Minimizing Risks to Patients in High-Stakes Provider-Payer Contract Disputes: Regulatory Strategies and Considerations for Policymakers

By Sabrina Corlette, Emily Curran, and Rachel Schwab

Support for this report was provided by the Robert Wood Johnson Foundation. The views expressed here do not necessarily reflect the views of the Foundation.
The Center on Health Insurance Reforms (CHIR), based at Georgetown University’s McCourt School of Public Policy, is composed of a team of nationally recognized experts on private health insurance and health reform. We work regularly with a multidisciplinary group of faculty and staff dedicated to conducting research on issues related to health policy and health services.

CHIR faculty and staff study health insurance underwriting, marketing and products, as well as the complex and developing relationship between state and federal rules governing the health insurance marketplace. CHIR provides policy expertise and technical assistance to federal and state policy-makers, regulators and stakeholders seeking a reformed and sustainable insurance marketplace in which all consumers have access to affordable and adequate coverage.
Introduction

Recent high-profile contracting disputes between health insurance companies and large, regional health systems have generated media attention and considerable concern among plan enrollees. A decade of provider and insurer consolidation, resulting in sprawling provider systems that own multiple hospitals, physician groups, and ancillary service providers, and insurers with 50 percent or more of local market share, has raised the stakes in provider-payer contract negotiations. Although rare, contract disputes that end with the provider leaving the health plan’s network can disrupt patient care and reduce access to services. Enrollees who relied on certain hospitals or physicians being in-network when they chose a plan may also be exposed to unexpected out-of-network costs.

No health plan enrollee ever has a guarantee that a particular physician or hospital will remain in their network, but there are policies designed to help consumers make plan purchasing decisions with as accurate information about providers’ network status as possible. For certain plans, there may also be protections for enrollees who are seriously ill or pregnant, so that they can maintain access to a treating provider at no additional financial cost. And network adequacy standards require insurers to have sufficient numbers and types of in-network providers to ensure access for enrollees within a reasonable time frame and distance.

Insurance regulators, primarily in state departments of insurance (DOIs), are responsible for ensuring that consumers have these basic protections when a major provider system leaves a health plan network. However, state policies and approaches to the oversight of provider-insurer disputes and their aftermath vary, as do the policies and procedures of the insurers themselves. This paper assesses the legal and regulatory tools available to state regulators and how they can be used most effectively to mitigate harm to consumers from a threatened or actual provider termination.

Research Approach

To assess the legal authority of state regulators, the authors reviewed insurance laws in six states: California, Georgia, Massachusetts, North Carolina, Pennsylvania, and Texas. The states were chosen for geographic diversity and because each had recently experienced a high-profile contract dispute between providers and payers that generated media attention. To better understand the policies and procedures followed up to and in the wake of a provider termination, we supplemented our legal analysis with structured interviews with DOI officials and representatives of insurance companies in the above states. While provider terminations affect health plan enrollees in both commercial and government coverage programs, our focus for this paper is on the regulation and oversight of fully insured individual and group insurance. Self-funded employer plans, Medicare Advantage, and Medicaid managed care are outside the scope of this analysis.

* In some states, the responsible regulatory agency is a department of health, or managed care, and not the DOI. For this paper, “DOI” refers to any responsible state agency.
Background

Contract disputes between payers and providers have increasingly dominated media headlines, catching the attention of state and federal officials. In 2019 alone, numerous high-profile disputes arose across the country, involving some of the largest publicly traded insurers and major hospital systems and affecting consumers in the Medicare Advantage, employer-group, and individual markets. For example, in Texas, 100,000 UnitedHealthcare Medicare and commercial insurance members lost in-network access to eight Houston Methodist hospitals and other outpatient facilities after the insurer and hospital system failed to reach an agreement before their contract expired in December 2019. In Pennsylvania, Highmark Health and the University of Pittsburgh Medical Center’s (UPMC) feud regarding consumers’ in-network access to at least eleven hospitals became so prolonged and contentious that it required the involvement of the state’s attorney general and Supreme Court. National insurer Cigna has disputed with provider systems across the country, from Dignity Health in California to Mission Hospital in North Carolina and Christus Health hospitals in Louisiana and Texas. These provider-payer disagreements have become almost commonplace as provider systems fight to maximize revenue and insurers are under increasing pressure to rein in rising costs. Each time, these conflicts risk moving providers out-of-network for consumers and causing disruptions in care, or increasing health care costs as insurers are forced to submit to higher pricing demands.

