protector of a common fund. Insureds place their trust in the insurer to guard the common pool of resources unless and until the one with the valid claim needs it, but otherwise to secure it from unworthy claims. Deborah A. Stone, *Promises and Public Trust: Rethinking Insurance Law Through Stories*, 72 TEX. L. REV. 1435, 1440–45 (1994).

308. *Health Reform*, *supra* note 40, at 439–40.

309. *Id.*

310. *Id.* As Mariner notes, virtually all bills considered by congressional committees during the development of the PPACA prohibited insurers from discriminating on the basis of preexisting condition or health status. *Id.*

311. *See generally id.* at 440 n.28 (“A recent poll of public opinions of the 2009 House and Senate Bills find that 63% of those surveyed favor provisions that prohibit insurers from denying coverage on the basis of health conditions.”).

312. *See also* PRICEWATERHOUSECOOPER, *supra* note 23 (discussing access to academic medical centers).

But who should bear the presumed added cost associated with ensuring higher-level care for those who need it?

### C. WHO BEARS THE COST OF BROADENED ACCESS?

Narrow networks raise a question of distributive justice around who should pay for care for the sickest.<sup>313</sup> When asked who should pay to cover the very sick, a number of answers might spring forth, such as the insurers, the providers, or the taxpayers. These all warrant important policy consideration. But, I will focus on a group most people would not typically consider: the other insureds.

Narrow networks trade provider choice for cheaper premiums.<sup>314</sup> For most consumers, this is a good calculus and they will gladly trade their choice of provider for money saved.<sup>315</sup> Some may even argue it is a right of these consumers to trade their health for low premiums, as the insurance advocacy group did in the *Fairfield* amicus brief.<sup>316</sup> But a counter-narrative suggests that nobody has a right to cheap premiums on the backs of the sick.<sup>317</sup>

Deborah Stone struggled with a similar question during the height of the managed care era where she seminaly characterized the practice of medical underwriting as the struggle over the soul of health insurance.<sup>318</sup> Stone framed the political debate over health insurance in the United States as two distinct and competing visions of distributive justice: actuarial fairness and the solidarity principle.<sup>319</sup> Actuarial

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313. As Smith nicely clarifies, “[d]istributive justice pertains to what is owed by society to its members in the microallocation of health resources while general justice charts what a proper standard of obligation and use is for individuals in the macro sense of sustaining the common or communal good.” George P. Smith, *Social Justice and Health Care Management: An Elusive Quest*, 9 HOUS. J. HEALTH L. & POL’Y 1, 7 (2008). Throughout this Article, the question of distributive justice might implicate decisions about how all plans must distribute their resources as well as individual questions of justice, as to when a plan makes a decision about access to care for a single individual. *Id.* at 5–7.

314. Pear, *supra* note 18.

315. See generally Burns, *supra* note 80 (discussing how narrow networks result in substantial savings, which attract consumers).

316. Brief of America’s Health Ins. Plans as Amicus Curiae in Support of Appellants, *supra* note 272.

317. Stone, *supra* note 37, at 288–90.

318. *Id.* at 308–14.

319. *Id.* at 289.

fairness, at its simplest, means that each individual pays for his or her own risk.<sup>320</sup> Insurance under the solidarity principle, however, operates as a form of social insurance—everyone must chip in a certain amount to ensure that all have access to medically necessary health care.<sup>321</sup> Admittedly, many “consumers do not purchase insurance for altruistic reasons or out of a sense of social responsibility. Rather, they try to obtain maximum protection for the cheapest rate, to their own advantage.”<sup>322</sup> Nonetheless, as Crossley notes, their selfishness still contributes to the common good:

In reality the contrast between social solidarity and individualism is less stark. For even if an individual seeks to obtain health insurance for the purely selfish purpose of protecting herself against the possibility of overwhelming medical costs, by purchasing insurance she enters into a community of risk sharers and thereby produces a public benefit.<sup>323</sup>

For insurance to achieve its purpose as a social safety net and form of mutual aid that would cover everyone, it simply cannot be that everyone must pay their own way. Stone argued that medical underwriting only served to emphasize people’s differences rather than their similarities, allocating the burden of health care costs across a few rather than on the whole.<sup>324</sup> Likewise, narrow networks hold the same potential if they can create affordable and adequate care for the healthy and expensive or inadequate care for the sick.<sup>325</sup> Without true pooling of the risks associated with serious illness (even if it requires tertiary care and even if the benefit accrues only to the very few with the most expensive costs), narrow networks allow health insurance to continue to treat the sick differently and to

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320. *Id.* at 290.

321. *Id.* at 290–91.

322. Hoffman, *supra* note 295, at 670.

323. Mary Crossley, *Discrimination Against the Unhealthy in Health Insurance*, 54 U. KAN. L. REV. 73, 80 (2005); accord Roberta M. Berry, *The Human Genome Project and the End of Insurance*, 7 U. FLA. J.L. & PUB. POL’Y 205, 223 (1996); Brian J. Glenn, *Risk, Insurance, and the Changing Nature of Mutual Obligation*, 28 LAW & SOC. INQUIRY 295, 296–97 (2003).

324. Stone, *supra* note 37, at 287–90.

325. See CORLETTE ET AL., *supra* note 29, at 3–5 (analyzing the risks narrow networks may create for consumers).

pile the costs of illness onto the very population that insurance was designed to protect.<sup>326</sup>

Segregating the providers that the very sick require into separate and more expensive plans is fair to the extent that the healthy are entitled to enjoy their good luck through adequate benefits and affordable premiums in ways that the sick are not.<sup>327</sup> The very system of insurance was designed to protect the sick at the expense of the healthy, because of the recognition that brute luck might strike anyone.<sup>328</sup> So too, anyone might need access to the highly specialized care that network adequacy does not currently consider.<sup>329</sup>

The battle over who should pay what for their health care goes back to early models of insurance.<sup>330</sup> This struggling vision between individual costs versus social good is endemic to American society, where the concept of individual reliance and “rugged individualism” butts up against the obligation to help others.<sup>331</sup> In fact, insurance is seen as a social good because it legitimizes the acceptance of some form of mutual aid, as the individual paid something in return for his benefits.<sup>332</sup>

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326. See Deborah S. Hellman, *Is Actuarially Fair Insurance Pricing Actually Fair?: A Case Study in Insuring Battered Women*, 32 HARV. C.R.-C.L. L. REV. 355, 357–59 (1997).

327. Hellman argues that price differences in insurance are only fair to the extent that individuals are entitled to reap all the benefits of their good fortune and good health at the cost of those who are less lucky. *Id.* at 398–403.

