NETWORK ADEQUACY IN RURAL WISCONSIN

by Mike Vanderboom, J.D.

Developed with the Rural Wisconsin Health Cooperative
while a clinical legal intern from the University of Wisconsin Law School

EXECUTIVE SUMMARY

Network adequacy refers to a health plan’s capacity to serve its members with quality, cost-effective and reasonably accessible care. Closed network plans are nothing new in many states including Wisconsin. Closed networks are getting a closer look thanks to the network adequacy requirements in the Patient Protection and Affordable Care Act of 2010 and its implementing regulations (ACA). In Wisconsin, closed networks have been the norm for almost three decades. The competing pressures of: (1) creating Accountable Care Organizations (ACOs), which would exert pressure toward narrowing networks; and (2) complying with the network adequacy requirements mean that we are headed into uncharted territory and probably choppy waters. In all of this uncertainty it is critical to keep a sharp focus on the rural consumers who make up so much of the Medicare population.

The ACA mandates that states participate in “Health Insurance Marketplaces” also known as health care exchanges. States have the option of participating in federal exchanges (which Wisconsin has opted to do) or implement state exchanges. The federal exchanges in each state are subject to the ACA network adequacy requirements enforced by the Centers for Medicare and Medicaid Services (CMS), and many states have parallel state regulation as well. All plans are regulated by the state agency, which in Wisconsin is the Office of the Commissioner of Insurance (OCI). The practical reality is that plans are primarily accountable to OCI in Wisconsin, which will be the key determinant of whether CMS considers plans to have met the requirements to be a "Qualified Health Plan" (QHP) approved to participate in the exchanges. Specifically, CMS relies on the determinations made by state officials throughout the process of determining plan adequacy.

Rural communities have a steeper hill to climb in getting access to the same health care quality, cost and choice offered to their urban counterparts. As insurers attempt to cope with the rollout of the ACA and to prepare for impending state legislation regulating network scope, a common practice has been to narrow networks in an attempt to save on costs and comply with the rules around creating ACOs. As networks are pared down, the challenge facing rural providers has become much more difficult; rural providers are frequently finding themselves unable to provide covered services to members of their communities.

The following memo: (1) Explains the structure of state and federal network adequacy regulations, (2) Investigates the development of a Network Adequacy Model Act being developed by the National Association of Insurance Commissioners (NAIC), and (3) Recommends a course of action designed to promote awareness of network adequacy issues. Ultimately, an “adequate” network is subjective, based on the varying needs and perspectives
of consumers, providers, and insurers. This subjectivity is underscored by the principle of freedom of contract. Insurers cannot be forced to contract with providers, just as consumers cannot be forced to contract with a specific insurer.

However, insurers should be regulated in a manner that effectively addresses the rural network adequacy deficiencies. To achieve this goal, those promoting this result will need to significantly raise awareness on this issue. As explained in more depth herein, this memorandum urges advocates for rural health to encourage taking proactive steps toward network adequacy. As an overview, these steps might include:

I. Track specific examples of rural care deficiencies created by network inadequacies. The examples are more likely to be impactful if they demonstrate:
   A. Absence of a particular health care service within geographic proximity of the consumer's residence (as opposed to the consumer choosing a specific provider who is geographically remote despite the availability of more convenient options);
   B. Impact on the consumer's health care or health condition, i.e., a demonstrated medical care need that is not being met.

II. Engage the plans themselves in conversation about the tracked identified health care inadequacies and attempt to develop solutions collaboratively with those plans outside of the regulatory process.

III. If unsuccessful in reaching a collegial resolution with the plan at issue, present clear and organized evidence of network inadequacy to regulators, keeping the plan in the loop to avoid unnecessary adversity.

IV. Monitor upcoming legislation (state and federal) addressing network adequacy and submit evidence-based commentary.

V. Engage rural communities in raising awareness - educate and broadcast this important message in plain language.

I. Introduction

The ACA presented individual states with a number of crucial decisions, including whether to develop a state based exchange (SBE), a federally facilitated exchange (FFE) or a partnership arrangement with the federal government. Many of these decisions were made in the early days of ACA implementation, as state and federal agencies rushed to keep up with legislative requirements. In the chaos, the critical issue of network adequacy has taken a back seat.

The ACA creates a paradox in simultaneously requiring providers to band together to be jointly accountable for more efficient care, while also requiring network adequacy. In response to the first requirement, many insurers have attempted to narrow the network of providers
credentialed to provide covered services.”¹ The ACA “sets the first national standard for network adequacy,”² although Wisconsin has regulated the issue since at least 1989. State regulation and enforcement will be a key determinant to how plans develop their networks while they are simultaneously “motivated to cut costs and to offer plans with a competitive premium.”³ As a result, insurers have turned “to other cost drivers – such as provider prices – to deliver more affordable premiums.”⁴

States address network adequacy in a variety of ways dependent on many factors including specific populations, geography, provider availability, and whether that state has opted to implement SBEs or FFEs. Minnesota, for example, specifies adequacy standards not considered in Wisconsin. Minnesota “requires ‘all health carriers that either require an enrollee to use or that creates incentives, including financial incentives, for an enrollee to use, health care providers that are managed, owned, under contract with, or employed by the health carrier’ to meet certain network geographic access requirements.”⁵ These requirements limit travel times to the “lesser of 30 miles or 30 minutes to the nearest provider of…primary care services, mental health services, and general hospital services,”⁶ while other health services such as specialty physician services, ancillary services, and specialized hospital services must be provided with the “lesser of 60 miles or minutes.”⁷