In some cases, major provider systems have terminated early in the plan year, shortly after consumers have selected an insurance product based on a provider being in their plan’s network. For instance, in Georgia, WellStar Health System and Anthem announced in January 2019, just weeks after the annual open enrollment period ended, that they would let their contract expire, placing nearly a dozen hospitals, ten urgent care clinics, and numerous physicians out-of-network for Anthem consumers with individual market policies. The insurer acknowledged that “some consumers may have enrolled in Anthem plans based on the incorrect assumption that WellStar would remain” in the plan’s network for 2019. While the parties eventually reached a temporary agreement in June 2019, consumers faced months of uncertainty, not knowing whether care would be covered or at what cost.

Changes to provider networks occur all the time. Providers come and go from plan networks as

Provider Consolidation: Defining Key Terms

- **Horizontal Integration**: Occurs when entities that are performing similar functions or that offer the same types of services/products come together, such as when a physician joins a provider practice or provider practices merge to form a larger group.

- **Vertical Integration**: Occurs when separate entities in the supply chain come together, such as when providers and health insurers merge to create a larger health care system (e.g., Kaiser Permanente, Mayo Clinic).

- **Anti-Competitive Contracting Clauses (examples)**:
  - **All or Nothing**: Requires that an insurer that provides coverage of a service or product at a single hospital also provide coverage of services and products offered at all other affiliated hospitals, even when lower-cost or higher-quality services may be available from a competitor.
  - **Anti-Tiering/Anti-Steering**: Prohibits insurers from offering financial incentives like lower cost-sharing in order to steer enrollees to providers who charge less.
  - **Price Secrecy (gag clauses)**: Forbids insurers from informing consumers about the costs of services and products so that enrollees are not able to seek out or demand better pricing.
they retire, change jobs, move out of state, and negotiate contract renewals. But as major provider systems have become increasingly consolidated through horizontal and vertical integration, and the use of anti-competitive practices like “all or nothing” contracting clauses has become more routine, the stakes for resolving these disputes have heightened (see Key Terms box on page 4). Ninety percent of metropolitan areas now have highly concentrated hospital markets and 65 percent have highly concentrated specialty physician markets. At the same time, in an attempt to cut costs and maintain their negotiating clout, insurers too have turned to consolidation, with several recent large-scale mergers and acquisitions. As each side attempts to strengthen its position, contracting discussions may become more contentious, with increasingly high stakes for all parties. State regulators thus face an increased risk of major disruptions, or the threat of disruptions, in access to services, particularly in areas where only one or two provider systems are available. WellStar Health System’s dispute with Anthem highlighted this very issue, as WellStar owns the only hospitals in Cobb County, Georgia and acts as the main provider for northwest Atlanta, while Anthem is the largest private insurer in the state. Consumers’ access to care would have been dramatically limited if coverage of the system had lapsed for the entire plan year.

While the parties more often than not reach a final agreement, when a termination does occur, states have at their disposal regulatory tools that may be brought to bear, including:

- **Unfair Trade Practices Acts (UPTA):** These laws prevent false or misleading marketing and prohibit business practices that may be deceptive or fraudulent, in order to ensure that consumers are making an informed purchase based on accurate information. These Acts may be used to hold an insurer accountable if it advertises that a provider or health system is included in its network when it is not. All 50 states and the District of Columbia have adopted a version of the UTPA.

- **Continuity of Care:** These laws allow certain enrollees to maintain access to their physician or health system for a limited period of time after the provider has been terminated from the plan’s network, such as when they are in the middle of a course of treatment or during pregnancy. These laws often require that enrollees be notified of the network change and be required to pay no more than the in-network cost-sharing amount. Approximately 45 states have adopted continuity of care protections.

- **Network Adequacy:** These laws require that plans provide access to a sufficient number of in-network providers to deliver the health care services that have been promised under the plan contract. These laws may require that in-network providers be available within a minimum timeframe and/or distance from plan enrollees in order for the plan network to be considered “adequate” (e.g., from any point within a plan’s service area, a primary care provider must be accessible within 30 miles). Nearly all states have adopted rules to ensure the adequacy of health plans’ provider networks.