328. *Id.*

329. When we enroll in insurance, we all face some chance that we will become the individual who needs expensive care, even if we did not know it at the time of enrollment. Anyone can become the individual who needs the broad network. Moreover, good health is viewed as “morally arbitrary,” meaning that illness is seen generally as luck of the draw and not some moral punishment on the individual. Baker, *supra* note 37, at 374–74, 392–93 (contrasting higher rates paid by frequent-firers for unemployment insurance versus higher rates of health insurance paid by victims of domestic violence).

330. For an interesting narrative, see Baker, *supra* note 37 (providing an example of the young fighting against subsidizing the old in fraternal organizations’ sickness insurance in Britain’s early nineteenth century). For a discussion of the conflict between those who view health care as a social good and those who view it as a commodity to be doled out based on ability to pay, see Stone, *supra* note 37.

331. See Stone, *supra* note 43, at 40–45 (“Equality is one of the great rallying cries in American politics.”); see also Jeffrey W. Stempel, *Adam, Martin and John: Iconography, Infrastructure, and America’s Pathological Inconsistency About Medical Insurance*, 14 CONN. INS. L.J. 229, 232 (2008) (demonstrating this point through the imagery of John Wayne).

332. Stone, *supra* note 43, at 15.

Besides our public system, the PPACA may be the closest that our country has come to recognizing a moral mandate to contribute to the overall cost of care for others through the mandate to purchase insurance.<sup>333</sup> The public is not unaware of this debate and its moral implications, raising important questions about whether it is just for individuals to subsidize care they will never need or need no longer (e.g., a forty-six year-old woman paying for obstetrics care).<sup>334</sup>

One might argue that this is a question of consumer choice and consumer rights.<sup>335</sup> Consumers should be free to vote on which plan best suits their medical needs, often with the sickest gravitating to the lowest cost-sharing while the healthier gravitate to higher upfront cost.<sup>336</sup> Yet, in reality, individuals may not have a choice about a sufficiently broad network, whether because the plan is not available on the exchanges or because it is simply unaffordable, which may call for separate but similar policy responses.<sup>337</sup> Or individuals may simply not realize when they enroll that certain providers are not covered, a matter that can be resolved with greater public education and familiarity with narrow networks.<sup>338</sup> And in a more general way, the ability of individuals to select the right

333. “The label ‘shared responsibility payment’ simultaneously expresses an individual obligation to buy insurance and a collective obligation to participate in a system in which everyone must share some responsibility for ensuring affordable coverage.” Brietta Clark, *A Moral Mandate & the Meaning of Choice: Conceiving the Affordable Care Act After NFIB*, 6 ST. LOUIS U. J. HEALTH L. & POL’Y 267, 318 (2013). “[T]he ACA’s message is one of collective aid, with a healthy dose of personal responsibility.” *Id.* at 318–19.

334. Compare Lori Gottlieb, *Daring to Complain About Obamacare*, N.Y. TIMES (Nov. 10, 2013), <http://www.nytimes.com/2013/11/11/opinion/daring-to-complain-about-obamacare.html> (“[N]ow if I have Stage 4 cancer or need a sex-change operation, I’d be covered regardless of pre-existing conditions. Never mind that the new provider network would eliminate coverage for my and my son’s long-term doctors and hospitals.”), *with id.* (“Yes, I’m paying an extra 200 a month, but I’m okay with doing that so that others who need it can have health care.”) (internal quotation marks omitted).

335. James Surowiecki, *Fifth Wheel: Extending Medicare*, NEW YORKER (Jan. 4, 2010), [http://www.newyorker.com/talk/financial/2010/01/04/100104ta\\_talk\\_surowiecki](http://www.newyorker.com/talk/financial/2010/01/04/100104ta_talk_surowiecki).

336. Some argue that consumer freedom to select a plan based on quality, cost, and convenience considerations is the very “raison d’être” for maintaining the private insurance system. *See generally id.* (“After all, measuring risk, and setting prices accordingly, is the raison d’être of a health-insurance company.”).

337. *See supra* Part III.B–C.

338. *See supra* Part III.C.

health care plan for themselves is debatable.<sup>339</sup> Moreover, to the extent that solidarity is important, there must be some pooling of risks by insureds.<sup>340</sup>

Efforts in the future to regulate network adequacy must balance all of these considerations and find a way to best protect a host of health care consumers.

#### D. WHAT IF COVERAGE FOR THE FEW CONFLICTS WITH ACCESS FOR THE MANY?

If managed care or insurers' predictions provide any insight, removing the insurers' ability to negotiate prices by requiring them to contract with tertiary providers could lead to skyrocketing premiums for patients.<sup>341</sup> What if these increases are so high that they actually price individuals out of market or make health insurance more expensive for everyone? Then, it is no longer a matter of individuals purchasing cheap plans at the expense of the sick. It is now a question of the inclusion of the sick posing challenges for access to insurance for others. It becomes a classic bird in hand problem. Is it better to provide insurance to the people who we know need it for serious health conditions or to individuals who certainly need it for its basic

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339. This is for a variety of reasons, a number of which are well covered in Carl E. Schneider & Mark A. Hall, *The Patient Life: Can Consumers Direct Health Care?*, 35 AM. J.L. & MED. 7, 15–16 (2009); see Troy J. Oechner & Magda Schaler-Haynes, *Keeping It Simple: Health Plan Benefit Standardization and Regulatory Choice Under the Affordable Care Act*, 74 ALB. L. REV. 241, 244–52 (2010–2011); Deborah Stone, *The False Promise of Consumer Choice*, 51 ST. LOUIS U. L.J. 475, 478–79 (2007).

340. Inherent in this is a question of whether we let consumers make (and later pay for) bad choices, for example if they suffer access issues after buying a narrow plan and then get sick. A true analysis is outside the scope of this Article, but it bears mentioning that PPACA provisions only limit bad choices to an extent (for example, only requiring smokers to pay one and a half times as much in premiums as non-smokers). See *ObamaCare Gives Smokers a New Incentive to Quit*, OBAMACARE FACTS, <http://obamacarefacts.com/obamacare-smokers/> (last visited Nov. 6, 2014). Moreover, the right to make bad decisions and still be protected may be important to a democratic society. See Daniels, *supra* note 276, at 5. Ultimately, if these consumers default on their medical bills it becomes a social problem. The question then, is more aptly framed as whether all plans offered on the exchanges offer adequate benefits, not whether people have freedom to buy cheap but less useful plans. This logic seems more in line with the broader goals of the PPACA and its market regulations.