Nebraska’s network adequacy statutes are more similar to Wisconsin’s, in that they provide a more general set of network requirements. Network sufficiency in Iowa “may be established by reference to any reasonable criteria used by the health carrier, including, but not limited to: provider-covered person ratios by specialty; primary care provider-covered person ratios’ geographic accessibility; waiting times for appointments with participating providers; hours of operation; and the volume of technological and specialty services available to serve the needs of covered persons requiring technology advanced or specialty care.”⁸ Nebraska does provide that a health carrier offering an insufficient network must “ensure that the covered person obtains the covered benefit and the health carrier shall reimburse the nonparticipating provider at the health carrier’s usual and customary rate or at an agreed upon rate.”⁹

Ultimately, a study of network adequacy provisions passed by other states is more expansive than the scope of this memo. Regardless of inter-state variability, one common

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² Wis. Stat. 609.01 was first promulgated in 1989, and updated in 2003.
⁴ Id.
⁶ Minn. Stat. 62K.10 (2)
⁷ Minn. Stat. 62K.10(3)
⁸ Neb. Rev. Stat. §44-7105(1)
⁹ Neb. Rev. Stat. §44-7105(1)(a)
theme is the essential struggle between clearly defined networks that are jointly accountable to consumers and sufficient network adequacy. A proverbial "light at the end of the tunnel" might be the current work by the NAIC to create a Network Adequacy Model Act, and individual states begin to pass versions of that act into state law. It is a turbulent time for state health insurance regulators, and the next several years will continue to dramatically alter the landscape of state regulations.

In the meantime, the current model for network adequacy governance seems to be broken. In many cases, network issues have become so extensive that consumers are being billed thousands of dollars for treatment at in-network providers, but performed by out-of-network doctors. Wisconsin has begun to experience this and other network adequacy issues, particularly among its rural communities. The following memorandum will target some of the network inadequacies currently taking place in Wisconsin. I will first discuss some statutory language that creates the guidelines for network behavior in the state. Next, I will examine the source of these problems and identify elements that may have legal implications. Finally, I will summarize a number of strategies that may be applicable to future growth of adequate networks in Wisconsin’s rural communities.

II. Statutory Requirements for Adequate Networks

A. Qualified Health Plans – Essential Requirements

At its most basic, network adequacy within the ACA is fundamentally related to the process by which the Exchanges certify Qualified Health Plans (QHPs). In order to be certified, a QHP must “comply with the minimum certification requirements outlined in subpart C of part 156” of the Code of Federal Regulations (CFR), and the Exchange must determine that “making the health plan available is in the interest of the qualified individuals and qualified employers” seeking to purchase insurance through the exchange. Furthermore, in order to certify a QHP for sale the Exchange must “ensure that the provider network of each QHP meets the standards specified” by 45 CFR §156.230.

45 CFR §156.230 establishes the basic requirements a health plan must include to be considered an “adequate network.” These requirements mandate that a QHP issuer:

must ensure that the provider network of each of its QHPs, as available to all enrollees… includes essential community providers in accordance with §165.235, maintains a network that is 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, and is

11 45 CFR §155.1000(c)
12 45 CFR §155.1050(a)
consistent with the network adequacy provisions of section 2702(c) of the PHS Act.\(^\text{13}\)

**B. Essential Community Providers**

A key network adequacy concept is "Essential Community Providers" (ECPs) which means providers who primarily provide services to low income and medically underserved individuals. CMS requires QHP issuers to maintain a sufficient number and geographic distribution of ECPs, 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, in accordance with network adequacy standards.\(^\text{14}\) There is a non-exhaustive list of ECPs maintained on the CMS website.

This requirement establishes a baseline from which states will work to establish new network adequacy standards. The pending Network Model Act being produced by the National Association of Insurance Commissioners (NAIC) is likely to significantly influence the development of state standards.

**C. Wisconsin & the NAIC Network Adequacy Model Act – Development**

**i. Introduction**

Wisconsin first implemented its current “Defined Network” statute in 1989 and updated the law in 2003. Thus, Wisconsin has had the advantage of three decades of experience with a closed network of insurers, providers, and consumers. The ACA, however, takes this concept to a new level of specificity, particularly for network adequacy issues.

The Wisconsin Office of the Commissioner of Insurance (OCI) has a significant voice in NAIC’s development of the Network Adequacy Model Act intended to address these new network adequacy requirements. When completed, the NAIC expects that any state insurance commissioner supporting the final model act will work to implement the model’s structure in that respective state.\(^\text{15}\) Based on Wisconsin’s involvement with the NAIC process, it is likely that OCI will ultimately implement significant portions of the model act.

The Wisconsin Hospital Association (WHA) and OCI have collectively determined that implementation of a future NAIC model act is unlikely prior to the 2017 rate year,\(^\text{16}\) meaning that current statutory structure will control insurer practices for the near future. This period could extend beyond 2017, given the rulemaking process.\(^\text{17}\) WHA and OCI anticipate considerable structural change and therefore multiple comment periods prior to final network adequacy rules in Wisconsin.

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\(^{13}\) 45 CFR §156.230(a)

\(^{14}\) 45 CFR §156.235(a).

\(^{15}\) Summary of Network Adequacy Council Meeting, August 18, 2014. Courtesy of WHA.

\(^{16}\) Id.