These laws allow states to ensure that consumers maintain some degree of protection in the event of a sudden network change or prolonged contract dispute. However, state authority to regulate in this area extends only to fully insured health plans. The federal Employee Retirement Income Security Act (ERISA) prevents states from setting standards or requirements for self-funded employer group plans, and the federal government alone sets standards for Medicare Advantage plans. Although the federal government does not have regulatory standards for network adequacy or continuity of care with respect to self-funded employer plans, there are relevant federal rules for the plans that qualify to sell through the Patient Protection and Affordable Care Act’s (ACA) health insurance marketplaces (called “qualified health plans” or QHPs). Federal rules require

* States may also set standards and requirements in their contracts with Medicaid Managed Care Organizations. These are outside the scope of this issue brief.
QHPs to maintain a network that is sufficient in the numbers and types of providers to ensure that enrollees can access services “without unreasonable delay.” The rules also require QHP insurers to ensure that enrollees in the middle of a course of treatment or pregnancy maintain access to providers until the treatment is complete or for up to 90 days, whichever is shorter.18 States may establish additional standards for QHPs if they choose. Although the federal government is ultimately responsible for certifying QHPs for the federally run marketplace, it largely defers to state DOI determinations of whether a plan meets the network adequacy standards.19 Insurers also have their own policies and procedures for notifying enrollees and state regulators of a potential or actual provider termination and for minimizing disruptions in network access. In some cases, these policies involve reaching out to consumers as soon as it is evident that a major termination is likely. Many insurers are also proactive about notifying their DOI about a contract dispute that poses a risk of termination. When a termination goes into effect, insurers may have different approaches for working with providers to maintain continuity of care for certain enrollees, including variations in what costs they are willing to reimburse and for how long. Insurers must juggle consumers’ requests for continued access to a provider and the desire to keep their members happy against the factors that led to termination in the first place. Insurers also have a range of procedures to keep track of who is in their network and to display this information accurately to consumers.

Findings

While there is general agreement among state officials over the rights plan enrollees should have up to and following a provider termination, differences in regulatory authority and practices can mean widely divergent experiences for consumers, depending on the state in which they live. Insurers also can differ significantly in their approaches to managing a provider transition. Regulators and insurers alike agreed that, as more provider systems and insurers consolidate, the stakes for contract disputes have become higher, with more consumers exposed to disruptions in treatment and higher costs for out-of-network care. Several regulators felt that they and their peers in other states need to be prepared for a greater number of high-profile contract disputes in the future. Interviews with state officials and insurers elicited several best practices for improving the consumer experience when a termination occurs, as well as some gaps in regulatory authority and the tools available to conduct effective oversight.

Consumer Protections May Vary, Depending on Where They Live

Our review of laws on network adequacy, continuity of care, and marketing practices revealed variation in consumer protections across states. In particular, although the National Association of Insurance Commissioners (NAIC) has developed a model network adequacy law for states, there was significant variation in whether and how it has been adopted in our six study states.20 California, Pennsylvania, and Texas set minimum quantitative requirements for the time it should take an enrollee to gain access to different types of providers and the distance they must travel to see those providers.21 For example, Texas insurers must provide enrollees access to primary care and general hospital care within 30 miles in nonrural areas and 60 miles in rural areas; the maximum travel distance is 75 miles for specialty care.22 California also has rules that require plans to maintain at least one full-time physician per 1,200 enrollees and at least one primary care physician per 2,000 enrollees.23
Georgia, Massachusetts, and North Carolina network adequacy laws take a different approach, requiring an assessment of insurers’ network adequacy through subjective standards such as “reasonable promptness,” or simply by requiring insurers to adopt a set of internal standards and adhere to them.24

Continuity of care laws tend to be more standard across our study states, and indeed across the country, although differences exist.25 Laws in each of the six study states ensure that certain populations can continue their course of care for a period of time, such as through postpartum care for pregnant enrollees. For example, Pennsylvania allows managed care plan enrollees in an ongoing course of treatment to continue treatment with a non-participating provider for up to 60 days, with the insurer covering services under the conditions and terms that they would cover if care was received through a participating provider.26 However, in some states, continuity of care standards are restricted to certain lines of business; in North Carolina, for instance, only members of Health Maintenance Organizations (HMOs) have care continuity protections under state law.27

The UTPA laws are similar in each of the six study states, which all adopted a version of the UTPA “model law” from the NAIC.28 Authority to monitor and punish deceptive or misleading marketing tactics is thus highly consistent across states.

