DECEMBER 2021

CHCF Issue Brief

Network Adequacy Standards in California:
How They Work and Why They Matter

Network adequacy standards are commonly used as a regulatory tool to ensure that health plans contain a network of health care providers adequate for enrollees to access medically necessary services in a timely manner. As health insurers design products to appeal to employers and individuals purchasing coverage, they must negotiate competitive rates with providers to offer low premiums and inclusive networks. If plans cannot negotiate price terms they deem reasonable with certain providers, they may try to exclude those providers from their network to contract with other lower-cost or higher-value providers. Without network adequacy protections, health plans may choose to exclude high-priced providers from a network, and a patient seeking care could be forced to go out of network. Depending on the type of health plan they have, when patients obtain care from out-of-network providers, they may be responsible for paying higher cost sharing or even the entire cost of their care. Consequently, the Affordable Care Act (ACA) required states to adopt minimum network adequacy standards to protect patients from networks with an insufficient number of providers, along with an independent, external review process that serves as a backstop for enrollees to appeal coverage denied by their plan to an independent review organization, often organized by a state or federal agency.[1]

How a state defines its network adequacy standards and how it considers exceptions and crafts safeguards to these standards have significant market implications. Generally, if network adequacy regulations require too few providers, patients may struggle to get timely care. Conversely, if network adequacy regulations require too many providers, regulators run the risk of inhibiting market competition and increasing costs, as plans that may be required to include certain high-priced providers will likely pass those increased costs on to enrollees through higher premiums.[2] While Congress and state legislators created and refined network adequacy requirements and external review processes to ensure that patients get access to the care they need, the most pressing issue for many patients is not just access, but *affordable* access. Network adequacy protections help ensure that patients have access to all necessary medical care at in-network cost sharing, but many patients struggle to afford even those copayments. Studies have also shown that increasing health care costs such as premiums or deductibles are a major barrier to access to care for patients across the country.[3] An extensive body of evidence demonstrates that consolidation of providers into large health systems with market power is a primary driver of increasing health care costs.[4] Consequently, affordable access requires allowing insurers to assemble networks with reasonably priced providers, but creating networks of high-value providers may be challenging in highly consolidated markets. Regulators seeking to improve affordability while ensuring access must balance the need to provide network adequacy protections with the need to allow plans to control costs.

This issue brief examines California's regulatory framework regarding network adequacy and how effectively existing laws provide adequate and affordable access to health care providers, particularly specialists, in the commercial insurance market. Part I of this brief describes California's current regulatory framework for network adequacy and adverse benefit determination review, including the external review process. Part II

examines other state and federal requirements for network adequacy and external review and compares them to those in California. Finally, Part III considers new market consolidation forces and discusses the balancing act required within the existing regulatory framework to facilitate affordable health access for all patients in California.

I. Network Adequacy and External Review in California

In the mid-1970s, some states adopted network adequacy standards as the popularity of health maintenance organizations (HMOs) with more restrictive networks began to rise.[5] In 2010, the ACA required all states to adopt minimum network adequacy standards that require plans to "maintain . . . a network that is sufficient in number and types of providers . . . to assure that all services will be accessible without unreasonable delay."[6] To further ensure adequate patient access to care, the ACA required states to develop an external review process that provides an independent channel for enrollees to dispute and appeal their health plan's denial of coverage. Congress, however, left it to the states to enact and implement specific standards and processes. As a result, all states have adopted network adequacy standards and external review processes, but the requirements vary among the states.

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California's network adequacy rules and external review process, established under the Knox-Keene Health Care Service Plan Act,[7] predate the requirements of the ACA and have evolved over time. In 1999, amendments to Knox-Keene created a new oversight agency for managed care plans, the Department of Managed Health Care (DMHC),[8] in addition to the state's existing Department of Insurance (CDI). DMHC now regulates 95% of state-regulated commercial and public health plans, including all HMOs and most preferred provider organizations, while CDI oversees the remaining 5%.[9] The two agencies, while separate, have similar requirements as to network adequacy and external review, with a few variances as described below.

California's Network Adequacy Standards

California, along with nearly half of all states, supplement the ACA's qualitative standard of "reasonable" access to a "sufficient" number and type of providers with additional quantitative standards of adequacy for at least some marketplace plans, based on the type of provider and type of health plan regulated (see Table 1 on page 3). For primary care and hospitals, both DMHC and CDI require that a network must adhere to a combination of three commonly adopted numeric standards: (1) the ratio of providers to enrollee population, (2) a geographic measure of travel time or distance to providers, and (3) timely access to appointments.[10]