341. *E.g.*, Barry R. Furrow, *Cost Control and the Affordable Care Act: CRAMPing Our Health Care Appetite*, 13 NEV. L.J. 822, 841–43 (2013).



payer function and may or may not need it for more serious conditions? Federal subsidies might take the burden of rising premiums off of consumers but this added cost would have to be accounted for elsewhere.

Narrow networks certainly seem to operate on a sort of scale, where more extensive coverage for a few who are sick could tip the scale toward costly coverage for the many and the loss of the benefits of insurance for some.<sup>342</sup> If this were proven to be true, then there would need to be significant considerations about these issues. But it is premature to say that such a zero-sum equation exists without more empirical evidence to suggest this and without other policy examinations to decide whether costs can be preserved elsewhere.<sup>343</sup>

Yet assuming this were proven to be the case, it poses its own distributive justice question, as overly stringent network adequacy laws could then be critiqued for “unfairly burdening low-income groups with expenditures they may not otherwise choose to make.”<sup>344</sup> In this way, mutual aid could be unjust if it priced out the poor just as the system is unjust if it prices out the sick.<sup>345</sup>

Where does one strike the balance between ensuring high quality coordinated care even for the very sick and keeping premiums low for everyone’s sake? Such questions circle back to the larger questions of the role of health insurance and health care to society and age-old questions about justifications for high-technology care. Do we aim to cover all medically necessary care at any cost or producing any outcome, necessary

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342. See also CORLETTE ET AL., *supra* note 29, at 5 (noting that “[s]tates seeking to address concerns about the adequacy of plans’ provider networks while also constraining premium cost growth” must engage in a balancing of “consumer protections with affordability”).

343. Furrow provides an extensive analysis of other possible cost controls set forth by the PPACA. See generally Furrow, *supra* note 341, at 848–52.

344. Thomas L. Greaney, *The Affordable Care Act and Competition Policy: Antidote or Placebo?*, 89 OR. L. REV. 811, 838–39 (2011).

345. Arguments can be made that the insurance system, if no longer burdening the sick, will automatically burden another group. For arguments that social pooling may be inherently unfair for the young, who are less likely to require medical care, see Tom Baker & Peter Siegelman, *Tontines for the Invincibles: Enticing Low Risks Into the Health-Insurance Pool with an Idea from Insurance History and Behavioral Economics*, 2010 WIS. L. REV. 79, 82 (2010); Charles P. Litchfield, Note, *Taxing Youth: Health Care Reform Writes a Costly Prescription that Leaves the Young and Healthy Paying the Bill*, 85 S. CAL. L. REV. 353, 354–60 (2012).

medical care even if it is costly and acute, or care that restores our normal functioning?<sup>346</sup> Some argue that under a Rawlsian theory of distributive justice, health care is a primary good where unequal access is justified so long as those worst off benefit,<sup>347</sup> while others argue that health care should be equally accessible to all,<sup>348</sup> and still others argue that some level of access to health care is part of an adequate standard of living.<sup>349</sup> Utilitarian, communitarian, egalitarian, and libertarian approaches all might have some bearing on these issues and lead us to different results.<sup>350</sup> Of course none of these standards can completely decide the issue as to what extent individuals are owed a right to perhaps expensive, high intervention care over individuals being given a right to basic health care. Is it about cost, about saving lives, about restoring function, or about greatest benefit to the greatest number? While the PPACA defines essential health benefits that should be made available to all through affordable insurance packages, it does not resolve the larger question of what adequate care is and larger questions of health care rationing.<sup>351</sup>

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346. Einer Elhauge, *Allocating Health Care Morally*, 82 CALIF. L. REV. 1449, 1467–68 (1994); Paul E. Kalb, *Defining an “Adequate” Package of Health Care Benefits*, 140 U. PA. L. REV. 1987, 1995–97 (1992).

347. Tom Stacy, *The Courts, the Constitution, and a Just Distribution of Health Care*, 3 KAN. J.L. & PUB. POL’Y 77, 80 (1993–1994) (citing ROBERT M. VEATCH, *A THEORY OF MEDICAL ETHICS* 261–64 (1981)); see Allen E. Buchanan, *The Right to a Decent Minimum of Health Care*, 13 PHIL. & PUB. AFF. 55, 60–62 (1984).

348. Stacy, *supra* note 347, at 87.

349. The level of adequate healthcare is important in this context, where some individuals will require expensive and more frequent medical care than others. *Id.* (citing VEATCH, *supra* note 347); see Buchanan, *supra* note 347; see also David Copp, *The Right to an Adequate Standard of Living: Justice, Autonomy, and the Basic Needs*, in *ECONOMIC RIGHTS* 231 (Ellen Frankel Paul et al. eds., 1992).

350. For a comprehensive discussion of the various frameworks that inform health ethics, policy, and law (and would be implicated in such a narrow networks debate), see Jennifer Prah Ruger, *Health, Capability, and Justice: Toward a New Paradigm of Health Ethics, Policy and Law*, 15 CORNELL J.L. & PUB. POL’Y 403, 405–06 (2006).

351. See, e.g., B. Jessie Hill, *What Is the Meaning of Health? Constitutional Implications of Defining “Medical Necessity” and “Essential Health Benefits” Under the Affordable Care Act*, 38 AM. J.L. & MED. 445, 447 (2012) (“This controversy highlights the extraordinarily hazy contours around the definition of health in a variety of legal and policy contexts and the significance of that definition for future debates surrounding the ACA.”).

Moreover, some might argue that an overly stringent law that requires plans to contract with tertiary providers could rob the public of better quality benefits. As Enthoven notes in his studies of managed competition that later became the forebear to the PPACA, giving patients unlimited choice in providers leaves them making poor choices about quality and robs the plans from being able to negotiate with providers for cost and quality considerations.<sup>352</sup> One significant feature of the PPACA is accountable care organizations (ACOs), which require providers and plans to unite with a shared purpose to lower prices, promote quality, and retain the savings associated with doing so.<sup>353</sup> ACOs by their very definition require select contracting plans, and providers must be free to select others who are committed to and capable of providing cost-conscious high-quality care.<sup>354</sup> To the extent that ACOs and managed competition actually do promote quality and reduce overall costs, limits on provider and plan freedom to contract may be troubling for the larger system. And, of course, it highlights the dilemma of whether and to what extent academic medical centers and tertiary care can be easily streamlined into an ACO, and the implications of this for patient care given the unique services these institutions provide.<sup>355</sup>

A full account of the distributive justice issues raised by narrow networks is beyond the scope of this Article and, admittedly, a variety of different justice arguments would favor

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352. Alain C. Enthoven, *The History and Principles of Managed Competition*, 12 HEALTH AFF. 24, 29 (Supp. 1993); see also Mark A. Hall, 29 WAKE FOREST L. REV. 1, 1 (1994) (discussing Enthoven's scholarship on managed competition).

