World Medical and Health Policy

Inadequate in the Best of Times: Reevaluating Provider Networks in Light of the Coronavirus Pandemic

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The coronavirus has affected billions of people worldwide. As of early June, estimates of infections exceeded six million individuals, about double the number from early May. The United States has experienced more cases than Spain, Italy, France, the United Kingdom, Germany, Turkey, Canada, Japan, and Russia combined. To make things worse, the structure of the U.S. health-care system may significantly impede access to needed medical services while exposing patients to financial liabilities. One particularly concerning feature may be the limitations on access imposed by provider networks. This article briefly reviews what we know about the narrowing of provider networks, and how findings from a series of recent articles illustrating the often-severe restrictions imposed by these networks may be particularly detrimental in the middle of a global health emergency. I also highlight how the actions taken by policymakers to temporarily mitigate these problems have fallen short and what potential long-term solutions might look like.

KEY WORDS: coronavirus, provider networks, health-care access

Introduction

The effects of the coronavirus pandemic have been dramatic for most Americans and they will linger with the nation for the foreseeable future. Current estimates put the number of worldwide infections at well above 6.4 million individuals with more than 380,000 having passed away by early June (Johns Hopkins University Center for Systems Science and Engineering, 2020).[1] The United States has been affected more than most other countries, accounting for just under one third of the cases and just over one quarter of the deaths. Unsurprisingly, the economic consequences have been unprecedented, with record numbers of Americans filing for unemployment, and Congress allocating billions of dollars to stabilize the economy and society. Of course, the pandemic has particularly affected the health-care sector. Unsurprisingly, most of the public's and policymakers' attention has focused on the spread and containment of the disease, the economic repercussion, and the ability of medical providers to maintain treatment capacity. At the same time, only limited attention has been paid to the potential consequence for those Americans seeking care whose insurance coverage often comes with an important caveat: narrow provider networks.

In this article, I briefly review what we have learned about the narrowing of provider networks in recent years. I then highlight a series of recent articles that

doi: 10.1002/wmh3.357

have shown how restrictive provider networks impede consumer access to medical providers, often, particularly in the rural context, severely so. The findings, based on analyses of Medicare Advantage, Affordable Care Act marketplace plans, and commercial insurance, are particularly relevant during the current pandemic when medical capacity is severely tested as large numbers of Americans seek care simultaneously. Policymakers have realized these limitations, but their haphazard approach has failed to offer comprehensive protections for many Americans. I conclude by suggesting some more permanent approaches to ensuring provider network adequacy for American consumers.

The Narrowing of Provider Networks

With ever-growing health-care costs putting a significant strain on employers and consumers alike, insurers have increasingly turned to restricting the number of providers offered in the networks of their respective plans as an instrument to hold down premiums and out-of-pocket costs (Haeder, Weimer, & Mukamel, 2015a; Polsky & Weiner, 2015; Wilensky, 2014). Not surprisingly, this phenomenon is least common among employer-sponsored insurance. However, even in this market category, almost a quarter of large-sized firms offer plans to their employees that are considered narrow (Kaiser Family Foundation, 2019). In other markets, particularly the Affordable Care Act insurance marketplaces, narrow networks dominate offerings by insurance carriers. A recent study found that more than 7 of 10 plans offered to consumers are made up of narrow networks (Carpenter & Sloan, 2018). This compares to just over 50 percent in 2015 (Pearson, Carpenter, & Sloan, 2017). While not as comprehensive in scope, one study of Medicare Advantage, the privatized cousin of the traditional Medicare program (Kelly, 2016), found that 35 percent of enrollees were beneficiaries of plans with narrow networks (Jacobson, Rae, Neuman, Orgera, & Boccuti, 2017). Notably, primary care provider networks in Medicare Advantage appear to be less prone to narrowing (Feyman, Figueroa, Polsky, Adelberg, & Frakt, 2019).

And indeed, more restrictive networks have benefitted consumers by reducing premiums (Dafny, Hendel, Marone, & Ody, 2017; Polsky, Cidav, & Swanson, 2016). This seemed to have been achieved leaving the remaining providers with higher levels of patient volume at lower reimbursement rates (Haeder, Weimer, & Mukamel, 2015b). Of course, if this instrument serves as the only vehicle to reduce costs, the potential to sustain premiums and out-of-pocket savings is limited by the need to include at least a modicum of providers in each network. Alternatively, more limited networks could potentially also reduce premiums by impeding access to medical services, particularly for high-cost, high-needs, or transportation-limited patients. These limitations could then push these patients to seek coverage from other insurance carriers with more comprehensive networks during subsequent open enrollment periods. There are some indications that this is indeed occurring, as switching from Medicare Advantage to traditional Medicare is particularly common among the sickest of patients (see Frakt, 2016; Neuman & Jacobson, 2018; Oberlander, 1997; Morrisey,

Kilgore, Becker, Smith, & Delzell, 2013; Rahman, Keohane, Trivedi, & Mor, 2015). Limiting the number of in-network providers may be particularly detrimental for specialties that tend to be geographically centralized (Haeder, Weimer, & Mukamel, 2020a). Importantly, restricting provider access by limiting the number of providers in a network may also be a direct cause of the increasingly common phenomenon of surprise or balance billing (Cooper & Morton, 2016; Garmon & Chartock, 2016). Finally, it has also been argued that the inherent narrowness of some provider networks may force patients to knowingly go out of network to seek care, for example, due to excessive wait times or transportation limitations (Haeder, Weimer, & Mukamel, 2016, 2019c).