Requirements for specialists, on the other hand, differ by the type of plan regulated. Both DMHC- and CDI-governed plans are required to provide timely access to nonemergency specialist appointments within 15 business days of a request, subject to a doctor's approval of a longer timeline.[11] Patients must receive emergency appointments within 2 days, or 4 days if prior authorization is required. In addition to timely access, CDI-governed plans are also required to meet a geographic standard that requires specialists to be available within 60 minutes or 30 miles of an enrollee's home or workplace.[12] Additionally, DMHC

Table 1. Network Adequacy Standards for State-Regulated Health Plans in California

	INDIVIDUAL AND GROUP PLANS REGULATED BY DMHC	PLANS REGULATED BY CDI	MEDI-CAL MANAGED CARE PLANS (DHCS REQUIREMENTS)
Primary Care	▸ **Provider ratio.** At least one full-time physician per 1,200 covered persons; at least one full-time primary care physician per 2,000 covered persons. ▸ **Geographic access.** Primary care network providers within 30 minutes / 15 miles of each covered person's residence or workplace. ▸ **Timely access.** Nonurgent appointments for primary care within 10 business days of request.	▸ **Provider ratio.** At least one full-time physician per 1,200 covered persons; at least one full-time primary care physician per 2,000 covered persons. ▸ **Geographic access.** Primary care network providers within 30 minutes / 15 miles of each covered person's residence or workplace. ▸ **Timely access.** Nonurgent appointments for primary care within 10 business days of request.	▸ **Geographic access.** Primary care provider within 30 minutes / 10 miles of enrollee's residence. ▸ **Timely access.** Nonurgent appointments for primary care within 10 business days of request.
Hospital	▸ **Geographic access.** Network hospital with sufficient capacity must be available within 30 minutes or 15 miles of each covered person's residence or workplace.	▸ **Geographic access.** Network hospital with sufficient capacity must be available within 30 minutes or 15 miles of each covered person's residence or workplace.	▸ **Geographic access.** Network hospital within 30 minutes or 15 miles from enrollee's residence.
Specialty Care	▸ **Timely access.** Appointment for nonurgent care within 15 business days of the request unless treating provider finds a longer wait will not have a detrimental impact on patient's health or for preventive services / periodic follow-up care, which may be scheduled in advance.	▸ **Geographic access.** Network specialists with sufficient capacity to accept covered persons within 60 minutes / 30 miles of home or workplace. ▸ **Timely access.** Appointment for nonurgent care within 15 business days of the request unless treating provider finds a longer wait will not have a detrimental impact on patient's health or for preventive services / periodic follow-up care, which may be scheduled in advance.	▸ **Geographic access.** *Rural counties:* 90 minutes / 60 miles from enrollee's residence. *Small counties:* 75 minutes / 45 miles from enrollee's residence. *Medium counties:* 60 minutes / 30 miles from enrollee's residence. *Large counties:* 30 minutes or 15 miles from enrollee's residence. ▸ **Timely access.** Appointment for nonurgent care within 15 business days of request.

Note: See the appendix for complete network adequacy requirements in California. This table shows the requirements of network adequacy under California law. How these standards are applied in practice varies, and the California Department of Managed Health Care (DMHC) or California Department of Insurance (CDI) may approve plans that do not meet these specific requirements (see next section). Even if the plan meets these standards, the provider ratio requirements may be insufficient if the providers do not accept many patients from the plan. Timely access standards are intended to provide a fallback to ensure patients get medically necessary care, but they shift the burden to patients to initiate the complaint process.

shares oversight with the California Department of Health Care Services (DHCS) for Medi-Cal managed care plans, which have stronger network adequacy requirements based on population density at the county level.[13]

Waivers and Alternative Access Standards

In certain cases, plans may be unable to comply with network adequacy requirements for reasons beyond their control, such as lack of provider availability in a geographic area. Beyond variances in provider specialties and geographic realities, plans also need leeway for market competition and other innovations like telemedicine or centers of excellence.[14] Recognizing this need for flexibility, many regulating agencies, including the DMHC and CDI in California, have adopted an approach that sets minimum standards for threshold entry into the market but allows plans to seek exceptions when market conditions do not reasonably allow compliance.

DMHC-regulated plans may propose alternative standards of accessibility if existing standards are "unreasonably restrictive" or if the plan's service area is within a county with less than 500,000 residents and has two or fewer full-service commercial health plans.[15] DMHC employs full-time network adequacy staff who review requests for alternative standards on a case-by-case basis.[16] When reviewing the request for alternative standards, DMHC uses retrospective historical aggregate data from the insurer's annual network review filings to analyze and compare the provider network against networks of other insurers in the same service area.[17] Specifically, the agency may consider whether the portion of the service area at issue is urban or rural, whether there are exclusive provider contracts in the service area, the distribution of enrollees and providers, patterns of practice, drive times, and wait times.[18] DMHC may grant alternative access, typically the next closest provider, after the plan has exhausted other "reasonable" options for contracting with providers in order to meet network adequacy standards.