\(^{17}\) See Wis. Stat. 227 for rulemaking procedures and requirements.
ii. Current Wisconsin Requirements

In Wisconsin, a “defined network plan” is an insurance product which “requires an enrollee of the health benefit plan, or creates incentives, including financial incentives, for an enrollee of the health benefit plan, to use providers that are managed, owned, under contract with, or employed by the insurer offering the health benefit plan.”\(^{18}\) Generally, these plans are grouped into one of three categories: “preferred provider plans,” “health maintenance organizations,” or “standard plans.” A preferred provider plan means a health care plan:

offered by an organization…or issued a certificate of authority…that makes available to its enrollees, without referral and for consideration other than predetermined periodic fixed payments, coverage of either comprehensive health services or a limited range of health services, regardless of whether the health care services are preformed by participating or nonparticipating providers.”\(^{19}\)

A health maintenance organization means a health care plan:

offered by an organization…or issued a certificate of authority…that makes available to its enrollees, in consideration for predetermined periodic fixed payments, comprehensive health care services performed by providers participating in the plan.”\(^{20}\)

Finally, a standard plan means literally everything else:

“a health care plan other than a health maintenance organization or a preferred provider plan.”\(^{21}\)

Amongst other provisions, consumers of preferred provider plans must be free to choose (within their network) their primary healthcare provider,\(^{22}\) their specialist provider,\(^{23}\) and can expect for any emergency care received outside of their network without prior authorization to be covered.\(^{24}\) Additionally, a defined network plan must “develop an access plan to meet the needs, with respect to covered benefits, of its enrollees who are members of underserved populations.”\(^{25}\)

A defined-network plan other than a preferred provider plan must “develop comprehensive quality assurance standards that are adequate to identify, evaluate, and

\(^{18}\) Wis. Stat. §609.01(1b)
\(^{19}\) Wis. Stat. §609.01(4)
\(^{20}\) Wis. Stat. 609.01(1m)
\(^{21}\) Wis. Stat. 609.01(7)
\(^{22}\) Wis. Stat. §609.22(3)
\(^{23}\) Wis. Stat. §609.22(4)
\(^{24}\) Wis. Stat. §609.33(6)
\(^{25}\) Wis. Stat. §609.22(8)
remedy problems related to access to, and continuity and quality of, care.\textsuperscript{26} The standards must include a minimum of six areas\textsuperscript{27}:

- Ongoing, written internal quality assurance programs;
- Specific written guidelines for quality of care studies and monitoring;
- Performance and clinical outcomes-based criteria;
- A procedure for remedial action to address quality problems, including written procedures for taking appropriate corrective action;
- A plan for gathering and assessing data; and
- A peer review process.

Finally, defined network plans must “develop a process for selecting participating providers [and] establish minimum professional requirements for its participating providers.”\textsuperscript{28}

\textit{iii. Wisconsin’s Marketplace Exchange}

When the Affordable Care Act was passed in 2010, states faced a choice regarding the creation and governance of their healthcare Exchange. Wisconsin, like a number of other states, opted to allow the federal government to establish a Federally Facilitated Exchange (FFE), meaning that the federal government was responsible for establishing and maintaining an Exchange through which Wisconsin citizens can purchase QHPs. Wisconsin’s OCI remains responsible for vetting network adequacy requirements of plans in and outside of the exchange, but the federal government maintains final say over whether an insurance product offered within the FFE meets network standards.

In fact, the regulation of network adequacy remains primarily reactive. OCI has recently asserted that “OCI reviews network adequacy primarily after receiving a complaint. Prior to the annual issuer certification, OCI requires insurer to attest that they have an adequate network, but does not conduct an in-depth review of the insurer submissions. OCI tracks complaints to identify issues and may carry out a more intensive market conduct examination.”\textsuperscript{29}

Despite lacking some of the authority that commissioner’s offices may have in state-based exchanges (SBEs), Wisconsin’s OCI retains authority over any organization or individual conducting the business of insurance within the state.\textsuperscript{30}

\begin{itemize}
  \item\textsuperscript{26} Wis. Stat. §609.32(1)
  \item\textsuperscript{27} Wis. Stat. §609.32(1)(a)-(f)
  \item\textsuperscript{28} Wis. Stat. §609.32(2).
  \item\textsuperscript{29} Summary of Network Adequacy Council Meeting, August 18, 2014. Courtesy of WHA.
  \item\textsuperscript{30} Wis. Stat. §601.04(1)-(3).\end{itemize}
III. Network Adequacy & Rural Communities – Issues

A. Introduction

States, like Wisconsin, that are performing plan management functions in an FFE have certain amounts of flexibility in assessing compliance with certification standards and adjusting processes when evaluating a healthcare plan’s network adequacy. Issuers interested in selling a product within an FFE should “follow state guidance regarding compliance with the processes and criteria for reviews conducted by the states.” Each Marketplace must “ensure that each service area of a QHP covers a minimum geographic area that is at least the entire geographic area of a county, or a group of counties defined by the Marketplace, unless the Marketplace determines that serving a smaller geographic area is necessary, nondiscriminatory, and in the best interest of the qualified individuals and employers.”

The adequacy of provider choice currently offered to rural insureds falls short of the statutory standards required. In conversations with a number of rural healthcare providers, a strategy for addressing these shortcomings is overdue. The following sections address these barriers to providing robust health care options to residents of rural communities.

B. The Distance Problem – Networks Forcing Consumers to Travel for Treatment

In parts of Wisconsin, rural communities often rely on independent, local healthcare providers (many of which qualify as ECPs) for their regular medical needs. Unfortunately, many insurers in these areas are offering healthcare plans without an adequate network of providers available and are ignoring historical patterns of care. In parts of the state, some local healthcare providers noted that insurers are making available only limited services in local communities, and then referring patients in need of any extensive care to “network” hospitals great distances away from communities, and occasionally out of state.