One state in our study—Pennsylvania—has unique authority to intervene in a provider-payer dispute, but only in disputes that involve Blue Cross Blue Shield plans. Known as “Act 94,” the law requires Blue Cross Blue Shield plans to notify the DOI 90 days before terminating a contract with a hospital.29 The law also requires the DOI to hold public hearings to investigate the reasons for the termination if the dispute impacts over five percent of the hospital beds in the plan’s service area, and gives the agency authority to freeze the terms of the disputed contract, including the previously agreed-to reimbursement levels, for up to six months.30 Insurers that are not Blue Cross Blue Shield plans are not subject to Act 94’s requirements.31

State Regulatory Practices Also Vary

Consumer protections are influenced not only by the laws states have enacted, but by the culture and practices of the DOIs charged with implementing and enforcing those laws. Here too, the six study states varied in their approaches, with California, Massachusetts, and Texas taking a relatively proactive stance with insurers, and Georgia and North Carolina adopting a more reactive approach. In Pennsylvania, the contentious dispute between Highmark and UPMC thrust the DOI into a high level of engagement with both parties, while Act 94 requires the state to take on a role akin to a mediator in disputes involving Blue Cross Blue Shield plans.

In California, 75 days before terminating a physician group or hospital that could affect 2,000 or more enrollees, insurers must submit a “block transfer” request with state regulators. The request must include a draft notice to enrollees and an explanation of why enrollees must be transferred from the terminated provider to a new provider.32 Department officials assess the provider being terminated, where they’re located, what services they provide, and how many enrollees they serve. They then assess the provider(s) accepting the transferred enrollees to determine whether they have the capacity to deliver the requisite services to take on the new patient volume. The insurer’s proposal must lay out their plan for redirecting enrollees to one or more contracting providers.33 In Texas, when regulators review an insurer’s proposed changes to its network, they contact any new providers to make sure they’re contracted with the plan and that “everything is moving along smoothly.” In Massachusetts, during a recent contract dispute between an insurer and a hospital group, state regulators reported holding weekly calls with the insurer to stay informed about the progress of negotiations.

In Pennsylvania, under consent decrees negotiated by the state attorney general, the DOI was required to review and pre-approve all marketing and communications material from both Highmark and UPMC. The agency also issued guidance to establish clear standards and expectations for how the parties should
communicate with consumers about current and future provider access during the dispute.

On the other hand, Georgia and North Carolina regulators are more likely to get involved in provider-payer disputes only after they receive consumer complaints. One regulator indicated that their power to examine compliance with continuity of care requirements is “based on patterns of complaints,” noting also the lack of a statutory mandate for insurers to give prior notice of a pending termination. Another regulator indicated that they have stopped conducting regulatory reviews of network adequacy “on the front end” (i.e., prior to the plan’s marketing and sale) after the state abolished an annual filing requirement for insurers.

**Some Insurers Are Better Actors Than Others**

All of the insurers in our study reported having internal policies and procedures to help manage the effects of a provider termination. Each insurer identified a corporate policy that requires it to notify its enrollees of a major network change within 30, 60, or 90 days prior to a termination. In most cases, notifications are sent to all affected consumers, with some insurers performing a second outreach to members who have received a service from the affected provider within the last 12 months. The insurers agreed that if a termination is foreseeable and likely, it is best to notify consumers as soon as possible, including posting news of the likely termination on the insurer’s website and provider authorization websites, so that members can start to be directed to new sources of care. However, insurers noted that there is a balance to be struck when contract negotiations are ongoing. For instance, one insurer explained: “If we think we’re close to an agreement then we’re a little bit more cautious in terms of notification because we don’t want to create unnecessary anxiety for consumers.” Several insurers stated that because contract dissolutions are a “normal course of business,” they hesitate to send notifications for every instance of a provider change. One insurer argued: “[If we were to notify members every time there’s a dissolution, there’d be chaos.]”