Plans governed by CDI may apply for a waiver for network adequacy requirements when (1) certain services are not available in a plan area, (2) a plan is unable to contract with a sufficient number of providers in an area, (3) a provider or facility leaves the network, or (4) a plan engages in an innovative network design that benefits enrollees.[19] Similar to DMHC-regulated plans, insurers may sell plans with waivers to enrollees without meeting network adequacy requirements, but administrators must provide alternative access for enrollees by locating nearby providers and assisting enrollees to access appropriate care in a timely manner.[20] Plans may also comply by providing transportation to care or by using telehealth services.[21]

These waivers and alternative access standards give plans flexibility to design networks in locations where they may struggle to contract with specialists or other providers, but relaxed standards in some cases could mean that patients are unable to get the care they need. Consequently, California lawmakers implemented a consumer appeal and review process to help patients get access to medically necessary care when their plan denies coverage or they cannot find the care in network.

Consumer Grievance and External Review

California law requires a state-regulated insurance plan or carrier,[22] including a Medi-Cal managed care plan, to provide all medically necessary care on a timely basis.[23] If a patient enrolled in such a plan was unable to obtain the care upon exhausting internal appeals of the coverage denial to the health plan, the enrollee may appeal to the state regulatory agency for further review. This process is administered by DMHC and CDI through two channels — the consumer complaint and the independent medical review, based on the type of coverage denial at issue.

An enrollee with a grievance or complaint against the plan typically initiates the review process by filing a complaint through the consumer complaint process

administered by the DMHC or CDI. The consumer complaint process addresses nonclinical contract issues, including improper denial or delay in settlement of claims, denial of services not covered by insurance contracts, and delays in obtaining a referral or authorization.[24] DMHC's consumer complaint process also addresses timely access issues under network adequacy standards and problems finding an in-network doctor, specialist, or hospital.[25] Often, enrollees can efficiently resolve a timely access issue through a three-way call with DMHC's Help Center and their health plan, without going through the standard complaint process.

Since plans have a legal obligation to provide all medically necessary care, timely access issues are often resolved by the plan or carrier without necessitating the consumer complaint process. When the plan or insurer denies coverage for a specialist, they often claim the care was not medically necessary or that the care could be provided by a less-specialized physician.[26] For these clinically based adverse plan determinations, DMHC and CDI use a separate channel called the independent medical review (IMR), which reviews coverage denials on the basis of medical necessity, experimental or investigational treatment, or the payment of emergency or urgent medical services.[27] The IMR process was first enacted by statute in 1999 as an amendment to the Knox-Keene Act for all state-regulated fully insured plans in California.[28] Since then, policymakers have expanded and refined the process such that in 2011, when the ACA mandated that all states adopt minimum external review standards, California already had an existing IMR process that met the ACA-imposed minimum standards for external review eligibility.[29] The IMR is conducted by an external, independent review organization and if the review decides in favor of the plan enrollee, DMHC-regulated plans must cover the medically necessary care unavailable in network at in-network cost sharing. Similarly, CDI-regulated plans must provide medically necessary services unavailable in network to enrollees at an in-network price.[30]

Of the IMRs conducted by DMHC in 2020, 53% ended in a favorable finding for the enrollee and 32% were upheld for the plan, while in the remaining 15% the plan rescinded its earlier denial.[31] Nonetheless, despite the availability of information and assistance, a no-cost appeal process, and enrollees' high success rate, very few Californians initiate the review process after being denied coverage for a service. In 2020, DMHC — which regulated plans covering 27.7 million Californians — closed just 3,793 requests for independent medical review.[32] Based on the agency's annual report for that year, the agency resolved 1.12 IMRs per 10,000 enrollees in full-service plans and 0.65 IMRs per 10,000 enrollees for all the plans it oversees (including specialty plans).[33]

Effect of Network Adequacy on Market Competition in California

Network adequacy requirements and external review processes in California have evolved over time to balance the need of patients to access medically necessary care with the need to control costs. In that time, however, the markets for health care providers in California have consolidated substantially. Researchers found that in 2018, the average measure of market consolidation in California exceeded the US Department of Justice and Federal Trade Commission threshold for "highly concentrated" markets for hospitals, insurers, and specialist physicians and the threshold for "moderately concentrated" markets for primary care physicians.[34] Furthermore, physician consolidation continues to increase rapidly. In California, the percentage of specialists in practices owned by a hospital or health system increased from 25% in 2010 to 52% in 2018 — an increase of 108%.[35] The situation may be particularly acute when one practice employs most of the specialists in an area. In the San Francisco Bay Area, for example, an increasing number of physicians have joined the large medical groups affiliated with Kaiser, Sutter, or UCSF.[36]