Provider Networks and the Coronavirus Pandemic

As described above, beneficiaries of the Affordable Care Act marketplace plans and Medicare Advantage often are subject to provider networks that include only a limited number of providers and can hence be considered narrow. The restrictions resulting from narrow provider networks may in turn limit access to care and expose patients to financial liabilities from out-of-network bills. Alternatively, it can push consumers to delay or forgo care. These issues raise concerns, even under relatively normal circumstances. Unquestionably, these concerns become exacerbated as the novel coronavirus pandemic sweeps across the United States. Importantly, the number of Americans potentially affected by these limitations is not negligible. For example, provider network restrictions may affect a large number of older Americans due to the growing number of seniors who have opted to enroll in Medicare Advantage. Indeed, about one in three Medicare beneficiaries, well over 22 million seniors, are enrolled in the private sector complement (Jacobson, Freed, Damico, & Neuman, 2019). Concerns have particularly emerged for this population, as seniors appear to be more susceptible to developing serious complications from COVID-19 as well as having a higher chance of dying (Begley, 2020; Guo et al., 2020). In addition to Medicare Advantage beneficiaries, consumers obtaining coverage through the Affordable Care Act marketplaces, more than 11 million (Kaiser Family Foundation, 2020), who also tend to be of poorer health and of socioeconomic status than those obtaining employer-sponsored insurance (Haeder, 2013), could be disproportionately affected.

Yet despite the potential exposure of millions of Americans to narrow networks, we have only recently begun to assess the implications of shifting populations that are disproportionately sicker and in more need of care into often severely constrained networks. This, of course, particularly applies to Medicare beneficiaries, who are trading a virtually open network with almost unconstrained choice of providers in traditional Medicare, for one that is highly regulated and restricted by the insurance carrier in Medicare Advantage. A number of recent papers assessing provider networks for a variety of specialties and procedures raise significant concerns about the potential effects for the health of Americans and offer important insights for the potential impact of the coronavirus epidemic for Medicare Advantage (Haeder, 2019a, 2019b, 2020) and

Affordable Care Act marketplace beneficiaries (Haeder, 2019b; Haeder et al., 2020a; Haeder, Weimer, & Mukamel, 2019a, 2020b) as well as commercial plans (Haeder et al., 2019a, 2020a, 2020b).

Despite the diversity in geography and medical specialties, the findings are remarkably consistent and easily summarized. Medicare Advantage, Affordable Care Act marketplace, and even commercial plans, albeit to a lower degree, consistently limit the choice of providers for consumers. The most rural areas appear to be particularly affected, over and above the inherent limitations resulting from the maldistribution of medical providers. To make things worse, particularly outside large metropolitan areas, insurance carriers not only offer less choice of providers, but they often also appear to severely limit access to providers, in many cases by creating "artificial provider deserts," that is, areas devoid of any contracted providers despite their physical presence in the areas. Notably, in some cases, these "deserts" extend well over 60 or 120 miles from consumers. Finally, the analyses find no evidence that insurance carriers are disproportionately contracting with higher quality providers to make up for the limitations in choice; indeed, there are indications the opposite may be true.

Networks and the Response to the Coronavirus Pandemic

While the emergent pandemic has highlighted the unquestionably large shortcoming of the U.S. health-care system as well as the decades-long disinvestment in public health, one of the less apparent effects has been to illustrate the access limitations caused by provider networks. While they existed prior to the current pandemic, policymakers and insurance carriers have recently acknowledged their potential implications for consumers, albeit only when confronted with significant public health crises. To counter the disease's spread, the Centers for Medicare and Medicaid Services (CMS) instructed Medicare Advantage plans to relax limitations on telehealth services and referrals (Livingston, 2020). Crucially, CMS also required Medicare plans to cover services at out-of-network facilities and offer the same cost-sharing arrangements as for in-network providers (Livingston, 2020). The Department of Health and Human Services also appears to also have inserted language in its stimulus funding agreements with providers that bans surprise billing during the pandemic at entities receiving federal support, although providers may challenge this stipulation in the courts (Huetteman, 2020). Some states have also taken action. For example, Washington and New York have required insurers to cover COVID-19 testing at out-of-network providers if consumers are unable to obtain access within their networks (Pollitz, 2020). Finally, some insurance carriers have also waived copayments for telemedicine and, at times, other services (Hancock, 2020).