Important during the open enrollment period when consumers are making their plan decisions.

Beyond notification, insurers spoke of the role consumer education can play in helping to resolve contract negotiations. During contentious contract disputes, educating consumers about the nature of the dispute has become a critical part of maintaining customer support and retention. One insurer indicated that explaining the rationale behind a termination or dispute can help enrollees understand “that we’re not fighting on our own behalf, but on their behalf.” Another insurer described that increasing awareness of the dispute among its members has helped to garner support to push back on the demands of provider systems for higher reimbursement. In doing so, the insurer has found that members' engagement in the dispute “absolutely has yielded a better result.”

If an agreement cannot be reached and the termination goes into effect, each insurer reported having procedures in place to connect consumers with new providers and ensure continuity of care. For example, some insurers mentioned having transitions teams that host community meetings and call members to introduce them to other providers in their networks. While one insurer remarked that it often hopes that any major termination will turn out to be a “false alarm,” the company nevertheless “always gear[s] up and prepare[s]” for consumers’ transitions.

In most instances, insurers are also responsible for alerting their state's DOI of network changes, though regulators report that some insurers are better than others at notifying officials of potential problems. For instance, while several insurers reported that they engage with their insurance department on a “very frequent basis,” some even weekly, some regulators expressed the desire for earlier communications or “a head's up” if an insurer thinks that it will experience a meaningful network change. One regulator explained that it is better to hear of potential issues before consumer complaints start to arise so that the department can prepare a response. While regulators noted that insurers are generally good at informing them of the pending terminations of larger hospital systems, they stressed that notifications regarding even individual physician terminations are
important because the state needs to ensure that continuity of care requirements are being fulfilled.

The insurers in our study also commented on marketing challenges when a contract negotiation is underway, as insurers must decide whether to “suppress” those providers from their directories prior to the end of the contract term. As a best practice, several insurers noted they would suppress a provider from their directory if they knew its contract was coming to an end. However, insurer approaches to this vary. For example, some would only suppress a primary care provider, but not specialty groups. “Is there any [industry] standard? I can’t say there is,” posited one regulator.

A few insurers took the view that if a provider’s information is not certified as up-to-date, then the provider would not be included in their directory. All insurers reported that maintaining accurate provider directories remains an ongoing challenge. One explained that because providers come and go with such frequency, and often do not inform the plan of their status (e.g., in the event of a retirement or move), it can be difficult to know when and where transitions are occurring.

**Proactive Oversight From Regulators Can Prevent Problems, but States’ Authority and Capacity are Limited**

**Oversight of Plan Marketing Can Prevent Misinformed Purchasing Decisions, but Requires Resources, Authority**

DOIs have broad authority to prohibit or require changes to marketing statements or information they deem misleading. For example, most states would consider knowingly including a terminated hospital or physician group in the health plan’s provider directory during the annual open enrollment season an example of misleading or deceptive marketing. In such cases, DOIs may require not only removal of the provider from the directory but also that the plan limit the enrollee’s costs for that provider to the in-network cost-sharing amount.

Most DOIs hold insurers responsible for directory inaccuracies only after receiving complaints, and after the consumer has made a purchasing decision in reliance on the plan’s representations. One DOI in our study required consumers to provide a screen shot of the directory at the time they made the plan purchase, an action most consumers are unlikely to have the foresight to take. California has taken a proactive approach, enacting legislation in 2016 that prescribes the information insurers must include in directories and mandating more frequent updates. Regulators have used that legislation to encourage more standardization of the directories, as well as printed disclaimers if the insurer is aware that a contract with a provider could expire in the near future.

Where there is clear evidence that enrollees relied on misleading information about a provider’s network status in deciding to purchase a plan, some regulators have called for those enrollees to be allowed to switch to a new insurer. However, most regulators appear to view such a “special enrollment” opportunity as a “last resort,” particularly if the insurer is able to demonstrate that enrollees continue to have adequate access to in-network providers.