For patients in need of serious care – for example, hip-replacements – this system often requires consumers to make multiple trips every week in order to receive the rehabilitative care necessary. This situation places unnecessary strain on any number of individuals: the patient, who must find the time to travel to and from regular appointments; their families, who may have to provide transportation to those unable to drive; even employers of both patients and their friends or families, as employees will miss a great amount of work needlessly.

This issue has manifested in a number of ways. One critically important issue is whether offering services anywhere within a county means the plan is credited for the entire county. In many areas of Wisconsin, plans nominally offer coverage in an entire county, but limit some (or all) services to only a small geographic portion of that county. "Checking the box" for coverage in a given county without actually providing access to all of that county's residents is putting form over substance and depriving rural communities of much-needed care. In some of Wisconsin’s larger counties, this network structure could mandate extensive travel

31 United States Department of Health & Human Services. 2015 Letter to Issuers – Affordable Exchanges Guidance, pg. 6
32 Id., at 18.
times, a frustrating issue when providers qualified as ECPs remain out-of-network even when they are much closer geographically and more in-touch with community expectations and needs.

CEOs of rural healthcare providers throughout Wisconsin have repeatedly focused on a common concern regarding these practices: the fact that by driving networks into a narrow system of providers and disregarding geographic and cultural concerns, insurers are harming historical and community based medical delivery systems. Many of these CEOs expressed the concern that in rural communities, consumers are not as mobile as in other parts of the state, and patients in need of care will often forego treatment if they are forced to travel significant distances.

Additionally, CEOs of rural hospitals commonly identify the concern that many residents of rural communities are less educated on health-related practices, and thus less equipped to proactively pursue appropriate and cost-effective care. Ultimately, the common theme expressed by these leaders can be paraphrased as this: In in rural communities, preventative services will reduce costs more than a limited network. Although this sentiment is well understood by providers, it is either ignored or not recognized by health plans, as a general observation.

The current legislative environment offers a number of opportunities for concerned individuals and entities to have a voice - one that might influence the development of network adequacy standards. The Wisconsin Hospital Association (WHA) has a network adequacy council, which is an excellent vehicle for raising awareness and seeking solutions for this perplexing problem. RWHC is an active participant in this council, and rural leaders believe that the council may be the most valuable tool available in terms of influencing specific statutory language.

Now is the time to make a difference. A concerted effort to provide information regarding specific network inadequacies is likely to be far more influential now, while the regulations are rolling out and the plans are figuring out their responsive strategies, than at any other time. The public nature of the rulemaking process, combined with mandatory comment periods, provides interested parties, such as RWHC members and other concerned citizens, significant opportunity to explain issues that are unique to rural healthcare. At this moment, his period of influence is particularly fertile. The NAIC’s efforts to create a model act are being spearheaded by an officer of Wisconsin’s OCI. Any information that can be funneled into OCI’s systems will be doubly effective, as they could plausibly influence both the NAIC model act, and subsequent alterations made to a final act passed in Wisconsin.

Advocates of rural health care should not ignore the potential of the OCI complaint process. This author’s conversations with numerous leaders of rural hospitals indicate that this method is not commonly used, perhaps because there is not a documented history of success. There is no limitation precluding providers from using this process - complaints to OCI may be filed by consumers, providers or can be a joint effort. It is this author’s position that the last option is likely to be the most effective in addressing network adequacy issues.
The OCI complaint form is an opportunity to have a voice. The applicability of that process to this issue is consistent with the language of the OCI complaint form, and is reinforced by comments directly from OCI representatives. Concerned providers may have a significant impact on the drafting of network adequacy language, either at the NAIC or state level. In my opinion, a strategy targeting specific cases of network inadequacy for submission to OCI via complaint could become a very effective means by which to communicate network issues facing rural healthcare consumers, particularly if providers can arrange to submit a consumer’s complaint alongside the provider’s.

C. Developing Solutions – Advocacy through the OCI Complaint System

Developing a strategy to maximize the effectiveness of a network adequacy complaint should be a goal of any organization concerned with inadequate health care networks. The following section will outline a procedure (Procedure) through which health care providers can work within their communities to systematically target network issues prevalent in the community.

i. Identify And Track The Issue

Arguably the most important step in any complaint process developed will be identifying a specific issue with sufficient weight to build a critical mass of complaints. It bears repeating that OCI has stated that it will “track complaints to identify issues and may carry out a more intensive market conduct examination.” This statement strongly implies that miscellaneous complaints regarding multiple issues will be insufficient to create an issue worth “tracking” by OCI.

RWHC is in a relatively unique position in that the organization is capable of creating a network with which independent providers target a narrow set of issues. The already established cooperation between the RWHC providers creates a rare opportunity: rural providers will have the ability to identify a specific issue facing their constituencies, they can address the shortcomings of the current system, identify areas where they, as rural providers and ECGs, could immediately alleviate the issue. They could clearly illustrate these issues to both insurers and the state insurance regulatory system.

Rural providers should be cognizant of their own capacity to serve a particular health care need in complaining to OCI that a network has been formed too narrowly by a plan. It would be less effective to use the complaint process to identify a limited option for rural consumers of surgical or obstetric services if the complaining provider does not have an alternative solution for local services in those specialties. Several of the RWHC members consulted for this memo specifically targeted orthopedic surgery and rehabilitation as areas in which they could immediately and dramatically improve patient care if a provider were to contract with the facility or certify practitioners.

ii. Specifics: Developing the Complaint Collection Mechanism

The next step is to develop a viable and user-friendly mechanism to collate information that will serve as the evidentiary basis of network inadequacy. Again, the most helpful data will
be examples of limited medical options for rural residents that would be potentially reversible through either state or insurer action, implementing a system to collect and organize those complaints is the logical next step. Any such system must be developed, implemented and maintained in a manner that complies with applicable standards and rules, such as those relating to patient confidentiality. The specifics of such parameters are beyond the scope of this memo.