Yet there are clear limitations to these ad-hoc solutions. For one, some of the protections offered by CMS may be affected by whether or not a state has officially declared a state of emergency (Miller, 2020). In turn, once the declaration expires, so do the temporary protections. Moreover, many insurance carriers seem to have waived copayments only for in-network providers, leaving those forced to seek care

elsewhere footing the bill alone (Hancock, 2020). To make things worse, insurance carriers have been slow to follow up on their public announcements and have largely failed to implement their new publicized policies. Decisions by carriers also do not apply to millions of Americans obtaining insurance coverage through self-funded (ERISA) plans. Importantly, some carriers have also limited the easement of their restrictions specifically only to COVID-19-related expenses, opening the door for hair-splitting over what services these policies apply to (Hancock, 2020). Similarly, federal protection for those seeking potential testing and treatment only apply if an actual COVID-19 test is administered (Rodriguez, 2020). Given the well-publicized testing shortage, many patients do not fall into this category. Some insurers have also steadfastly refused to allow patients, even those suffering from cancer, to seek out-of-network care even in cases where their regular providers are at capacity with COVID-19 patients (Lazarus, 2020). Many patients will also have to seek care through an emergency room, the largest culprit of surprise medical billing (Rosenthal & Huetteman, 2020). And of course, even during a pandemic, patients cannot control whether ancillary providers supporting their care, like laboratories, radiologists, anesthesiologists, are within their network (Cooper & Morton, 2016). Moreover, it appears unsettled at this point when coronavirus cases first emerged in the United States, as more and more evidence points toward an earlier occurrence than previously acknowledged (Hanna, Moon, & Chan, 2020). This, in turn, means that earlier cases that fall before any emergency declarations or policy announcements will not be able to benefit from any of the aforementioned temporary protection measures. The implications of the pandemic will linger with many patients for long periods of time. Emergent evidence indicates that coronavirus infections may significantly damage organs beyond the lungs such as the kidneys, liver, and brain (Pawlowski, 2020), requiring continuous treatment long after the pandemic, and likely well beyond the time frame of temporary policies. Finally, nearly half of Americans have also chosen to forgo or delay care during the pandemic, potentially exacerbating their medical conditions and requiring more expensive care in the future (Lawrence, 2020).

After the Pandemic

The aforementioned temporary easing of network restrictions is unquestionably laudable as Americans struggle with the fallout, health-related or otherwise, from the current pandemic. However, they will fall short for many Americans, even during the immediate pandemic. Moreover, access restrictions are likely to consistently impact consumers and their health, even outside a global pandemic. The findings from the aforementioned studies on Medicare Advantage, Affordable Care Act marketplace, and commercial plan networks thus illustrate the need to rethink common approaches to regulating network adequacy. These problems have been amplified by the coronavirus pandemic, but unquestionably they existed well before. Importantly, these limitations emerged even as a number of regulators currently oversee and monitor network adequacy.

Unquestionably, the regulation of provider networks in general, and network adequacy in particular, is fraught with technical and political challenges (Haeder, Weimer, & Mukamel, 2019b). As a result, it is unclear whether top-down approaches, devoid of a significant investment into regulatory capacity, may offer sufficient protections to patients (Mukamel, Haeder, & Weimer, 2014). Once the pandemic subsides, setting up procedures and support system for consumers struggling to access services, while increasing transparency, may be the most pragmatic step forward. Similarly, one relatively simple solution avoiding the complexities of network adequacy regulation would be to require insurers to pay for nonemergency medical transportation, a benefit required in Medicaid (Adelberg & Simon, 2017) and offered by a few Medicare Advantage plans (Pope, 2016). This benefit could also be added to the Affordable Care Act's *Essential Health Benefits* package (Haeder, 2014). However, in the long-term, there is a clear need to reach a consensus among stakeholders that better protects patients' access to important medical services, even when the country is not struggling with a global pandemic.

The coronavirus epidemic has laid bare the many failures and inherent inequities present in the U.S. healthcare system. Provider network restrictions are part of these limitations. It deserves noting that the United States is largely alone in exposing individuals to restrictive provider networks and potentially large financial liabilities, problems large unknown in many other developed countries like Canada and Germany (Ridic, Gleason, & Ridic, 2012). While the reforms of the Affordable Care Act have significantly improved access to insurance and care for many (see Haeder, 2020), much remains to be done to improve both access to and quality of care more broadly while limiting exposure to financial costs.

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Notes

Conflicts of interest: None declared.
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1 The data were last accessed on June 3, 2020 at https://coronavirus.jhu.edu/map.html.

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