Some DOIs also have authority to review and pre-approve an insurer’s marketing materials before they are used, including those that make representations about provider participation. However, in practice, such a review process can strain DOI resources. During the Highmark-UPMC dispute in Pennsylvania, “our communications shop was entirely inundated,” reported a former regulator. She went on to note that while the department’s authority to review communications was meant to deter the companies from developing misleading marketing material in the first place, it failed in that goal. “It didn’t stop it,” she said, theorizing that the fierce competition between the two entities for consumers’ hearts and minds led to marketing pitches that pushed the bounds—and in some cases went beyond the bounds—of what was permissible. “All of a sudden the communications team was just paralyzed by having to sort through every single ad they wanted to put out.”

In the lead-up to and after a provider termination, insurers must also send notices to enrollees. The content of those notices should help enrollees understand their options—and their rights—when a local hospital or their chosen physician is no longer in their plan’s network. One state in our study encourages, but does not require,
insurers to share those communications with the DOI in advance. “We can help them make sure they clarify things . . . to make sure they provide information that is clear and complete,” an official said. “The smart ones take us up on it.”

**Better Oversight of Alternative Access Plans Can Help Protect Consumers, but Require Staff Time, Resources**

During California’s block transfer process (described above), officials conduct proactive oversight before concluding whether an insurer’s alternative access plan will fully meet the needs of enrollees. As one official described it: “We make sure that all services are still going to be available to enrollees; we look at distances to facilities, [primary care], and hospitals within the redirection to make sure there is not an expansion of time or distance traveled for consumers, and then ultimately, we would give disapproval or approval for the plan to move forward.” The agency also checks to make sure that if a transition to a new hospital is proposed, that new hospital can deliver the same array of services provided by the previous one.

Review and approval of such transfers can help ensure a smooth transition for policyholders, but also takes time. Indeed, the department receives 300-400 block transfer requests per year. Insurers in the state noted that it can take two years for their alternative access plans to be approved, by which time it is not uncommon for the terminated provider to have returned to the network. “It’s a huge resource problem for the health plan to justify a network that no longer exists,” said one executive. “Networks fluctuate quite a bit.”

**Regulators Face a Balancing Act: Access to Providers vs. Access to Insurers**

Many state laws require insurers to, at a minimum, have in-network providers within a reasonable timeframe and distance to ensure enrollees’ access to services. If insurers are unable to meet that standard, many will then require them to limit plan enrollees’ cost-sharing liability to the in-network amount for care provided by local out-of-network providers. However, reasonableness is a subjective standard, and regulators noted that if they set the bar too high, an insurer’s failure to meet the state’s network adequacy standards, or a requirement they pay full billed charges from out-of-network providers, could prompt exits from certain service areas, leaving consumers with fewer or no coverage options. As one regulator put it, “There are obviously things we can do to require continued access to care at an in-network benefit level, but the carrier can always just decide not to offer coverage in that county.” This balancing act prompts regulators to be cautious about holding insurers to a network access standard that would be challenging to meet.

**Clearer Standards, Authority, and Improved Oversight Tools Needed**

State officials and insurers shared a range of recommendations to improve the consumer experience and smooth the transition to new care providers in the event of a contract termination (see Table 1). There was general agreement that proactive regulatory engagement can protect more consumers than a complaint-based approach, but that regulators need improved oversight tools.

**Complaint-Based Enforcement Limits Access to Protections**

Few consumers are aware they have a state insurance department, let alone know that these agencies can help protect their rights and hold insurers accountable for misrepresentations or failure to maintain network access.35 “Our office is lost on many consumers,” said one insurance official, acknowledging the limits of his state’s reliance on complaints to conduct enforcement. Regulators across our study states assert they are proactive in responding to complaints about provider access, and will hold insurers accountable if a network access or misrepresentation problem is found. However, for every one policyholder who complains there are likely dozens more in the same situation who do not complain. Furthermore, the redress offered—generally a “hold harmless” to the in-network cost-sharing amount—does not protect the enrollee from an out-of-network provider sending a bill for the balance of the charge.
Regulatory Actions Can Shift the Balance in Negotiations, but There Are Mixed Views Over DOIs in a Mediator Role

State insurance officials generally agree that mediating a contract dispute, or otherwise using the power of their office to encourage the parties to come to agreement, is outside their purview—not to mention politically risky. With the exception of the authority granted under Pennsylvania’s Act 94, state DOIs can generally only regulate insurers, and have no authority to influence providers’ behavior. “We’d like to hold the hospitals and other providers who are holding out for more money more accountable,” said one DOI official, but “that’s tough to do fairly . . . when there’s only one party that you can legally impose punishments upon.”

