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Network Adequacy: The Regulation of HMOs' Network of Health Care Providers

I. INTRODUCTION

In the last 15 years, purchasers of health care services have developed a variety of strategies to combat rapidly rising health care costs.¹ Collectively, these strategies have come to be called "managed care."² Perhaps the single most important and widely used managed care technique is to restrict patients to a limited network of health care providers,³ thereby gaining for the benefit of the purchaser the ability to negotiate discounts from providers, as well as the ability to monitor outcomes and to impose practice guidelines on health care providers more effectively.⁴

"Managed care plans operate by regulating the consumption of health care resources, with the clear intent of lowering consumption."⁵ One method of reducing consumption of health care is through the use of restricted networks of health care providers.⁶ Because use of such networks has become "pervasive,"⁷ the ability of a health insurance carrier to deliver the services promised to its customers through the limited network of health care providers has become "the subject of intense public and private debate."⁸

In June 1996, that debate in Missouri led to the establishment of the Joint Interim Committee on Managed Care, with Senator Joe Maxwell from Mexico, Missouri, and Representative Tim Harlan from Columbia, Missouri, as co-chairs of the committee.⁹ The Committee, made up of five House members and five Senate members,¹⁰ held several hearings, and took testimony from more than 175 citizens.¹¹ The purpose of these efforts was to find ways to "improve the quality

1. Bradford H. Gray, *Trust and Trustworthy Care in the Managed Care Era*, HEALTH AFFAIRS, Jan.-Feb. 1997, at 34, 36-37.

2. Gray, *supra* note 1, at 37.

3. Gail A. Jensen et al., *The New Dominance of Managed Care: Insurance Trends in the 1990s*, HEALTH AFFAIRS, Jan.-Feb. 1997, at 125, 125.

4. Gray, *supra* note 1, at 37.

5. Donald W. Moran, *Federal Regulation of Managed Care: An Impulse in Search of a Theory?*, HEALTH AFFAIRS, Nov.-Dec. 1997, at 7, 13.

6. Gray, *supra* note 1, at 37.

7. Moran, *supra* note 5, at 13.

8. Moran, *supra* note 5, at 13.

9. RECOMMENDATIONS TO THE MISSOURI GEN. ASSEMBLY, FINAL REPORT OF THE JOINT INTERIM COMMITTEE ON MANAGED CARE 1 (Nov. 1996).

10. *Id.*

11. *Id.*

of health care for Missouri citizens, while preserving the considerable cost savings achieved by managed care."¹²

The Committee's first two categories of recommendations to the General Assembly each involved the ability of enrollees in a Health Maintenance Organization (HMO) to have adequate access to health care providers.¹³ Specifically, the first of these recommendations was that the General Assembly adopt "network adequacy" criteria to ensure that "citizens should not have to drive long distances for care, especially if care is available in their local communities." The criteria were to be based on the National Association of Insurance Commissioners (NAIC) model legislation.¹⁴

This and many other recommendations of the Joint Interim Committee on Managed Care were signed into law in June 1997, when Governor Carnahan signed Senate Substitute for Senate Committee Substitute for House Substitute for House Committee Substitute for House Bill 335 (HB 335).¹⁵ HB 335 makes a variety of sweeping changes in how managed care is to be delivered in the state.¹⁶ Whereas the network adequacy provisions of the legislation will affect all enrollees in HMOs and Point of Service (POS) Plans,¹⁷ most provisions of the legislation will affect a much smaller number of people: those who access health care services more frequently.¹⁸ The network adequacy provisions of HB 335, therefore, have the potential to have a greater impact on the state's health delivery system than any of the other provisions enacted in the legislation.

In light of the potential impact of the network adequacy provisions of HB 335, the manner in which such provisions are implemented will play a significant role in how the state's health care delivery system will look in the

12. *Id.* at 2.

13. *Id.* at 1-2.

14. *Id.* at 1.