Network adequacy standards may amplify the harms of provider market power that result from consolidation. In concentrated provider markets, if network adequacy standards require a specific number of providers or require a provider within a specific distance from enrollees' homes or workplaces, health plans may have little choice but to include specific hospitals or provider groups. These requirements might be especially restrictive when it comes to certain specialists if one group practice employs most of the specialists in an area. In these areas, especially smaller towns or rural areas, network adequacy requirements could necessitate the inclusion of certain providers that already have market power, further stripping insurers of their negotiating power and giving those providers even greater leverage to charge anticompetitive prices. Without waivers or exemptions from certain requirements of state network adequacy laws, plans may have little choice but to contract with a specific provider group in a geographic region regardless of the cost. Since all insurers face the same requirement, they can pass the increased costs on to employers and enrollees through increased premiums and cost sharing without risking losing market share.

Policymakers may look to other states and the federal Medicare Advantage program for best practices in network adequacy and external review of adverse plan decisions that could minimize the impact of network adequacy requirements on market power.

II. Network Adequacy and External Review in Other States and Medicare Advantage

Pursuant to the ACA, all states require minimum network adequacy standards and an external review mechanism, but states vary substantially in how those basic requirements are implemented. While some state processes may be more efficient than others, the federal Medicare Advantage program provides a combination of flexible network adequacy standards and an external review process that ensures patients have access to medically necessary care with in-network cost sharing.

Network Adequacy Standards in the States

According to a 2020 report, 21 states require only the ACA minimum qualitative standard for network adequacy of their state-regulated plans.[37] This approach allows plans to self-certify and attest to the adequacy of their networks and does not quantitatively specify what the state considers "sufficient" in number and type of provider or "reasonable" access.[38] Alternatively, the majority of states (29) have adopted at least one quantitative standard of adequacy for at least some marketplace plans that follow one of three commonly adopted models. The first, most common quantitative measure, adopted in most states (26) that require numeric standards, is a geographic access standard that measures maximum travel time or distance from the enrollee's home or workplace to a provider. The second type of standard, adopted in 17 states, imposes a maximum wait time for accessing appointments. The third measure requires a minimum ratio of providers to the enrolled population and is used in 13 states. Many states use a combination of the three quantitative standards, and seven states, including California, use all three metrics.[39]

While quantitative standards may be useful in helping state regulators monitor network adequacy, they may be too stringent in certain situations. States regulators must balance the need for robust standards with market conditions, allowing enough variance and flexibility to account for the wide range of provider types and specialties and geographic regions.[40] The specific numeric standards adopted in the states, therefore, vary widely depending on the type of provider — primary care vs. specialist — and geographic region — urban vs. rural. In Illinois, for example, geographic access standards require a maximum travel time or distance that ranges from 30 minutes or 30 miles in urban areas to 60 minutes or 60 miles in rural areas for primary care physicians, and a maximum distance of 45 minutes or 60 miles in urban areas to 75 minutes or 100 miles in rural regions for specialists.[41]

Beyond variance in the specific metrics, states also customarily allow exceptions and waivers in applying these quantitative standards in certain situations. For example, in rural communities that lack providers, plan enrollees often experience higher premiums and more severe access issues.[42] In those circumstances, state regulators allow flexibility by granting exceptions or waivers to their network adequacy requirements. For example, in states such as Illinois, Colorado, and Nevada, regulators allow the insurer to offer a proposed network with alternative access accommodations that ensure the adequacy of the network.[43] Some states also engage with the insurers regarding the composition of their proposed network. Depending on the level of resources available to the state regulating agency, some states may be more experienced and engaged in this review process.

In Nevada, for example, the legislature established the Nevada Network Adequacy Advisory Council, tasked with making annual recommendations to the insurance commissioner to adopt additional or alternative standards for determining whether a network plan is adequate.[44]

Similar to DMHC in California, the Nevada Division of Insurance compiles historical aggregate data to assess the reasonableness of each proposed provider network. Factors considered for granting exceptions include any established patterns of care and the availability of providers in the specialty type related to the deficiency within the applicable geographic service area.

External Review in the States

State network adequacy standards, whether qualitative or quantitative, help regulate health plans to ensure adequate access to care for patients, but in some cases, patients still find it difficult to obtain medically necessary care in the network. An external review process serves as an additional protection for patients in the event that network adequacy falls shorts. The ACA mandates that states provide external review processes that allow patients to appeal to an independent review organization if their insurer denies coverage based on the determination that a requested service is not medically necessary or is experimental or investigational, or for eligibility and rescission of coverage.[45] This external review may be organized by a state or federal agency. A few states, including Alabama and Texas, follow the federal external review process as provided and administered by the Department of Health and Human Services.[46] Most states, however, developed their own external review processes and administer the process through a state regulating agency, typically the state department of health or insurance.