353. *Accountable Care Organizations (ACO)*, CENTERS FOR MEDICARE & MEDICAID SERVICES, <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/> (last updated Mar. 22, 2013).

354. See generally *id.* ("Accountable Care Organizations . . . are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their Medicare patients.").

355. Academic medical centers may face cultural and financial barriers with adopting an ACO model, especially given their added costs around tertiary care, teaching, and research. While the pressure to form ACOs and drop prices exists, academic medical centers have been less willing to adopt the new model or less successful so far, as only 20% of the approved Medicare Share Savings ACOs to date have been academic medical centers. Bill Toland, *Academic Hospitals, Research Units Face Accountable Care Cost Challenges*, PITTSBURGH POST-GAZETTE (July 22, 2014, 10:03 PM), <http://www.post-gazette.com/business/2014/07/23/Academic-hospitals-research-units-face-accountable-care-cost-challenges/stories/201407250003>.

extending resources to a wide variety of different populations, whether more resources for the sick, for the healthy, for the largest net benefit, or for the greatest quality of life.<sup>356</sup> Instead, my purpose is to suggest that network adequacy poses a distributive justice problem which policymaking processes need to take into greater account.<sup>357</sup>

More information may be necessary to determine the extent to which required contracts with tertiary care providers could implicate the cost of care overall and access for others, but certainly there is a strong normative argument to be made that access to tertiary care is an important consideration and that the costs of this care might be spread across the larger pool of insurance.

## VI. POLICY SOLUTIONS FOR NARROW NETWORKS

Time will tell whether narrow networks are a reaction to more immediate and anticipated market instabilities or, more likely, something longer lasting. Empirical studies will help to reveal the positives and negatives of narrow networks for patient care, insurance and health care access, and health care costs and to what extent broad access could compromise the ability of insurers to lower premiums. For now, we know that narrow networks tend to exclude tertiary care centers, a question that is not directly addressed in state or federal law.<sup>358</sup> More clarity is needed in the regulations to address the problem raised by the Seattle Children's case—that network adequacy is not just an issue of care for rural patients or for poor patients, but also for those rare patients who truly require access to specialty care that cannot likely be provided

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356. See generally Smith, *supra* note 313 (summarizing nicely a variety of arguments around microallocation of resources).

357. Policymaking and political processes may be the only just way to account for these distributive justice issues after all. As Daniels admits, once we do the normative work of identifying a distributive justice tension, reasonable people can disagree on where resources should be distributed. All we can hope for is a transparent political process that fully considers all of the issues. See Daniels, *supra* note 276, at 2–3, 8–9. Other scholars also recognize the inherent place of health care rationing in allocation decisions and the importance of a democratic process in promoting justice and avoiding invisible rationing. Leonard M. Fleck, *Just Health Care Rationing: A Democratic Decisionmaking Approach*, 140 U. PA. L. REV. 1597, 1601–04 (1992).

358. Chen, *supra* note 1.

anywhere else.<sup>359</sup> Any effort to regulate network adequacy needs to find compromise between recognizing the unique and necessary services that tertiary care centers provide while also respecting that, with too stringent of network adequacy standards, an insurer will be left with little or no power to bargain down higher rates that may have little to do with uniqueness and quality of care and more to do with market share. A shared interest in lower premiums must be balanced with the need to incentivize insurers to offer high quality care and sufficient access.<sup>360</sup>

I make some tentative recommendations below for how to address the more immediate tertiary care needs of patients while we await more information about the implications of network adequacy for a broad population of patients.

#### A. RECOMMENDATION 1: BOTH STATE AND FEDERAL LAW SHOULD PROTECT PATIENTS FROM BALANCE BILLING FOR MEDICALLY NECESSARY OUT-OF-NETWORK CARE

Network adequacy questions are broad and encompass access to primary, secondary, tertiary, and acute care. To the extent that any of the services are essential health benefits, plans should be held accountable for delivering that care to the patient and, if it must be delivered out-of-network, it should not result in any additional costs to the patient beyond what the patient would have paid in-network. Particularly, recognizing that few low- or medium-price hospitals provide trauma care, neonatal intensive care, and other types of tertiary care that patients require and which is often costly, there should be standards in place that promise that such care will be made available out-of-network without balance billing if not available in-network.

Some states already have such a law, whether targeted at managed care or not.<sup>361</sup> So-called “hold harmless” laws are limited, though, in whether they shield just the enrollees from costs or also address payment for providers, and whether

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359. See *supra* notes 1–14 and accompanying text.

360. CORLETTE ET AL., *supra* note 29.

361. WASH. STATE OFFICE OF THE INS. COMM’R, RULE-MAKING ORDER CR-103P (Apr. 25, 2014), available at <http://www.insurance.wa.gov/laws-rules/legislation-rules/recently-adopted-rules/documents/2013-22103P.pdf>.

balance billing is prohibited only when the out-of-network care is referred by an in-network provider.<sup>362</sup>

B. RECOMMENDATION 2: STATES AND THE FEDERAL GOVERNMENT SHOULD ADOPT A STANDARD TO ADDRESS TERTIARY CARE

Network adequacy laws are strongest at the state level where they can be better tailored to the particular needs and resources of the state and local geography (e.g., the extent of rural versus urban populations, the availability and number of tertiary providers, and the number of insurers competing on the exchange).<sup>363</sup> The greatest impact on network adequacy can be had at the state level where states might certify plans, have or are developing their own laws, and have a greater understanding of the needs of their citizens and their health care markets.<sup>364</sup> States can be used as laboratories to experiment with a variety of network adequacy regulations as we come to better understand narrow networks' role in the new marketplace and particular issues they pose for cost and access.

These types of network adequacy issues require extensive empirical, policy, and normative considerations. For example, (1) do all exchanges offer some plan with access to academic

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362. See, e.g., STATE OF N.Y. INS. DEP'T, OGC OP. NO. 09-10-07, BALANCE BILLING BY HEALTH CARE PROVIDERS (2009), available at <http://www.dfs.ny.gov/insurance/ogco2009/rg090404.htm> (holding patients harmless for out-of-network care referred by an in-network provider). For a list of relevant state laws, see *State Restriction Against Providers Balance Billing Managed Care Enrollees*, *supra* note 83.