15. Scott Charton, *Managed Care Law Aimed at 'Abuses'*, ST. LOUIS POST DISPATCH, June 26, 1997, at A1.

16. *See, e.g.*, MO. REV. STAT. § 354.609 (Supp. 1997), pertaining to contract termination between HMOs and health care providers; MO. REV. STAT. § 354.615 (Supp. 1997), requiring standing referrals to specialists for patients diagnosed with a life-threatening illness, or degenerative disease; MO. REV. STAT. § 354.618 (Supp. 1997), requiring that HMOs offer an "open referral plan" under certain circumstances; MO. REV. STAT. § 376.1361 (Supp. 1997), requiring, among other things, that utilization review programs be "based on sound clinical evidence," that decisions be reviewed by a licensed clinical peer, and be completed in a timely manner; MO. REV. STAT. § 376.1367 (Supp. 1997), adopting a "prudent layperson" standard for emergency services; MO. REV. STAT. § 376.1387 (Supp. 1997), providing for the independent review by the Director of the Department of Insurance and independent medical panels with which the director contracts for the resolution of disputes between health carriers and patients.

17. MO. REV. STAT. § 354.603 (Supp. 1997).

18. Walter A. Zelman, *Consumer Protection in Managed Care: Finding the Balance*, HEALTH AFFAIRS, Jan.-Feb. 1997, at 158, 161.

future. This Law Summary will examine how HB 335 has changed the manner in which the state may regulate HMOs' health care provider networks, and make recommendations concerning how that new authority should be utilized.

II. LEGAL BACKGROUND

In 1983, the General Assembly passed HB 127 which, for the first time, addressed the state regulation of HMOs separately from that of traditional insurance companies.¹⁹ The General Assembly required that any HMO doing business in the state at that time apply to the Director of the Division of Insurance for a Certificate of Authority to do business in Missouri.²⁰ In order to grant such a certificate, the Director of the Division of Insurance had to be satisfied that, among other things, "the health maintenance organization will effectively provide or arrange for the provision of basic health care services on a prepaid basis . . . except to the extent of reasonable requirements for copayments."²¹ The term "[b]asic health care services" was defined as "services which an enrolled population might reasonably require in order to be maintained in good health."²² The requirement that the HMO be able to effectively provide "basic health care services" was the only language in the statute upon which the Division of Insurance could rely to compel an HMO to maintain an adequate network of health care providers.²³

In order to implement HB 127, the Division of Insurance promulgated rules affecting HMOs.²⁴ Under Missouri administrative law principles, the Division of Insurance could not impose upon a regulated entity "a statement of general applicability which should have been promulgated as a rule."²⁵ A rule includes "each agency statement of general applicability that implements, interprets, or prescribes law or policy, or that describes the organization, procedure or practice requirements of any agency." Therefore, any general standards used to evaluate the adequacy of an HMO's network used by the Department of Insurance (DOI) would have to be promulgated as a rule.²⁶

Although the Division of Insurance had authority to promulgate "reasonable rules . . . as are necessary or proper to carry out the provisions of sections 354.400 to 354.550,"²⁷ the only rule which even arguably addressed network

19. MO. REV. STAT. § 354.400 (1994).

20. MO. REV. STAT. § 354.405.2 (1994). The Division of Insurance became a department due to a constitutional amendment, adopted August 7, 1990. MO. CONST. art IV, § 36(b).

21. MO. REV. STAT. § 354.410.1(2) (1984).

22. MO. REV. STAT. § 354.400.1 (1984).

23. See MO. REV. STAT. §§ 354.400-354.550 (1984).

24. See MO. CODE REGS. ANN. tit. 20, § 400 (1993).

25. MO. REV. STAT. § 536.021.1(8) (1994).

26. NME Hosps., Inc. v. Div. of Med. Servs., 850 S.W.2d 71, 74 (Mo. 1993).

27. MO. REV. STAT. § 354.485 (1984).

adequacy failed to set standards for evaluating whether an HMO had an adequate network of health care providers.²⁸ The rule, entitled "Service Area Expansion," merely required that HMOs wishing to expand their service area provide the Division of Insurance with a list of health care providers under contract with the HMO to provide health care services.²⁹ Therefore, prior to the enactment of HB 335, the requirement that HMOs provide the broadly defined "basic health care services" was the only regulatory constraint on an HMO offering to an enrollee a possible inadequate network of health care providers.³⁰ The result was that the Division (and later, Department) had limited ability to enforce network adequacy standards on HMOs.³¹ In fact, Department of Insurance personnel relied on market forces to address the adequacy of HMOs' networks, at least where competition existed.³²