While most state external review laws align with the minimum requirements of the ACA, a handful of states go beyond the ACA and permit enrollees, and in some cases, providers, to utilize the review process for additional types of coverage complaint and appeals. For example, states including Maryland, Michigan, Minnesota, and Ohio allow an appeal of any adverse plan determination or any consumer grievance not resolved by the plan, including out-of-network and contractual issues. Similar to California, consumers appeal to a single complaint system for all complaints

related to adverse plan decisions. The state regulatory agency typically employs an internal process to separate the reviews based on the type of grievance. Generally, an independent review organization (IRO) reviews appeals regarding medical necessity or clinical review, whereas agency staff handles nonclinical or contractual issues. For example, in Ohio, an enrollee is entitled to an external review by an IRO for any adverse benefit determination involving a medical judgment or relating to an experimental or investigational service, whereas an enrollee is entitled to a review by the Ohio Department of Insurance for any adverse benefit determination based on a contractual issue that does not involve a medical judgment or any medical information.[47] Similarly, Minnesota's health plan oversight, split between two agencies like California's,[48] allows enrollee appeal and review for any adverse determination and follows the same internal process. If department staff determines, upon an initial review of the appeal, that coverage is required according to the law and that no factual dispute exists, the department may require the plan to cover the disputed service or services without sending the case to an independent reviewer.[49] Separately, both departments offer a mediation option to enrollees.

Other states, on the other hand, maintain separate complaint processes for different types of claims. For example, New York explicitly permits its external review process, available through the state's Department of Financial Services, to be used by both enrollees and providers to address disputes regarding out-of-network care, in addition to medically necessary and experimental or investigational services.[50] It maintains a separate complaint process to address other nonclinical issues concerning prompt payment, reimbursement, coverage, network adequacy, benefits, rates, and premiums.[51] Washington, which permits external review for any denial of a request for service, payment, or coverage, also has a separate complaint process that enrollees may use to grieve cancellations or refusals to ensure, billing problems, claim denials or delays, poor service, or other issues identified by a complainant. The website for the state insurance commissioner, which handles both processes, encourages enrollees to consider filing a review request and a complaint at the same time, as the processes are different.[52]

Despite the various channels available for enrollees to appeal coverage denial by their plans, one of the most persistent problems with the external review process has been lack of use. Even in states that provide high-quality information to plan enrollees and expanded access to the review process, the uptake has been minimal. For example, Washington offers a detailed guide with sample letters for filing all types of grievances, while Maryland's Office of the Attorney General provides a special unit that offers direct assistance to enrollees seeking help with internal plan grievances and external reviews. Nonetheless, Washington processed just 916 IMRs in 2020.[53] Similarly, Maryland's insurance administrator received fewer than 800 complaints in 2020,[54] despite plans reporting more than 75,000 adverse decisions to the Maryland attorney general that year. These data demonstrate that enrollees filed complaints only approximately 1% of the time after their plan makes an adverse decision.[55]

Lessons from the States

Many states have adopted quantitative network adequacy standards with external review processes that mirror those of California's. Like DMHC and CDI in California, other state regulatory agencies allow variances as well as exceptions to numeric adequacy standards to provide sufficient flexibility in the composition of provider networks based on different situations. To adequately take into consideration new market conditions, California may consider a process similar to Nevada's Network Adequacy Advisory Council annual review and recommendations. At the very least, this mechanism could help preemptively identify market outliers in network access for certain high-cost specialty care and make such information transparent and publicly available in the relevant market, potentially serving as an inhibitor for monopoly conduct by certain providers.

Similar to California, many states have also adopted enrollee appeal and external review processes that allow an appeal of any adverse plan determination or any consumer grievance not resolved by the plan, including out-of-network and contractual issues. While the specific channels and processes for review vary among the states, other states also experience a similar lack of uptake of the external review process as in California, even in states that have allocated significant resources to helping patients navigate the process.

Overall, California's network adequacy and external review processes appear to be on par with many other exemplar states, so policymakers could look to the Medicare Advantage program for additional policy options for improving its regulatory framework.

Medicare Advantage Network Adequacy Standards

Medicare Advantage plans (also called Medicare Part C) are insurance plans offered by private insurance companies that must follow rules set by Medicare. Medicare Advantage plans must cover services covered by Medicare Part A (hospital insurance) and Medicare Part B (medical insurance), and typically cover additional benefits, like vision, hearing, and dental services.[56] Similar to the standards adopted in many states, Medicare Advantage plans are required to meet a standard for maximum travel time or distance and timely access to appointments based on whether the provider offers primary care or specialist services and whether the enrollee is located in an urban or rural region.[57] Additionally, the federal government allows the Centers for Medicare & Medicaid Services (CMS) to make exceptions to those network adequacy requirements when Medicare Advantage plans present evidence that the "existing landscape of providers/facilities does not enable the organization to meet the current CMS network adequacy criteria."[58] Moreover, Medicare Advantage plans are subject to more relaxed network adequacy requirements for certain specialty providers. Currently, CMS requires quantitative network adequacy standards for 13 facility types and 27 specialty provider types. For all other specialty types, however, Medicare Advantage plans may attest to adequate enrollee access without submission of compliance with specific network adequacy standards.