If rural providers and advocates are to band together to make an impact on OCI regulation of network adequacy, it should be well planned on the front end. Those planning to execute such advocacy should thoughtfully develop a system to identify the problems (narrowly drawn networks) and the proposed solutions (rural alternatives for the services). The process should be structured to involve consumers and OCI itself in this system. Consumers should explicitly consent to having their complaints conveyed to OCI through either the formal complaint process or informal conversation. The confidentiality and ethics of patient concerns should be top of mind and should be comprehensively addressed.

Beyond consent issues, the complaint process is extremely straightforward. OCI’s three page “Insurance Complaint Form” is available in PDF form from the office or via the Internet, and requires only basic information regarding the relevant problem (See Appendix A). Specifically, this form requires contact and identification information for the insured and the insurer, a statement regarding the problem, a suggestion for how the problem should be solved, and an attestation of who is filing the complaint (insured, agent, provider, insurer, third-party, or other). The simplicity of this form exacerbates the need for planning and organization within a large-scale complaint process.

The OCI form allows the complainant to provide a narrative account of the problem. Accordingly, complaints without a focused target could lose track of the issue and lack the focus needed to draw OCI’s attention to the matter. Conversely, an organized, streamlined complaint procedure could easily guide the reporting process to clearly delineate a specific issue. For example, rather than consumers reporting “long travel times,” a policy oriented procedure could choose to report every instance of consumers traveling more than 20 miles for care they could have received by an independent provider or ECP in their community.

Designating a central hub to collect and organize these complaints could be a valuable tool in the process. One central unit would have the benefit of collecting complaints from networks statewide, and organizing them in a manner crafted to target any number of network adequacy issues. RWHC has served a similar function in the past, and is willing to “take point” for this issue moving into the future. An additional benefit would be RWHC’s ability to create distance between providers developing complaints and the insurers who they will have to work with for the foreseeable future.

These targeted complaints could gain critical mass extremely quickly. Returning to the issue of patients traveling long distances throughout the recovery period following orthopedic surgery demonstrates this clearly. As some RWHC Member CEOs mentioned, many Wisconsin insurance consumers will be forced to travel long distances multiple times each week in order to rehab following an orthopedic procedure. If properly organized, regular
documentation of these network shortcomings could simply but powerfully convey the extent of the issue (See Appendix B for Sample Complaint Form).

A “standard form” complaint could be easily tailored to meet an interested provider’s complaint needs. Essentially, a provider complaining on their own behalf, or on behalf of themselves and the consumer, could use identical language as the “Consumer Complaint” form, and add additional narrative sections identifying how these shortcomings are impacting their ability to provide quality and affordable healthcare within their communities.

This additional “Provider Complaint” could be used to guide the consumer’s complaint towards the targeted issue by incorporating provider knowledge of traditional community health care provision, rural community practices, or other relevant topics. Furthermore, providers can promote the likelihood that consumers will submit a complaint by either issuing on the complaint on their behalf or providing “standard form” guidance to facilitate the process.

### iii. Involve the Insurer

A common concern amongst RWHC Member CEOs was the potential to damage existing relationships or negotiating positions with insurers by “rocking the boat” through the OCI complaint process. As a result, this Procedure encourages a policy of complete transparency and openness to conversation with insurers, particularly during the early stages of development. The basic motivation behind party action is fairly clear: insurers are attempting to provide a product to consumers that is both profitable and in line with State and Federal regulations, while RWHC Members interested in the complaint process are striving to provide high quality, community-based care at affordable prices.

While different insurers approach the new regulatory framework in different ways, it appears to this author that the majority of insurers and providers have the goal of maintaining an organization that provides profitable, quality and sustainable products.

If this assumption carries through, it is at least possible to develop partnerships in seeking network adequacy between insurers and providers. A policy of complete transparency in the early stages of a complaint procedure will be essential to nurture any such partnerships. Rural providers would be well served to begin conversations with insurers early and keep having them often. Moreover, any effort to use the OCI complaint process should be undertaken only after less adversarial measures have been unsuccessful, and with the insurer's full knowledge of the intent to complain. 33

Establishing communication with insurers prior to submitting complaints could, in the long run, be the most important step in the process of addressing network inadequacy. Negotiations are almost universally built around understanding of adversarial party’s goals, the level of doubt regarding the understanding of those goals, and the level of trust between the parties. Transparency can help express an organization’s goals in detail.

33 Insurance Complaint Form provided by the State of Wisconsin Office of the Commissioner of Insurance.
By submitting complaints to OCI without any prior communication, a rural provider does very little to improve their negotiating position with an insurer, and could easily damage that position. A policy of transparency, however, could change this, particularly as the current status quo does not seem likely to change. A complaint procedure geared towards improving the quality of health insurance networks must be cognizant of the dynamics between players in a particular system of networks, and should focus on being inclusive and cooperative rather than exclusive or belligerent. Language addressed to insurers meant to mitigate feelings of ill will should express this sentiment, and attempts should be made to include insurers in the process, rather than to exclude them as targets.

Information regarding the goals of a potential complaint policy, the issues facing rural communities that are being specifically targeted, and the beliefs of rural providers should be shared with insurers as it is collected. Any entities involved in the Procedure should target landmarks in the development and implementation of the Procedure, identify insurers potentially impacted by the complaints, and keep these insurers up to date regarding goals and motivations behind specific complaint gathering strategies.