The Joint Interim Committee on Managed Care recommended that the General Assembly adopt network adequacy standards based on the NAIC Managed Care Plan Network Adequacy Model Act (Model Act).³³ The purpose of the Model Act was "to establish standards for the creation and maintenance of networks by [HMOs] and to assure the adequacy, accessibility and quality of health care services offered under a managed care plan."³⁴ According to Josephine Musser, NAIC president and commissioner of insurance in Wisconsin, the Managed Care Plan Network Adequacy Model Act is one of several model acts "targeted toward addressing issues that consumers consider to be problems."³⁵

The NAIC Model Act applies to "health carriers,"³⁶ which are defined to include "any . . . entity providing a plan of health insurance, health benefits or

28. MO. CODE REGS. ANN. tit. 20 § 400-7.090 (1993).

29. MO. CODE REGS. ANN. tit. 20 § 400-7.090 (1993).

30. MO. REV. STAT. § 354.410.1 (Supp. 1997).

31. *See, e.g.*, Letters from Jim Casey, Supervisor, Department of Insurance Life & Health Section, to United HealthCare of the Midwest, Inc. (Dec. 4, 1996) and to Prudential Health Care Plan, Inc. (June 27, 1997) (on file with author); Memorandum from Jim Casey, Supervisor, Department of Insurance Life & Health Section, to Tom Bixby, Department of Insurance Director of the Division of Consumer Affairs, and Wendy Taparanskas, Department of Insurance Health Care Specialist (Dec. 23, 1997) (on file with author).

32. *Id.*

33. RECOMMENDATIONS TO THE MISSOURI GEN. ASSEMBLY, FINAL REPORT OF THE JOINT INTERIM COMMITTEE ON MANAGED CARE 1 (Nov. 1996).

34. MANAGED CARE PLAN NETWORK ADEQUACY MODEL ACT § 2 (National Ass'n of Ins. Commr's 1996).

35. John K. Iglehart, *State Regulation of Managed Care: NAIC President Josephine Musser*, 16 HEALTH AFFAIRS 36, 38 (1997).

36. MANAGED CARE PLAN NETWORK ADEQUACY MODEL ACT § 4 (National Ass'n of Ins. Commr's 1996).

health services.”³⁷ Under the Model Act, health carriers are required to “maintain a network that is sufficient in numbers and types of providers to assure that all services to covered persons will be accessible without unreasonable delay.”³⁸ The adequacy of a network is to be “established by reference to any reasonable criteria used by the [health] carrier”³⁹ in an “access plan” filed with the state insurance commissioner.⁴⁰

The “reasonable criteria” are to include factors such as physician to patient ratios, geographic accessibility, waiting times for appointments, and hours of health care providers’ operation.⁴¹ The health carrier must ensure that if it does not have under contract the type of provider needed to meet its customers’ needs, then any person needing such services may obtain them at no greater cost than if the provider were in the carrier’s network.⁴² The plan must “establish and maintain adequate arrangements to ensure reasonable proximity of participating providers . . . [while giving] due consideration to the relative availability of health care providers in the service area under consideration.”⁴³ Furthermore, the access plan must include a description of the health carrier’s network,⁴⁴ and a “process for monitoring and assuring on an ongoing basis the sufficiency of the network to meet the health care needs of populations that enroll in managed care plans.”⁴⁵

The Model Act contemplates that each health carrier establish its own independent “reasonable criteria” in the development of a plan⁴⁶ and that the plan be submitted to (or otherwise be available to) the state’s insurance

37. MANAGED CARE PLAN NETWORK ADEQUACY MODEL ACT § 3. Under ERISA, the state’s jurisdiction would not extend to self-insured plans. 29 U.S.C. § 1001-1461 (1994). In 1995, 46% of people with health insurance through their employers were covered by ERISA qualified self-insured plans, so surprisingly few people are affected by state insurance regulation. Jensen, *supra* note 3, at 128.