Importantly, to ensure the optimal balance of network adequacy and market competition, CMS conducts an annual network adequacy review to adjust standards and to address new market conditions that arise. For example, in the *CMS Medicare Advantage and Section 1876 Cost Plan Network Adequacy Update* released in June 2020, outpatient dialysis was removed from the list of provider types subject to network adequacy requirements to help "plans serving members in concentrated areas achieve network adequacy despite the consolidation of the outpatient dialysis industry."[59] In the new rule, CMS allows plans to attest to providing medically necessary dialysis.

The Medicare Advantage model balances flexibility to insurers to address market power that arises in certain consolidated specialist markets while ensuring that patients have access to medically necessary care.

Medicare Advantage's Automated External Review

Medicare's external review is broadly permitted for any adverse determination. The most unique feature of Medicare's external review is its automatic external appeal for certain denials. Medicare offers five levels of review for payment disputes, with review processes differing based on the Medicare product involved.[60] For Medicare Advantage plans, an enrollee can initiate a Level 1 appeal with their plan, called a request for reconsideration, if the plan denies a claim or request for care.[61] If the plan fails to meet the deadline for issuing a reconsideration decision or the decision is not in the enrollee's favor, the plan must forward the appeal to an independent entity for a Level 2 review.[62] If the Level 2 review is not in the enrollee's favor, they may initiate additional levels of review as desired, though some conditions apply. In 1997, the rate of review of

Medicare managed care coverage issues was 1.65 per 1,000 — more than 10 times the most recent rate for state-regulated plans in California.[63] Researchers credited the automatic nature of the reviews as one of the factors contributing to the higher review rate.[64] This automatic external review system ensures the appeal process is easy to navigate and free of administrative burdens for enrollees to efficiently resolve any coverage denials that result from network adequacy gaps.

Given the variances and flexibilities in network adequacy standards adopted by state and federal regulating agencies, an effective external review process is an essential and complementary regulatory tool that protects patients in the event that network adequacy falls shorts.[65] Medicare Advantage effectively combines flexible network adequacy standards with an automated external review process to fill any gaps from potentially inadequate networks. This external review system helps alleviate the need to design comprehensive network requirements and pinpoint the exact level of network adequacy standards to meet all needs.

Lessons from Medicare Advantage

Medicare Advantage offers California policymakers ways to incrementally improve network adequacy and external review processes. First, DMHC and CDI could use Medicare Advantage as a model to adjust network adequacy standards for specialists in concentrated markets and to publish guidance or other public notices to identify and address new market conditions that arise from merger activity. For example, DMHC and CDI could offer guidance on specific provider groups whose market power appears to limit the ability of plans and carriers to reasonably negotiate with those groups and provide automated waivers or alternative access review for plans that would likely need to include these groups to meet standard network adequacy requirements. Whether this guidance would substantially improve the ability of plans to negotiate reasonable rates with these providers remains uncertain.

California policymakers could also consider an automated appeal process for state-regulated plans — similar to Medicare Advantage — to ensure that patients utilize and receive the necessary follow-up assistance from regulating agencies upon exhausting their internal plan processes. Evidence has shown a high enrollee success rate and likelihood of plans to rescind their denial of coverage upon appeal in IMRs initiated through DMHC in 2020.[66] Similarly, DMHC's Help Center can efficiently assist enrollees with timely access to necessary care without triggering further review. A key component of this success, however, relies on patients to seek out and initiate the requisite process. Exploring and navigating an unknown process for patients or their loved ones in the middle of a health crisis can be daunting. Patients would likely benefit if plans or carriers were required to report to DMHC or CDI following an adverse benefit determination or failure to access care. A report to the agencies to automatically trigger either the IMR or consumer complaint process would take the administrative burden off patients and help ensure maximum utilization of the processes available to them.

Nonetheless, while an automated review may help certain patients access specialized care at in-network cost-sharing rates in the case of an inadequate network, it may also give specialist providers additional leverage to negotiate higher in-network prices, as insurers required to provide coverage may choose to expand their networks rather than face additional out-of-network costs. Furthermore, an automated external review process would likely require a significant increase in staff and other resources at DMHC and CDI. As a result, automated review may increase access for patients needing highly specialized care, but it will require substantial state resources and is unlikely to make an impact on the most pressing issue — affordable access to care for all Californians.