363. See *infra* notes 383–93 and accompanying text.

364. Much comes down to locality in health care anyway, particularly with respect to quality. For example, plans have to meet certain measures of quality set by local performance standards on national surveys of quality. Patient Protection and Affordable Care Act § 1311(c)(1)(D)(i), 42 U.S.C. § 18031 (2012) (requiring that health plans “be accredited with respect to local performance on clinical quality measures such as the Healthcare Effectiveness Data and Information Set, patient experience ratings on a standardized Consumer Assessment of Healthcare Providers and Systems survey, as well as consumer access, utilization management, quality assurance, provider credentialing, complaints and appeals, network adequacy and access, and patient information programs by any entity recognized by the Secretary for the accreditation of health insurance issuers or plans (so long as any such entity has transparent and rigorous methodological and scoring criteria).”). Health plans also must implement quality improvement strategies. *Id.* at § 1311(c)(1)(E).

medical centers, (2) how much price difference exists between such plans and their narrow counterparts, and (3) how much will it affect premiums if we ensure affordable access to tertiary care for the sick? But meanwhile, patients like Gabriella may be denied access to medically necessary care.<sup>365</sup> We cannot wait until more is known about network adequacy to ensure care for patients. Thus, I propose a standard for consideration while we await information on narrow networks.

State legislative or administrative processes should consider explicitly requiring some measure of tertiary care in their network adequacy standards.<sup>366</sup> A Massachusetts statute on network adequacy provides a good starting place to address the problems that cases like Gabriella's raise.<sup>367</sup> Specifically, it requires state insurance commissioners to evaluate the plan for the "range of services provided by providers in the plan and plan benefits that recognize and provide for extraordinary medical needs of members that may not be adequately dealt with by providers within the plan network."<sup>368</sup> These needs should be provided at no additional cost to the patient (compared to any in-network expense) when care is provided out-of-network.<sup>369</sup> Insurance officials should examine plans for whether they satisfy this standard at all levels of care (primary, secondary, tertiary, and acute). The burden can be on the out-of-network provider to clarify the scope of their medical services and the types of extraordinary medical needs that they provide, whether by showing information about services, patient populations, care coordination, and/or quality.<sup>370</sup> The Massachusetts statute provides good model language for states

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365. Press Release, *supra* note 2; Chen, *supra* note 1.

366. See Hoffman, *supra* note 290, at 1873; see also Jost, *supra* note 293, at 607.

367. See MASS. GEN. LAWS ch. 176J, § 11 (2011); see also Chen, *supra* note 1.

368. 176J, § 11(e). This standard is in addition to the typical factors about geographic location of providers, range of services, etc. that are present in most other state and federal network adequacy regulations.

369. *E.g.*, CONSUMER BILL OF RIGHTS, *supra* note 156, at pt. II.

370. The burden can be on the out-of-network provider to inform insurers of when and how care for certain conditions can better be provided at their institution, whether by showing information about care coordination and/or quality. In selecting this standard, I recognize it will require adaptation. For example, even the term "medically necessary" may face challenges. *E.g.*, Hill, *supra* note 351, at 448–51. The goal is really to create some early standard to emphasize access to tertiary care, until more can be known later.

to consider because it recognizes the special needs of certain patients and requires insurance plans to prepare for them in advance.<sup>371</sup> It also allows the insurance commissioner to consider the plan through the lens of the very sick patient, asking whether the plan can meet extraordinary needs which ideally can encompass questions about access to tertiary and acute care, access to coordinated care, and access to high quality and experienced providers.<sup>372</sup> Of course, much work would be needed to define what an extraordinary medical need is, but providers may play a useful role here in notifying both plan and state insurance officials about the types of specialty care they engage in and the types of patients they frequently see to better inform this process.<sup>373</sup>

Ideally, any new laws or amendments will reach to the unique services issue that Seattle Children's raises, and also will address more broadly questions of care coordination, quality, and outcomes.<sup>374</sup> Extraordinary medical needs should be interpreted broadly to encompass episodes of care that might better be performed in a tertiary center.<sup>375</sup> For example, Gabriella's extraordinary health needs might require that the non-unique CT scan be performed out-of-network to facilitate coordinated care among her many specialists. Or a surgery might be regularly performed in-network but not on a patient

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371. See *id.*; see also CORLETTE ET AL., *supra* note 29.

372. What this standard may not reach are issues of patients wanting to keep their old doctor. Yet, arguably, the "keep your old doctor" issue may be appropriately placed subordinate to ensuring that networks adequately cover a host of necessary medical care, including tertiary care, at least until more is known about the implications of more tightly regulating network adequacy. Accommodating any and all requests to keep one's doctor will eliminate any possibility of having a network. However, this is not to diminish the importance of this issue for patient comfort and continuity of care. This is only to say that, while network innovation is at its peak and exchanges remain uncertain in their stability and success, we might favor more the call for access over preference. See CORLETTE ET AL., *supra* note 29.

373. See, e.g., N.H. INS. DEPT, *supra* note 268.

374. See Chen, *supra* note 1 (describing the unique services issue surrounding Seattle Children's); see also CORLETTE ET AL., *supra* note 29, at 6–8 (discussing the advantages of having "clear quantitative standards"); Hill, *supra* note 351, at 448–51 (analyzing the multiple definitions and "concepts concerning 'health'"); Press Release, *supra* note 2 (emphasizing the importance of proper care coordination).

375. See, e.g., N.H. INS. DEPT, *supra* note 268; see also CORLETTE ET AL., *supra* note 29.



with significant comorbidities.<sup>376</sup> Insurance officials should be careful that the standard is applied in a way that is not too broad to allow claims for care that could easily and competently be provided in-network, but not so restrictive that it creates harmful access issues.<sup>377</sup> Insurers might consider a similar standard at the level of individual access decisions.<sup>378</sup>

Other models may be useful for states to consider, but have some drawbacks. The NAIC Model Language requires plans to cover out-of-network care at no extra cost when in-network providers are “insufficient.”<sup>379</sup> Yet this language could be narrowly interpreted to reach only to availability, and not skill, experience, or coordination.<sup>380</sup> The Consumer Bill of Rights language is closer (it requires plans to consider whether they have providers with the “appropriate degree of specialization”),<sup>381</sup> but this only speaks to provider skill, and not coordination, quality, or experience.<sup>382</sup>

At the very least, recognizing the issue in either regulations or administrative cases can help to: (1) address the issue of tertiary care which is not currently being actively considered and (2) shift the decision of adequacy from the plans and consumers who may want cheap premiums at any cost to the state officials who may have fewer conflicts of interest.<sup>383</sup>

While tertiary care might highlight the issue, network adequacy could also go further in considering the quality of providers generally.<sup>384</sup> The PPACA does have provisions requiring that plans meet certain quality standards, but states might also consider reviewing providers’ training, education, and performance on quality measures.<sup>385</sup> Quality matters at all

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376. See generally Chen, *supra* note 1.