38. MANAGED CARE PLAN NETWORK ADEQUACY MODEL ACT § 5A (Nat’l Ass’n of Ins. Commr’s 1996).

39. MANAGED CARE PLAN NETWORK ADEQUACY MODEL ACT § 5A (Nat’l Ass’n of Ins. Commr’s 1996).

40. MANAGED CARE PLAN NETWORK ADEQUACY MODEL ACT § 5B (Nat’l Ass’n of Ins. Commr’s 1996).

41. MANAGED CARE PLAN NETWORK ADEQUACY MODEL ACT § 5A (Nat’l Ass’n of Ins. Commr’s 1996).

42. MANAGED CARE PLAN NETWORK ADEQUACY MODEL ACT § 5A(1) (Nat’l Ass’n of Ins. Commr’s 1996).

43. MANAGED CARE PLAN NETWORK ADEQUACY MODEL ACT § 5A(2) (Nat’l Ass’n of Ins. Commr’s 1996).

44. MANAGED CARE PLAN NETWORK ADEQUACY MODEL ACT § 5B(1) (Nat’l Ass’n of Ins. Commr’s 1996).

45. MANAGED CARE PLAN NETWORK ADEQUACY MODEL ACT § 5B(3) (Nat’l Ass’n of Ins. Commr’s 1996).

46. MANAGED CARE PLAN NETWORK ADEQUACY MODEL ACT § 5A (Nat’l Ass’n of Ins. Commr’s 1996).

commissioner.⁴⁷ Some states would give the commissioner approval authority over the plan,⁴⁸ but all states adopting the Model Act would allow the commissioner to “institute a corrective action” in the event that the “health carrier has not contracted with enough participating providers to assure that covered persons have accessible health care services in a geographic area, or that a health carrier’s access plan does not assure reasonable access to covered benefits.”⁴⁹ Although the commissioner is given wide latitude in determining whether a violation has taken place,⁵⁰ it is the responsibility of each health carrier to establish the specific criteria by which its own network should be evaluated for adequacy under the Model Act.⁵¹

One of the purposes of the Model Act is to assure that enrollees receive high-quality health care from managed care plans.⁵² However, the regulatory structure of the managed care industry (indeed, the health insurance industry as a whole) creates “perverse incentives” to “avoid enrolling potentially high cost patients and . . . to displease high-cost patients among existing enrollees.”⁵³ Generally speaking, health insurers—including managed care companies—are free to weed out or isolate high-risk patients or groups.⁵⁴ Although competition for healthy patients may be fierce, the ability to avoid high-risk patients is key to an insurer’s ability to keep costs down.⁵⁵

The “perverse incentive” to weed out high-risk patients can be focused to an extraordinary degree: one percent of patients account for thirty percent of health care costs, and five percent account for sixty percent of costs.⁵⁶ The result is that the health insurance industry’s “perverse incentive” encourages HMOs to

47. MANAGED CARE PLAN NETWORK ADEQUACY MODEL ACT § 5B (Nat’l Ass’n Ins. Commr’s 1996). *See also* the drafting note for Section 5B.

48. MANAGED CARE PLAN NETWORK ADEQUACY MODEL ACT § 5B(Nat’l Ass’n Ins. Commr’s 1996). *See also* the drafting note for Section 5B.

49. MANAGED CARE PLAN NETWORK ADEQUACY MODEL ACT § 10 (Nat’l Ass’n Ins. Commr’s 1996).

50. MANAGED CARE PLAN NETWORK ADEQUACY MODEL ACT § 10 (Nat’l Ass’n Ins. Commr’s 1996).

51. MANAGED CARE PLAN NETWORK ADEQUACY MODEL ACT § 5A (Nat’l Ass’n Ins. Commr’s 1996).

52. Iglehart, *supra* note 35, at 38.

53. Iglehart, *supra* note 35, at 38.

54. There are few requirements that insurers provide health coverage to those they would rather not cover, and those few requirements invariably allow insurers to set rates based on concentrating the high-risk patients into high-risk rating pools. For example, although the Small Employer Health Insurance Availability Act requires that insurers sell policies to small employers, it allows those employers to be concentrated into isolated pools. MO. REV. STAT. § 379.400-379.415 (1994).