III. Considering Affordable Access to Specialty Care: The Intersection of Network Adequacy, Market Consolidation, and Prices

Insurers design plans with networks that allow enrollees to get medically necessary care from in-network providers. California's network adequacy and external review requirements administered by DMHC and CDI help ensure that state-regulated plans have an adequate numbers of doctors, including specialists, within that network. Nonetheless, some patients will need to go out of the network for care, whether due to gaps in network adequacy or lack of providers in the network who are available to take new patients. As a result, they may incur out-of-network costs. Incremental improvements to network adequacy regulations and external review, while useful in enhancing access to medical care for patients needing highly specialized care, are unlikely to improve access to care at affordable prices for all residents of California. Even before the coronavirus pandemic, at least one-third of insured adults surveyed in 2018 reported difficulty affording routine costs of health insurance like premiums and deductibles, and half of all US adults said they or a family member delayed or skipped necessary medical care due to cost concerns.[67] The pandemic and associated job loss will likely worsen the situation.[68] Consequently, policymakers interested in improving affordability could consider addressing market power and prices directly.

California lawmakers have already set payment standards for some out-of-network care under its surprise-billing laws. California law prohibits all surprise medical bills by limiting the amount patients can be billed for emergency care at an out-of-network facility or for nonemergency care by an out-of-network physician at an in-network facility to the cost sharing or copays that would have applied if they had received the care from an in-network provider.[69] Furthermore, reimbursement to the out-of-network provider for *emergency* services received out of network is capped at a "reasonable and customary" rate.[70] AB 72, a surprise-billing law passed in 2016, also limits the amount that plans must pay to providers for nonemergency care by an out-of-network physician at an in-network facility to the greater of (1) the average contracted rate or (2) 125% of Medicare reimbursement for similar services in the same geographic area.[71] AB 72 also created an independent dispute resolution process that allows providers to dispute the payment amount if a provider believes they are entitled to a higher rate.[72] While California's surprise-billing laws protect a patient who unintentionally sees an out-of-network provider and caps the reimbursement rate to the out-of-network provider, they do not limit the amount the insurer pays the provider when patients need to see an out-of-network specialist for care that is highly specialized and not available from an in-network physician. In these situations, the provider derives significant leverage from the requirement that plans must provide all medically necessary care, sometimes forcing plans to reimburse the provider for the highly specialized care at rates significantly above the discounted in-network rates.[73] To minimize these situations, plans will typically try to include many providers in their networks.

Nonetheless, providers with market power understand these dynamics and can use this knowledge to increase payment rates for in-network services. Excessive out-of-network rates for nonemergency care can similarly compel plans to include high-priced specialists. Adding to these market dynamics are rising trends in provider consolidation. Widespread recognition of hospital consolidation and resulting price increases have increased antitrust oversight,[74] but the consolidation of physicians, especially specialist physicians,[75] has received less attention. As of 2018, 77.5% of the metropolitan statistical areas in the US had highly concentrated markets for specialist physicians and nearly 60% of counties in California have highly concentrated specialist markets, with a few counties having near monopolies for some specialties.[76] The intersection of

network adequacy standards and highly consolidated specialty practices in California may inadvertently further drive up costs for specialist care.

Medicare Advantage recognizes the potential for excessive provider rate demands, and statutory and regulatory provisions require a specialist provider that refuses to contract with a Medicare Advantage plan to accept payment for out-of-network care for Medicare Advantage plan members at the rate applicable under traditional Medicare.[77] Some academic researchers have proposed capping the rates that providers can charge for out-of-network health care services,[78] but to avoid market distortions and equity concerns, these out-of-network prices caps would need to be applied for all insurance plans, including self-funded employer plans.[79] If the rate caps were applied only to specific plans (i.e., commercial plans regulated by DMHC or CDI), providers may refuse to provide care to enrollees covered by these plans, further entrenching access issues, and employers may choose to offer plans not regulated by DMHC or CDI. Applying the out-of-network cap to all delivery systems, including Medi-Cal plans, could help promote health equity and affordable access in California. Including all insurance plans could prevent the further expansion of disparities, but policymakers could consider targeting the cap to apply to certain highly concentrated provider specialties or in highly consolidated geographic regions. As seen in Medicare Advantage and Nevada, an annual network adequacy review can identify such market conditions that arise and make the information available as a public notice or guidance to further inform policy.

Conclusion

California's existing regulatory framework seeks to ensure the optimal balance of network adequacy and market competition. As markets continue to consolidate in California, network adequacy protections should be evaluated through the lens of market competition to reach a balancing act that ensures health care access and affordability for all Californians. Any policy options to refine network adequacy rules with the goal of reducing costs for patients must balance and ensure access to care. California lawmakers could follow regulatory processes used in Nevada and Medicare Advantage and publish notice or guidance to increase the transparency of specialist market power in forming adequate networks. Such shaming tactics may be helpful. But to more effectively mitigate the ability of certain specialty practices to exert market power anticompetitively while ensuring patients maintain access to necessary specialty care, a broader systemic reform may be needed in the state, including provider rate caps on out-of-network care. Although California's current network adequacy protections strike an important balance between protecting patient access and preventing growth in provider market power, achieving affordable access to care for all residents will likely require policies that, in the interest of health equity, directly address high prices across all delivery systems.