377. E.g., N.H. INS. DEP’T, *supra* note 268; see also CORLETTE & VOLK, *supra* note 21.

378. E.g., Brown & Hartung, *supra* note 85, at 25–33.

379. NAIC MODEL ACT, *supra* note 155, at 74-4; see CONSUMER BILL OF RIGHTS, *supra* note 156, at pt. II.

380. See generally Hill, *supra* note 351, at 448–51 (discussing why skill, experience, and coordination matter).

381. CONSUMER BILL OF RIGHTS, *supra* note 156, at pt. II.

382. See generally Hill, *supra* note 351.

383. See Enthoven, *supra* note 352, at 29; see also Hall, *supra* note 352, at 5.

384. See CORLETTE ET AL., *supra* note 29, at 7–9.

385. Patient Protection and Affordable Care Act § 1311(c)(1)(D)(i), 42 U.S.C. § 18031 (2012); see also CORLETTE ET AL., *supra* note 29, at 6–9.

care levels. Likewise, states can engage in frequent monitoring for evidence of network inadequacy.<sup>386</sup>

States might consider applying numeric time and distance standards to address tertiary access, though this could have limited success. In the case of tertiary care where there are likely few institutions available, numeric standards may be difficult to create unless they involve a clear order to contract with at least one tertiary hospital, or access to a tertiary hospital within a certain distance (where available).<sup>387</sup> States must also weigh the benefits and burdens of prospective and retrospective review of plans for network adequacy.<sup>388</sup> In the case of tertiary care, the latter may be preferable. Again, with few tertiary centers, it is easy to see when one is being excluded from a network and whether any other substitutes apply.<sup>389</sup> Moreover, the high stakes for some of these patients may make retrospective review inappropriate.<sup>390</sup>

Notably, in some states, there will be an added issue of rural health.<sup>391</sup> Narrow networks may create distinct challenges for rural health because of “long distances to

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386. Items that could be reviewed include balance billing data, whether providers are actually accepting patients, numbers of times plans have to use spot contracting, access to tertiary care generally, how many times they deny or refuse spot contracting, quality of providers, patterns of exclusions, patient grievances, and consequences for patient outcomes. *See, e.g.*, CORLETTE ET AL., *supra* note 29; *see also* Abbi Coursolle, *Network Adequacy in Medicaid Managed Care: Recommendations for Advocates*, NAT'L HEALTH L. PROGRAM (Sept. 20, 2013), [http://www.healthlaw.org/issues/medicaid/managed-care/network-adequacy-in-medicaid-managed-care#.VDnr9\\_ldViI](http://www.healthlaw.org/issues/medicaid/managed-care/network-adequacy-in-medicaid-managed-care#.VDnr9_ldViI).

387. Finding a standard that makes sense for both rural and urban areas of a state, reflecting numeric standards that actually work for the new and somewhat unknown quantity that is the new purchaser on the exchange, the reality that the review only captures one moment in time for the network and not long term comings and goings of the network, and lack of training by state insurance agencies to conduct these reviews are all possible drawbacks of the numeric standard. However, subjective standards may not provide enough guidance if insurers think a plan is adequate but providers and patients may disagree. *See* CORLETTE ET AL., *supra* note 29.

388. *See* MCCARTY & FARRIS, *supra* note 169.

389. *E.g.*, PRICEWATERHOUSECOOPER, *supra* note 23.

390. *See generally* Chen, *supra* note 1.

391. *See* Jean. A. Talbot et al., *Rural Considerations in Establishing Network Adequacy Standards for Qualified Health Plans in State and Regional Health Insurance Exchanges*, 29 J. RURAL HEALTH 327, 327–28 (2013); *see also* Sidney D. Watson, *Mending the Fabric of Small Town America: Health Reform & Rural Economies*, 113 W. VA. L. REV. 1, 4–18 (2010).

available providers, health professional shortages, higher poverty rates than those found in urban areas, and higher rates of uninsurance or underinsurance.”<sup>392</sup> Rural network adequacy presents a different issue about how to bring health care resources within geographic reach of everyone, calling for larger evaluation of federal funding, physician education and training, and the like.<sup>393</sup>

A federal floor is appropriate, in addition to state regulation. More extensive federal regulation is unlikely to the extent it might require Congressional activity. Agency action seems more appropriate and feasible. While it may be problematic to have too stringent of a federal standard that removes freedom from the states,<sup>394</sup> federal guidance can go further in establishing a federal floor that sufficiently protects the interests of the very sick and their need for specialty care.<sup>395</sup> For example, the CMS guidance should be amended to also consider some other specialist providers like pediatric institutions, particularly given the inability of children to have a say in which type of health plan they are insured by.

### C. RECOMMENDATION 3: MODELS TO OPERATIONALIZE A TERTIARY CARE STANDARD

States may consider a variety of models in requiring plans to contract, in some way, with tertiary providers as required to meet extraordinary medical needs of enrollees.

One possibility is good-faith contracting or AWP standards, which a number of states already have.<sup>396</sup> In this manner, the plan would be required to offer terms to all providers that a

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392. Talbot et al., *supra* note 391, at 327–28. Indeed, rural areas may face network adequacy issues that have more to do with availability of providers in general than with intentional marketing by insurers. In fact, too small of a pool of providers may render narrow networking impossible in some areas. Generally, for issues related to health reform and rural communities, see Watson, *supra* note 391.

393. For example, see a complaint that, even with the 30% ECP standard proposed by CMS, in Montana this could mean providers being as far as 300 miles away. Robert Pear, *To Prevent Surprise Bills, New Health Law Rules Could Widen Insurer Networks*, N.Y. TIMES (July 19, 2014), <http://www.nytimes.com/2014/07/20/us/insurers-face-new-health-law-rules-to-widen-network-s-and-prevent-surprise-bills.html>.