However, insurers and DOI officials both noted examples of insurance regulation influencing provider-payer negotiations and in some cases strengthening insurers’ hands. In California, insurers must obtain prior regulatory approval of an alternative access plan for enrollees if they terminate a large provider from their network. In some cases, insurers have sought those approvals early in their negotiations with providers. Once received, the company can use the approval to put pressure on the provider to come to more agreeable terms, knowing they won’t face a network adequacy problem if they ultimately can’t reach a deal. In Pennsylvania, the DOI’s Act 94 authority to convene a public hearing that brings both parties to the table (and potentially place a temporary freeze on the contract terms) has been credited with helping to “escalate” the issues in disputes and bring the parties together to work through any impasses. At the same time, such engagement, particularly in a public way, can be risky for the state if negotiations do not go well.

However, some insurers were surprisingly accepting of a state role in negotiations over provider payment. “We would appreciate their involvement,” said one. A Massachusetts insurer felt that the state’s Health Policy Commission (HPC), which was created in 2012 to help reduce health care cost growth, has helped level the playing field between insurers and providers. Although the HPC cannot directly intervene in a contract dispute, the insurer noted that the agency can subject a provider to “really bad public shaming” if they ask for a price increase that does not support the state’s affordability targets. The agency also collects and publicizes data on providers’ relative commercial reimbursement rates, can review insurer-provider contracts for adherence to the state’s cost-growth goals, and may refer cases of anti-competitive behavior to the state’s attorney general. “Their work can influence negotiations,” said the insurer, “but they have not to date weighed in on a specific negotiation.”

Regulators Report Need for Better and More Standardized Tools to Assess Network Adequacy

Insurers and DOIs in our study states generally use computer software platforms to analyze whether providers in a given service area are located within a reasonable distance of current or projected enrollees, and whether these providers have capacity to absorb those enrollees. However, regulators felt these data platforms could be improved. One called for greater standardization. Officials noted that the software platforms can generate different results from the same data. They noted for example that insurers might use an “as the crow flies” metric to assess distance, while the DOI would more likely use road mapping. Similarly, measuring travel time using different times of day (i.e., midnight vs. 5 p.m.) could generate different results. Variations in results can stem from how users input data as well as differences in the software designs of different vendors.

Another regulator called for more frequent updates to the data underlying the assessment tools. “We need . . . to understand [network adequacy] in real time,” commented one regulator. “Right now I don’t feel we have a robust ability to fully understand the ramifications of a provider’s exit.” At the same time, other DOIs observed that even if they had improved software tools to assess network adequacy, they lacked the staff resources to make good use of them.
Table 1. Recommended Best Practices for Managing a Provider Termination