55. U.S. GOV’T GENERAL ACCOUNTING OFFICE, HEALTH CARE REFORM: CONSIDERATIONS FOR RISK ADJUSTMENT UNDER COMMUNITY RATING 4 (Sept. 1994).

56. Gray, *supra* note 1, at 45.

focus marketing efforts on the healthy, and to (at best) ignore the unhealthy.⁵⁷ This marketing focus is reflected—whether through intentional action or not—in data collection and quality evaluation techniques.⁵⁸ Health plans typically evaluate quality of care based on “primary care and preventive services [rather] than on care of patients with significant health care problems.”⁵⁹ Data useful for assessing the quality of care provided to those patients with serious illnesses is not “routinely available.”⁶⁰ Although such data is not available in part because of the complexity and expense necessary to make such data meaningful,⁶¹ the fact that it is not collected makes it difficult for those with serious illnesses to make informed decisions based on the quality of care provided by an HMO.⁶² Quality of care data available to enrollees typically focuses on quality of care for those individuals who are most healthy.⁶³

The result of this “perverse incentive” also is reflected in consumer satisfaction surveys: the better an enrollee’s self-reported health, the higher his or her satisfaction with the HMO.⁶⁴ Obviously, the converse is also true: the lower an enrollee’s self-reported health, the lower his or her satisfaction with the HMO.⁶⁵ This statistical relationship is “quite strong”⁶⁶ and is the only variable, other than ability to choose between plans, to have a significant impact on the extent of a member’s satisfaction with an HMO.⁶⁷

In sum, the regulatory structure of the health insurance industry produces a powerful incentive to encourage the enrollment of healthy patients, and discourage the enrollment of unhealthy patients.⁶⁸ HMOs, employers, and enrollees have yet to overcome this incentive in addressing quality of care issues.⁶⁹

57. Gray, *supra* note 1, at 45.

58. Gray, *supra* note 1, at 45.

59. Gray, *supra* note 1, at 45. HEDIS (Health Plan Employer Data and Information Set), the most widely used industry standard for data collection, has “itself acknowledged [these] shortcomings.” Gray, *supra* note 1, at 45.

60. Elizabeth A. McGlynn, *Six Challenges in Measuring the Quality of Health Care*, 16 *HEALTH AFFAIRS* 7, 19 (1997).

61. McGlynn, *supra* note 60, at 19.

62. McGlynn, *supra* note 60, at 19.

63. Gray, *supra* note 1, at 45.

64. Ralph Ullman, et al., *Satisfaction and Choice: A View from the Plans*, 16 *HEALTH AFFAIRS* 209, 213 (1997).

65. Ullman, *supra* note 64, at 213.

66. Ullman, *supra* note 64, at 213.

67. Ullman, *supra* note 64, at 213.

68. Gray, *supra* note 1, at 45.

69. Gray, *supra* note 1, at 45.

III. RECENT DEVELOPMENTS

A. *Factors Leading to the Passage of HB 335*

In the late 1980s and early 1990s, health care costs increased dramatically, leading many to describe the problem as a “crisis.”⁷⁰ Managed care is generally credited with playing a significant role in getting health care costs under control⁷¹ and has been able to do so because “[t]he use of managed care has skyrocketed since 1993.”⁷² Missouri’s experience has been similar to that of the rest of the nation: although HMO membership growth remained fairly slow between 1987 and 1991, growing from 413,017⁷³ to just over one-half million enrollees in 1991 (an average growth of five percent per year),⁷⁴ by the end of 1996, the number of people in the state covered by HMOs had increased to more than 1.3 million enrollees (an average growth rate of more than twenty-one percent per year).⁷⁵

This growth in membership was particularly rapid in public sector health programs. Medicaid and Medicare enrollment increased from no enrollees in 1992,⁷⁶ to more than one-quarter million in 1996.⁷⁷ Furthermore, the University of Missouri and the Missouri Consolidated Health Care Plan⁷⁸ (providing health care coverage to most state employees) both moved to HMO plans in 1994 and 1995. This large new market provided the incentive for HMOs to move to central Missouri, which went from having one HMO in 1992⁷⁹ to fourteen in 1996.⁸⁰ The result was that in a very short period of time, many enrollees were

69. Alain C. Enthoven & Sara J. Singer, *Markets and Collective Action in Regulating Managed Care*, 16 HEALTH AFFAIRS 26, 27 (1997).