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The Source on Healthcare Price & Competition provides up-to-date and easily accessible research and analysis on health care price and competition in the US.

About the Foundation

The California Health Care Foundation is dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California, particularly those with low incomes and those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford.

CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

Appendix. California Network Adequacy Standards

	DMHC-REGULATED PLANS	CDI-REGULATED PLANS	MEDI-CAL MANAGED CARE (DHCS REQUIREMENTS)
Primary Care	▸ **Provider ratio.** At least one full-time physician per 1,200 covered persons; at least one full-time primary care physician per 2,000 covered persons. ▸ **Geographic access.** Primary care network providers within 30 minutes / 15 miles of each covered person's residence or workplace. ▸ **Timely access.** Nonurgent appointments for primary care within 10 business days of request.	▸ **Provider ratio.** At least one full-time physician per 1,200 covered persons; at least one full-time primary care physician per 2,000 covered persons. ▸ **Geographic access.** Primary care network providers within 30 minutes / 15 miles of each covered person's residence or workplace. ▸ **Timely access.** Nonurgent appointments for primary care within 10 business days of request.	▸ **Geographic access.** Primary care provider within 30 minutes / 10 miles of enrollee's residence. ▸ **Timely access.** Nonurgent appointments for primary care within 10 business days of request.
Hospital	▸ **Geographic access.** Network hospital with sufficient capacity must be available within 30 minutes / 15 miles of each covered person's residence or workplace.	▸ **Geographic access.** Network hospital with sufficient capacity must be available within 30 minutes / 15 miles of each covered person's residence or workplace.	▸ **Geographic access.** Network hospital within 30 minutes / 15 miles of enrollee's residence.
Specialty Care	▸ **Timely access.** Appointment for nonurgent care within 15 business days of the request unless treating provider finds a longer wait will not have a detrimental impact on patient's health or for preventive services / periodic follow-up care, which may be scheduled in advance.	▸ **Geographic access.** Network specialists with sufficient capacity to accept covered patients within 60 minutes / 30 miles of home or workplace. ▸ **Timely access.** Appointment for nonurgent care within 15 business days of the request unless treating provider finds a longer wait will not have a detrimental impact on patient's health or for preventive services / periodic follow-up care, which may be scheduled in advance.	▸ **Geographic access.** *Rural counties:* 90 minutes / 60 miles from enrollee's residence. *Small counties:* 75 minutes / 45 miles from enrollee's residence. *Medium counties:* 60 minutes / 30 miles from enrollee's residence. *Large counties:* 15 miles / 30 minutes from enrollee's residence.

	DMHC-REGULATED PLANS	CDI-REGULATED PLANS	MEDI-CAL MANAGED CARE (DHCS REQUIREMENTS)
Mental Health / SUD	▸ **Timely access.** Nonurgent, nonphysician mental health appointment within 10 business days of request.	▸ **Geographic access.** Mental health professionals within 30 minutes / 15 miles of each covered person's residence or workplace. ▸ **Timely access.** Nonurgent, nonphysician mental health appointment within 10 business days of request.	▸ **Geographic access.** *Rural counties:* 90 minutes / 60 miles from enrollee's residence. *Small counties:* 75 minutes / 45 miles from enrollee's residence for mental health; 90 minutes / 60 miles for SUD. *Medium counties:* 60 minutes / 30 miles from enrollee's residence. *Large counties:* 30 minutes / 15 miles from enrollee's residence. ▸ **Timely access.** Outpatient, non-psychiatrist mental health appointment within 10 business days of request.
Ancillary Services	▸ **Geographic access.** Ancillary services such as laboratory, pharmacy, and similar services within a reasonable distance of the PCP. ▸ **Timely access.** Nonurgent ancillary care appointments (lab work, diagnostic testing, treatment of illness or injury) within 15 business days of request.	▸ **Geographic access.** *Outpatient retail pharmacies:* adequate number located in sufficient proximity to covered persons to permit adequate routine and emergency access. *Laboratories and other services:* available within a reasonable distance of the prescribing provider. ▸ **Timely access.** Nonurgent ancillary care appointments (lab work, diagnostic testing, treatment of illness or injury) within 15 business days of request.	▸ **Geographic access.** *Pharmacy:* 30 minutes / 10 miles from enrollee's residence; request for prior authorization within 24 hours.

Endnotes

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