At best, this sharing of information (particularly the number/content of collected complaints) may provide sufficient pressure to alter the status quo of negotiations between insurers and providers prior to OCI involvement. This could be particularly true if a sufficient number of complaints are collected and passed to insurers along with an invitation to discuss issues facing insurance coverage in rural communities.

Ultimately, any success in involving insurers more extensively with network adequacy conversations can only increase overall understanding of various parties’ issues and motivations. In the worse case scenario, communications geared towards transparency will ensure that uncooperative insurers are not blindsided by large-scale complaint submissions, and may minimize any negative repercussions that result.

RWHC Members who involve themselves in a complaint procedure should make decisions geared towards developing long-term relationships with insurers wherever possible. Ultimately, providers and insurers acting in Wisconsin will be working together for the foreseeable future, regardless of how network adequacy standards are finalized. Developing a means by which providers can share detailed and organized issues with insurers (and potentially regulators) could establish some areas of policy overlap in which both sides could agree to work jointly.

iv. Submit Complaints to OCI

Filing a critical mass of relevant complaints with OCI remains the most likely source of influence in network adequacy issues. Despite any optimism surrounding the potential for developing relationships between insurers and providers, the atmosphere surrounding healthcare remains politically charged and economically uncertain. Based on current insurer behavior, it seems clear that profitability remains the bottom line for many insurers. It is no secret that shaping narrow networks is a strategy aimed at controlling costs, particularly as the ACA continues to promote uncertainty.
It is clear that many rural providers have fundamentally different views regarding the economics of providing health care to rural constituencies. While this memo notes the potential benefits in developing positive relationships with insurers by illustrating network inadequacies facing rural communities, it does not ignore the reality that many of the insurers offering products are aware and unconcerned with the issues caused by their products. Accordingly, Procedure participants must be committed to the submission of linked network adequacy issues in an effort to produce the “critical mass” of actionable complaints necessary for an OCI response.

v. Post-Submission Communication with OCI and Insurers

Constant communications should be considered a valuable tool in any complaint procedure established. The standard form reporting procedure established by OCI is a means to provide basic information. Rural healthcare providers, however, possess the unique ability to provide scope to basic issues through narratives and information sharing. Consumers will provide the source of complaints, but providers are the actors with sufficient knowledge and information to aggregate and summarize the specific issue that complaints represent.

Communication with OCI will, as mentioned previously, be particularly valuable during the current period of regulatory development. OCI’s perspective will reverberate not only within Wisconsin, but nationwide, due to OCI’s prominent position in the NAIC Network Adequacy Model Act development process. Every effort possible should be made to inform OCI personnel involved with network adequacy issues about the goals of a complaint procedure, both general and specific. Specifically, OCI should be informed about general concerns that led to investigation of the complaint procedure, the specific issues being targeted, the issues implicated by each batch of complaints, and most importantly, recommendations for regulation that could alleviate these issues based on rural experience.

Ultimately, the complaint process should be viewed as a retroactive opportunity to comment on any regulations, but also to support those comments with facts and narratives. The scope of the current changes to network adequacy regulation being considered is massive. Correspondingly, any positive influence that improves the situation of rural health care consumers could be equally inflated, and every effort should be made to positively influence the results. Tailoring this Procedure to maximize influence and to educate as many people as possible about the issues facing rural healthcare providers will be key in attaining broader, more comprehensive network adequacy standards.

Keeping open communications with insurers could be nearly as impactful as communicating with OCI. As the complaint process unfolds, providers will have the opportunity to update insurers on issues being addressed, consumer response to the general movement, and any insight that develops as complaints are sought and scrutinized. As previously mentioned, insurers and providers will be working side-by-side regardless of any changes ultimately made to network adequacy regulations. Again, it may be rather optimistic to hope for cooperation and understanding being built through open communication, but the effort involved in sharing organized complaints, analysis, or provider responses to issues seems minimal, and the potential benefits of future cooperation are likely the most important that could be achieved.
vi. Prepare to Comment

This complaint process should be geared towards preparing for the comment processes that will take place during OCI development of a final network adequacy regulation. This period will likely take place beginning in 2016, meaning that advocates for heightened network adequacy standards have an opportunity to invest at least a year establishing a framework of complaints upon which to base any comments to proposed rules. The current political climate makes any legislation regarding health care contentious, so developing a strategy to amplify an organization’s voice in the process may be beneficial in the long run. This would be particularly true as OCI considers specific enforcement mechanisms for network adequacy, or as specific guidelines involving travel time or mileage limits are developed.

C. Developing Solutions – Education

i. The Contract Problem – Insurers Unwilling to Contract with Rural Providers.

A closely related issue facing rural healthcare providers seems to be a general unwillingness to contract between insurers and rural providers. Many providers interviewed for this analysis stated that insurers offering plans mandating significant travel times were unwilling to partner with free standing healthcare providers acting as ECPs in rural communities. Several CEOs question whether this refusal to contract could be considered “bad faith” in the light of network adequacy. Others voiced concerns regarding anti-trust issues that may arise in areas that are becoming subject to near monopolies of insurer/provider entities.

OCI does not have jurisdiction over the providers that specific insurers choose to contract with. As a result, a specific insurer’s choice to refuse to contract with a provider or certify a specific doctor is an issue that OCI cannot immediately act upon. As previously mentioned, the best strategy to address these issues seems to be the complaint process surrounding situations demonstrating an inadequate network. If insurers continue to provide services that do not provide sufficient and accessible healthcare coverage to a consumer, OCI will likely not become aware of the situation unless a complaint is filed. OCI has taken the position that attestation of adequacy by an insurer leads to a presumption of adequacy. The only direct means to rebut that presumption is to provide evidence that current systems are, in fact, failing consumers.