394. See Enthoven, *supra* note 352; see also Hall, *supra* note 352.

395. See CORLETTE ET AL., *supra* note 29.

396. Noble, *supra* note 215.

willing, similarly situated non-ECP provider either has or would accept.<sup>397</sup> Providers are free to either take the offer or reject it; of course that similarly situated provider might need to be found at a national rather than state level when looking at tertiary care reimbursements.<sup>398</sup> The ability of the plan to exclude providers because they are expensive should have its limits.<sup>399</sup> If the provider is willing to accept the same rate as a similarly situated provider, then the only excuse the insurer has left is loss of the market share that could negotiate lower premium prices. And this might be insufficient when we consider the stakes for certain patients and for the possibility that the volume of patients requiring access to tertiary care could be relatively low for any single health plan. However, states considering this option need to be sensitive to the possibility that a requirement to contract will strip plans of the ability to negotiate prices downward.<sup>400</sup> To avoid this, Massachusetts passed a law in 2010 in which hospitals cannot bargain for preferred network status as a condition of their participation in a network.<sup>401</sup> Or, states might allow plans to use centers of excellence outside of the state if they are accessible to patients and meet quality standards, thus widening competition and perhaps dropping prices.<sup>402</sup>

States can also encourage broader participation by insurers on the individual market.<sup>403</sup> This may be an alternative way to keep premiums low without narrow networks. Had all insurers that participated in the individual market in 2011 chosen to participate in the 2014 exchange market, researchers predict that premiums would have been 11.1% lower and federal subsidies would have dropped by 1.7 billion dollars.<sup>404</sup> That reduction is comparable to rate savings seen in the 2014 exchange year from narrow networks (where narrow plans were 13% to 17% cheaper than broad

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397. See, e.g., Letter to Issuers, *supra* note 184 (adopting the 2015 federally-facilitated exchange rule definition).

398. See *id.*

399. See N.H. INS. DEP'T, *supra* note 268.

400. See Enthoven, *supra* note 352; see also Hall, *supra* note 352.

401. White et al., *supra* note 24, at 330.

402. E.g., CORLETTE ET AL., *supra* note 29.

403. CORELETTE ET AL., *supra* note 29, at 4–7.

404. See, e.g., Gruber and Colleagues Call for More Research on Health Plan Competition, *supra* note 110.

counterparts).<sup>405</sup> Of course, this is limited by the availability and willingness of insurers. But states and federal agencies might consider their role in stabilizing the market to welcome more participants. For example, if insurers are reluctant to contract with tertiary centers (whether through spot contracting or some other means), states or the federal government might consider removing the financial risk for the insurer.<sup>406</sup> Though there are many incentives for narrow networks, contracting with specialty centers is almost certain to increase the insurer's pool of higher risk enrollees.<sup>407</sup> Perhaps this is enough to discourage insurers from coverage. Strengthening risk adjustment and gaining trust in the insurers that it is effective in redistributing risk could be imperative for encouraging insurers to broaden their networks.<sup>408</sup> Alternatively, states and the federal government might consider requiring plans to purchase some form of reinsurance that lumps all claims for tertiary and out-of-network care. In this way, the insurers would share the burden of patients with higher claims, helping to spread risk and promote adequate coverage to tertiary care.

Another model would be to require plans to spot contract for unique medically necessary services as in the Seattle Children's case.<sup>409</sup> Such a requirement might allow for some measure of access without destroying the insurer's ability to negotiate for prices<sup>410</sup> (though admittedly if the service is unique, they will have few other providers to negotiate with).<sup>411</sup> But such an allowance does not resolve larger questions of coordination of care and practical issues about how to handle a whole hospital visit,<sup>412</sup> for example in the case of the Blankers family and the increased costs and impracticality associated with attempting to treat a complex illness through a variety of

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405. See MCKINSEY CTR., *supra* note 92, at 7.

406. See Greaney, *supra* note 344, at 839. See generally Furrow, *supra* note 341, at 848-52.

407. E.g., PRICEWATERHOUSECOOPER, *supra* note 23.

408. See N.H. INS. DEPT, *supra* note 268.

409. See Chen, *supra* note 1; see also Press Release, *supra* note 2.

410. See, e.g., N.H. INS. DEPT, *supra* note 268; see also CORLETTE ET AL., *supra* note 29.

411. See Greaney, *supra* note 344, at 839. See generally Furrow, *supra* note 341, at 848-52.

412. See Hill, *supra* note 351, at 448-51.

different providers at once.<sup>413</sup> Spot contracting might be an answer, but only with certain transparency and other protections in place for consumers and with a clear recognition that the full course of care for the patient needs to be covered, not just unique services.<sup>414</sup> Models in managed care could be illustrative here, particularly those that deal with last chance or expensive therapies.<sup>415</sup> Ombudsman and neutral third parties to handle patient grievances may be a reasonable model for addressing fair use of spot contracting at the individual patient level.<sup>416</sup>

States might also consider their own ability to negotiate prices. The PPACA is silent on whether exchanges should be a clearinghouse, allowing all health plans that meet minimum certification standards to be offered on the exchanges<sup>417</sup> or, alternatively, an active purchaser of health plans that uses selective contracting, competitive bidding, and price negotiation to impact price and quality.<sup>418</sup> For 2014, seventeen states ran their own exchanges.<sup>419</sup> Of these, nine followed a clearinghouse model,<sup>420</sup> six were active purchasers,<sup>421</sup> and two

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413. Press Release, *supra* note 2; Chen, *supra* note 1.

414. See, e.g., CORLETTE ET AL., *supra* note 29; see also Coursolle, *supra* note 386.

415. E.g., Fleck, *supra* note 294.

416. For a discussion of models proposed in the managed care era to address denials of expensive care for individuals, see Norman Daniels & James E. Sabin, *Last Chance Therapies and Managed Care: Pluralism, Fair Procedures, and Legitimacy*, 28 HASTINGS CENTER REP. 27, 33–37 (1998) (stressing a theme of public engagement and legitimacy through transparent public processes).

417. Minimum certification standards include accreditation, network adequacy, essential community providers, marketing practices, quality improvement, price and quality ratings, and transparency. See Quattrocki, *supra* note 214; see also CTR. FOR CONSUMER INFO. & INS. OVERSIGHT, CTRS. FOR MEDICARE & MEDICAID SERVS., GENERAL GUIDANCE ON FEDERALLY-FACILITATED EXCHANGES 8 (2012), available at <https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/ffe-guidance-05-16-2012.pdf>.

418. Betsy J. Rosen, Note, *Procurement Law Governing the Certification of Qualified Health Plans in Federally Facilitated Health Insurance Exchanges*, 42 PUB. CONT. L.J. 847, 848–58 (2013).

419. *State Health Insurance Marketplace Types*, KAISER FAM. FOUND., <http://kff.org/health-reform/state-indicator/health-insurance-exchanges/> (last updated Nov. 4, 2014).