<table>
<thead>
<tr>
<th>Recommendations for State Officials</th>
<th>Recommendations for Health Insurers</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Legislatures should give DOIs authority to require that insurers notify them and consumers of likely terminations.</td>
<td>• Insurers should notify consumers of a pending termination as soon as it is obvious that a contract will lapse; notifications should be sent to enrollees and also posted on the insurer’s website and should include information about the enrollees’ right to continuity of care and an adequate network.</td>
</tr>
<tr>
<td>• DOIs should require that consumer notices include information on enrollees’ rights to continuity of care and an adequate network.</td>
<td>• Insurers should suppress from their marketing materials and plan directories providers with whom they are in a contract dispute, and who are more likely than not to drop out-of-network.</td>
</tr>
<tr>
<td>• Providers should be required to inform patients when a termination has occurred or on what date the provider will be out-of-network.</td>
<td>• Insurers should communicate early and often with DOIs during a contract dispute.</td>
</tr>
<tr>
<td>• When a contract decision date arrives, DOIs should follow up with insurers to determine whether the contract was renewed and, if not, when documentation of material change or updated marketing materials should be expected.</td>
<td>• Insurers should work with consumers to help connect them with an available in-network provider by assessing their claims history and determining what services need to be continued; insurers should prepare to act on these care transitions if contract negotiations begin to fall apart.</td>
</tr>
<tr>
<td>• DOIs should require insurers with a potential provider termination of more than de minimis impact to submit alternative access plans.</td>
<td>• Insurers should ensure that consumers who have already been authorized to receive a certain service remain covered without having to go through reevaluation.</td>
</tr>
<tr>
<td>• DOIs should assess the capacity and contract status of proposed alternative providers to ensure they can deliver the same services as the terminated provider(s).</td>
<td>• Insurers should continue to look for ways to update their provider directories as quickly and accurately as possible; provider contracts should include penalties for failure to timely notify insurers when their information changes (e.g., new addresses, retirement).</td>
</tr>
<tr>
<td>• DOIs should have the staff and resources necessary to conduct timely review and approval of alternative access plans.</td>
<td>• Insurers should test their networks frequently to ensure they are meeting network time and distance requirements, using the same data standards as the DOI.</td>
</tr>
<tr>
<td>• DOIs should require insurers to clearly identify in their marketing materials providers who will no longer be available after a certain date or to suppress these providers from their marketing materials altogether.</td>
<td>• Insurers should consider working with clinicians to secure their admitting privileges at alternative hospitals, rather than terminating all of the clinicians at a formerly in-network facility.</td>
</tr>
<tr>
<td>• DOIs should require that insurers limit enrollees’ cost-sharing to the in-network amount if in-network services are not reasonably accessible during a contract lapse. “Reasonably” should be assessed using pre-established time and distance standards.</td>
<td>• Insurers should continue to look for ways to update their provider directories as quickly and accurately as possible; provider contracts should include penalties for failure to timely notify insurers when their information changes (e.g., new addresses, retirement).</td>
</tr>
<tr>
<td>• DOIs should require insurers to submit the data required to conduct an assessment of network access in a standardized form and on an as-close-to-real-time basis as technically feasible. DOIs may also want to share with insurers the vendors, tools, or methodologies they use to conduct assessments.</td>
<td>• Insurers should consider working with clinicians to secure their admitting privileges at alternative hospitals, rather than terminating all of the clinicians at a formerly in-network facility.</td>
</tr>
<tr>
<td>• When DOIs receive consumer complaints regarding a lack of in-network providers, DOIs should contact insurers and providers to assess network access and, when appropriate, require insurers to protect plan enrollees from out-of-network cost-sharing.</td>
<td></td>
</tr>
</tbody>
</table>
Conclusion

In many parts of the country, some provider health systems have become “too big to fail.” In other words, they have become so consolidated they dominate the hospital and physician market within their geographic region. Insurers, if they want to sell plans in that area, are essentially required to maintain these provider systems in their networks. However, insurers are also under increasing pressure from consumers and employers to constrain health care cost growth. When dominant provider systems demand higher prices, contract negotiations can become contentious and are more likely to attract media attention and concern among the public and policymakers. The respondents in our study states generally predicted that such high-stakes disputes will become more frequent, placing more pressure on DOIs to protect consumers from disruptions in services and the financial burden of unexpected out-of-network costs.

To mitigate the disruption caused by a pending or completed provider termination, many—but not all—state DOIs have several tools, including notice requirements, the advance review and confirmation of the adequacy of alternative access plans, and the ability to require insurers to hold enrollees harmless if reasonably proximate and timely services are not available. A few DOIs, such as Pennsylvania’s, may have additional tools, such as the ability to temporarily extend a disputed contract and/or hold public hearings to elevate the issues between the parties.

To enhance these tools, states should consider requiring the submission of a standardized set of data to assess network access, require insurers to suppress from directories providers with whom there is a known contract dispute, and conduct a proactive assessment of insurers’ proposals for alternative access, including an investigation of whether the inheriting providers have contracts in place and the capacity to take on the transitioning enrollees.

Acknowledgments

The authors thank the Robert Wood Johnson Foundation for their generous support for this project. We are also grateful to Olivia Hoppe for her research and editorial assistance.
Endnotes


18. 45 C.F.R. §156.230.


23. Cal. Code Regs., Tit. 10, § 2240.1(c); Cal. Code Regs., Tit. 28, § 1300.67.2(d).


30. Ibid.

31. Ibid.

32. 28 Cal. Code of Reg. § 1300.67.1.3.

33. 28 Cal. Code Regs. 1300.67.1.3.