Throughout this process, it must be remembered that targeting the specific impact on insureds is crucial to meaningful OCI involvement. For example, long travel times for consumers will not create a presumption towards an inadequate network. The surrounding factors of the situation must be included in order to complete an effective complaint. Consumer expectation is extremely important in this area. In the “distance traveled” area of complaints, providers must ask targeted questions such as whether the consumer was led to believe that their community providers would be included. If the consumer had no reason to expect their community provider to be included, OCI is unlikely to find any network shortcomings.

Issues such as out-of-network practitioners within in-network providers require less narrative to establish the breadth of the network shortcomings. One of my conversations with RWHC CEOs highlights the extent to which OCI remains reactive in the face of demonstrable
network inadequacy. This CEO discussed an incident where a patient had been injured in an ATV accident, and sought treatment at an emergency room that he knew to be in-network. After being billed for his treatments, this patient learned that an assistant surgeon who had been involved in his treatment was out-of-network. This patient is now facing a serious amount of untenable medical debt (and will likely drive provider costs higher), despite taking the steps to ensure treatment at an in-network facility. This failure by the healthcare system is being repeated across the United States, as was discussed in the New York Times article cited earlier.

It seems unlikely that this type of press is deemed desirable by any government agency. It is a reality that within the American political system, an issue’s “bottoming out” can be necessary in order to spur action. The fact that network inadequacy is becoming so prevalent a topic gives further support to the idea that organized plans to provide high “quality” complaints to OCI rule makers may have an impact in the realization of provider goals. Taken to an additional level, complaints could be targeted to address specific issues, and submitted simultaneously to analysis or correspondence explaining the purpose of a specific batch of complaints.

Efforts such as these could be pivotal in developing a network adequacy statute with any true teeth. Should a sufficient number of complaints provoke OCI to act on a “hot spot” of network inadequacy, stubborn insurers could be persuaded to expand their networks by contracting with additional rural providers. Even more, if OCI can be persuaded to craft a network adequacy act containing an effective enforcement mechanism, sanctions or other forms of OCI pressure could also provide the pressure needed to change the status quo of negotiations between insurers and providers.

An additional method of addressing the contract issue could be through consumer education and network transparency. The ACA does not take for granted the complexity of the health insurance system, and depends heavily on Navigators and Certified Application Counselors (CACs) to provide guidance throughout the enrollment process. Unfortunately, Navigator funding is not sufficient to provide a sufficient number of Navigators, limiting the guidance available to those unfamiliar with choosing closed-network plans. Even if there were sufficient navigators to cover Wisconsin’s rural communities, navigators may not provide advice about which health benefit plan is better or worse for a particular individual or employer, and can only provide general guidance and information. While current litigation may ultimately limit such state-based restrictions on Navigators, any judicial intervention in Wisconsin is likely some way off.

As a result, communication with insurers and OCI regarding Navigators and CACs could go great lengths toward defining the propriety of information given to consumers. A major purpose of federal regulations regarding Navigators and CACs is to provide information that clarifies the distinctions among health coverage options and helps inform consumers who are

34 Wis. Stat. §628.95(2)(d).
35 See St. Louis Effort for Aids v. Huff, Case Number 1:2013cv04246, Western District Court of Missouri, 2013 (State legislation imposing licensure requirements on navigators and CACs and restricting their activities are preempted by Federal statute).
making decisions during the health coverage selection process.\textsuperscript{36} Using a complaint system to define exactly what plan information should be provided to consumers both in and outside the exchange could have a major impact in developing a standard for when consumers are being properly informed.

Obviously, activity within government processes will not address every issue facing rural healthcare providers in Wisconsin. At this moment in the development of network policy, however, it seems to be the strongest tool available. The following section will briefly discuss a number of other options that could be considered, and describe the legal shortcomings that may hinder any action taken in these directions.

IV. Any Willing Provider, Bad Faith Insurance, and Market Share/Antitrust Issues

A. Any Willing Provider & Freedom of Choice Laws

Any Willing Provider (AWC) laws “require managed care plans to accept any qualified provider who is willing to accept the terms and conditions of a managed care plan.”\textsuperscript{37} Freedom of Choice (FOC) laws “permit an enrollee to obtain reimbursable health care services from any qualified provider even if the provider has not signed a contract with the managed care plan.”\textsuperscript{38} Those in favor of AWC and FOC laws often argue that inclusion of such laws decrease costs because providers “are reimbursed at the same rate as other network providers.”\textsuperscript{39} The opposition to AWC and FOC laws begins with freedom of contract considerations.

Historically, the right to choose who an individual or entity does or does not contract with is an established right. More specifically, the opposition to AWC and FOC laws argues that without selective contracting, “plans are unable to obtain volume discounts because they are so powerless to channel patients to selected providers.”\textsuperscript{40} Regardless, AWC and FOC laws are somewhat of a non-issue, as the state commissioners developing NAIC Model Act language are “generally opposed” to “any willing provider” language.\textsuperscript{41}

This gridlock demonstrates, once again, the need for providers in rural communities.