420. States following the clearinghouse model were Colorado, Connecticut, District of Columbia, Hawaii, Idaho, Maryland, Minnesota, Nevada, and Washington. *Id.*

were undecided.<sup>422</sup> Federally facilitated exchanges chose a clearinghouse model for 2014.<sup>423</sup> Guidance for the 2015 exchanges again appears to be silent on the issue.<sup>424</sup> Active purchase states thus far have enjoyed the greatest competition on the exchanges,<sup>425</sup> but whether this was because of active purchasing or because those states that felt most comfortable with active purchasing had large competition anyway is unclear. Active purchase states recruited insurers before deciding which plans would be allowed on the exchanges.<sup>426</sup> For example, California approved eleven plans ultimately for exchange purchase, but thirty-three plans originally applied.<sup>427</sup>

While federal guidance appears to be reluctant to move toward active purchasing by the exchanges,<sup>428</sup> such measures could allow the exchanges to use their own market share to improve cost and quality.<sup>429</sup> The exchanges would act as a gatekeeper in making insurers compete for quality of benefits and network adequacy.<sup>430</sup> Competitive bidding by the exchanges would also be more in line with other government contracting processes, which encourage open competition and competitive bidding.<sup>431</sup> Allowing active purchasing could mean greater quality and easier purchasing for consumers.<sup>432</sup> Currently in many markets, the exchanges are occupied by large numbers of plans and consumers may find it difficult to

421. Active purchasers included California, Massachusetts, New York, Oregon, Rhode Island, and Vermont. *Id.*

422. Undecided states were Kentucky and New Mexico. *Id.*

423. CTR. FOR CONSUMER INFO. & INS. OVERSIGHT, *supra* note 417 (“[A]t least in the first year HHS intends to certify as a QHP any health plan that meets all certification standards.”).

424. To a lesser degree states can manage competition through rate reviews, allowing plans to justify increased rates and, more aggressively, to require plans to have their rates approved before the plan can be offered on the exchanges. *See, e.g.,* KAISER FAMILY FOUND., *supra* note 110.

425. *Id.*

426. MCKINSEY CTR., *supra* note 105.

427. Some suspect that state run purchasers may seem more approachable, quicker, and easier to work with than a federally facilitated exchange. *See id.*

428. *See* CTR. FOR CONSUMER INFO. & INS. OVERSIGHT, *supra* note 417; Rosen, *supra* note 418, at 858–61.

429. *See* SCHONE & BROWN, *supra* note 67, at 18–23.

430. Rosen, *supra* note 418, at 858–61.

431. For example, Betsy Rosen points to the Federal Acquisition Regulation (FAR) as a model for how the exchanges might function. *Id.* at 859–66.

432. *Id.*

weed out quality plans from poorer quality.<sup>433</sup> Moreover, with a clearinghouse model, there may be a race to the bottom with plans meeting the minimum certification standards, and then competing only on price.<sup>434</sup> Without consumers understanding what they are buying, the plan does not need to compete on quality.<sup>435</sup> However, informed state exchanges could create a minimum threshold for quality as well as cost in a way that might be more realistic than consumer choice.

States so far have seemed reluctant to play too active of a role in the insurance market,<sup>436</sup> but they also have been dealing with an uncertain market where insurers may not have been willing to offer products on the exchange, at least until the costs and health of enrollees was better known. This may change over time as new insurers join and more old insurers become willing to market products on the exchanges.<sup>437</sup>

#### D. RECOMMENDATION 4: TRANSPARENCY AND CONSUMER EDUCATION

Individuals need information about network options in order to make a choice that is best for their family, recognizes their preferences, and anticipates their needs. Requiring frequent updates to published provider networks and transparency about whether the plan is a broad or narrow design could go a long way in informing a consumer choice.<sup>438</sup> Other options include giving special windows for new enrollment if enrollees are not given adequate network information, making information available about in- versus out-of-network pricing,<sup>439</sup> or even requiring plans to explicitly mention if they have not contracted with certain types of providers and instead plan to use spot contracting or other methods.<sup>440</sup>

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433. See Enthoven, *supra* note 352; see also Hall, *supra* note 352.

434. See generally CTR. FOR CONSUMER INFO. & INS. OVERSIGHT, *supra* note 417; Quattrocki, *supra* note 214.

435. See generally Enthoven, *supra* note 352; Hall, *supra* note 352.

436. See Rosen, *supra* note 418, at 858–61.

437. For a summary of known market competition in states to date, see CYNTHIA COX ET AL., KAISER FAMILY FOUND., SIZING UP EXCHANGE MARKET COMPETITION (2014), available at <http://kaiserfamilyfoundation.files.wordpress.com/2014/03/8562-sizing-up-exchange-market-competition1.pdf>.

438. Pear, *supra* note 393.

439. See, e.g., CORLETTE ET AL., *supra* note 29.

440. See Coursolle, *supra* note 386.



However, these measures are only useful to the extent that individuals can make informed decisions about narrow networks.<sup>441</sup> Individuals cannot predict their future health needs and they may have difficulty understanding the implications of the narrow network. Moreover, like essential health benefits, there is an argument to be made that plans must be held to some accountable level of care and that consumers, no matter how informed, should not be allowed to purchase a bad plan. To the extent that a plan does not have appropriate provider coverage for essential benefits, including and especially tertiary care, it may well be that even the most informed consumer should not be able to make such a purchase.

## VII. CONCLUSION

Network adequacy, in many ways, presents age-old questions of health law, policy, and ethics. How do we guarantee a system that protects everyone and controls cost? The PPACA makes a valiant effort to make health care almost universally available but, inevitably, it creates its own access challenges—both expected and unanticipated. A single-payer system could go a long way toward eliminating many of the problems addressed in this Article—both technical and broader access concerns. But we must work in the system we currently have. There are a variety of ways in which states, federal governments, and the courts can improve network adequacy while we await more information on the implications of narrow networks for patient care and health care costs.

Narrow networks may pose important distributive justice challenges about to what extent the healthy must pay for the care of the sick and which we ought to favor: broader and more affordable access to insurance for many and/or access to necessary specialty care for a few. More normative and empirical work is needed to inform these questions. Yet, while we wait, real patients are finding that their insurance may not deliver the benefits they need and serious consequences may result. In this Article, I suggest that rapid response is necessary to ensure access for patients to tertiary care. This matter cannot wait until we know more about narrow

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441. See generally Enthoven, *supra* note 352; Hall, *supra* note 352.

networks, it must be acted upon now and adjusted as we gain more knowledge.

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