B. Bad Faith Insurance

Many RWHC member CEOs interviewed for this memo used the phrase “bad faith” to describe the network actions of some insurers. In the context of insurance law, “bad faith” refers specifically to the recent development of a new “tort” specifically targeting insurance practices. “It is well established within contract law that a “covenant of good faith and fair dealing...requir[es] that neither party do anything which will insure the right of the other to

\textsuperscript{36} 45 CFR §155.210(e)(2).
\textsuperscript{38} \textit{Id}.
\textsuperscript{39} \textit{Id}.
\textsuperscript{40} \textit{Id}.
\textsuperscript{41} NAIC Network Adequacy Council Presentation, 10/8/2014 – Courtesy of WHA.
receive the benefits of the agreement.” Correspondingly, authorities may find a breach of contract when a party to a contract, “by his bad faith conduct, has jeopardized or destroyed a promissee’s opportunity to reap the expected benefit of the bargain, even though that conduct failed to violate expressed provisions of the agreement.” In a fairly recent development, courts have recognized “Bad Faith” to be an actionable category of tortious action that permit an injured party “remedial relief that would not have been available in an action founded on contract, including damages for mental suffering, economic losses not foreseeable at the time of execution of the contract, and punitive damages.”

Bad Faith insurance torts were first recognized in Wisconsin in 1978, when the Supreme Court of Wisconsin ruled that, “upon the pleading of appropriate facts, an insured may assert a cause of action in tort against an insurer for the bad faith refusal to honor a claim of the insured.” In order to establish an actionable “bad faith” insurance claim, an injured party must allege that an insurer intentionally and maliciously for the purpose of harassing the plaintiffs to discourage them from asserting their rightful claim and to prevent them from collecting the amounts due under the insurance policy.”

The Wisconsin Legislature has codified bad faith insurance by asserting that an insurance company or self-insured employer can be found to act in bad faith if they “without credible evidence which demonstrates that the claim for the payments is fairly debatable, unreasonably fails to make payment of compensation or reasonable and necessary medical expenses, or after having commenced those payments, unreasonably suspends or terminates them, shall be deemed to have acted with malice or in bad faith.”

In the context of network adequacy, bad faith insurance torts may have a place in future development of network standards. At the current time, Wisconsin case law is devoid of bad faith insurance claims specifically targeting inadequate networks as the cause of denied benefits. As any complaint process continues to move forward, it would seemingly be worth scrutinizing consumer complaints that implicate a bad faith refusal to provide benefits. The specific requirements of a bad faith cause of action, however, are more difficult to produce in a single case, and significant litigation would likely be required to establish network inadequacy as a branch of the “bad faith insurance” tort tree.

C. Anti-Trust & Monopolies

In addition to federal protections, any contract or conspiracy restraining trade is illegal under Wisconsin law. Any person who “makes any contract or engages in any combination or
conspiracy in restraint of trade or commerce “violates anti-trust laws and is subject to serious repercussions.”49 Furthermore, any person “who monopolizes, or attempts to monopolize, or combines or conspires with any other person or persons to monopolize any part of trade or commerce” is also subject to penalty.

The express purpose of this state anti-trust legislation is stated in Wisconsin law as follows:

The intent of this chapter is to safeguard the public against the creation or perpetuation of monopolies and to foster and encourage competition by prohibiting unfair and discriminatory business practices which destroy or hamper competition. It is the intent of the legislature that this chapter be interpreted in a manner which gives the most liberal construction to achieve the aim of competition. It is the intent of the legislature to make competition the fundamental economic policy of this state and, to that end, state regulatory agencies shall regard the public interest as requiring the preservation and promotion of the maximum level of competition in any regulated industry… 50

The breadth of this language has been applied by Wisconsin courts on a number of occasions, prompting the ruling that the Wisconsin antitrust statutes apply to both interstate and intrastate commerce, as long as the conduct at issue substantially affects the people of Wisconsin or has impacts in the state.51 As such, insurance contracts that can be categorized as, conspiracy or restraint of transactions commerce may fall subject to anti-trust statutes.

Network adequacy issues are relevant to antitrust laws. Antitrust law “generally forbids agreements that restrict output and raise prices above that which would be achieved in normal market competition.”52 The nuances of how the two concepts related have not yet been charted given the infancy of the ACA and network adequacy regulation but providers and insurers should be aware of restraint of trade issues in forming and managing provider networks.

Similarly, the concept of monopolies has been discussed in connection with closed or narrow networks. There is undoubtedly the potential for insurers and providers to act in a manner that could be seen as an “attempt to monopolize,” but proving these facts at law is a technical and complex process. Any behavior in violation of state or federal law would have to be documented extensively, and any action taken should involve an expert in the field of anti-trust or monopoly law.

49 Wis. Stat. §133.03(1).
50 Wis. Stat §133.01.
52 Id, at 339.
V. Conclusion

Network adequacy is a serious issue facing consumers, providers and insurers in a number of different ways. Consumer trust is crumbling in the face of anecdotal and publicized evidence of narrow networks and limited local options for service. There are dramatic inequities prevalent in current network schemes. Rural counties are at risk of being drastically underserved. Providers face an uncertain future, as they attempt to provide quality and affordable service while struggling to engage in contracts that allow them to cover services provided to members of the communities that they serve. Insurers must face strict new regulations that have already begun to implement new strategies in an attempt to save money while adjusting to the federal requirements contained in the ACA and its regulatory progeny. The current status quo seems untenable, as consumers are, with greater frequency, being subject to network inefficiencies that carry massive consequences.

The only certainty in the current system of regulating network adequacy is uncertainty. State insurance departments are working to cope with changing requirements, insurers are changing policy rapidly, and providers and consumers are often left struggling to keep up with these changes. Regardless of this fluidity in the current system, the time to address network inadequacy is now. Legislatures and state agencies across the country are beginning to develop the framework for regulations that will ultimately shape network adequacy regulation for decades to come. Insurers, providers and consumers are, and will remain to be, the most logical source for abundant information about network function, and the manner in which state and federal regulations are falling short. Developing a means to convey this information to lawmakers is crucial, as the opportunity to change regulatory schemes will disappear for the foreseeable future as soon as final network adequacy statutes are promulgated in the next three to five years.