71. Enthoven & Singer, *supra* note 70, at 27.

72. Jensen, *supra* note 3, at 126.

73. STATISTICS SECTION, DIVISION OF INSURANCE, MISSOURI DEP’T OF ECONOMIC DEVELOPMENT, MISSOURI HEALTH MAINTENANCE ORGANIZATION REPORT, COMPILED FOR YEAR ENDING DECEMBER 31, 1987 (1988).

74. STATISTICS SECTION, MISSOURI DEP’T OF INSURANCE, MISSOURI HEALTH MAINTENANCE ORGANIZATION REPORT 15 (1995).

75. STATISTICS SECTION, MISSOURI DEP’T OF INSURANCE, MISSOURI HEALTH MAINTENANCE ORGANIZATION REPORT 15 (1997).

76. STATISTICS SECTION, MISSOURI DEP’T OF INSURANCE, MISSOURI HEALTH MAINTENANCE ORGANIZATION REPORT 15 (1997).

77. STATISTICS SECTION, MISSOURI DEP’T OF INSURANCE, MISSOURI HEALTH MAINTENANCE ORGANIZATION REPORT 15 (1997).

78. *Managed Competition to Save State \$110 to \$150 Million over Five Years*, MISSOURI CONSOLIDATED HEALTH CARE PLAN MEDIA RELEASE 2 (Sept. 27, 1994).

79. STATISTICS SECTION, MISSOURI DEP’T OF INSURANCE MISSOURI HEALTH MAINTENANCE ORGANIZATION REPORT (1992). Only one of the plans reported in the document covers counties in central Missouri.

80. STATISTICS SECTION, MISSOURI DEP’T OF INSURANCE, MISSOURI HEALTH MAINTENANCE ORGANIZATION REPORT 1996, at 6 (1997).

exposed to HMO coverage for the first time, and many health care providers began contracting with HMOs for the first time.⁸¹

The exposure to utilization review, new payment methods, practice monitoring and practice guidelines associated with managed care,⁸² as well as the discounts negotiated by managed care plans, have led many health care providers to protest their loss of autonomy and power.⁸³ "Managed care shifts much control over the flow of dollars and patients from physicians to [HMOs] that have strong economic goals and the power to influence patient care in the pursuit of those goals. This combination of purpose and power" has led to dissention among HMOs, providers, and the groups representing those providers.⁸⁴ These provider groups typically have "far more political clout than a coalition of 'out-of-town gunslinger' HMO companies,"⁸⁵ and they brought that clout to bear in support of HB 335.⁸⁶

Similarly, consumer concerns with managed care include the "reduction in choice of physicians that is inherent in most managed care plans."⁸⁷ The result of the concerns of health care providers in conjunction with concerns of health care consumers has been "an unprecedented assault, driven by charges and fears that the rush to lower costs will reduce access to care, quality of care, choice of providers, and basic consumer protections."⁸⁸ The "assault" has been sufficiently effective to gain the attention of the National Governors' Association, which recently held a conference devoted solely to the regulation of managed care.⁸⁹ President Clinton, whose Advisory Commission on Consumer Protection and Quality in the Health Care Industry developed a

81. STATISTICS SECTION, MISSOURI DEP'T OF INSURANCE, MISSOURI HEALTH MAINTENANCE ORGANIZATION REPORT 1996, at 6 (1997).

82. Gray, *supra* note 1, at 37.

83. Gray, *supra* note 1, at 37.

84. Gray, *supra* note 1, at 37.

85. Moran, *supra* note 5, at 9.

86. *E.g.*, the Missouri State Chiropractors Association, the Missouri Association of Osteopathic Physicians and Surgeons, the Missouri Society of the American College of Osteopathic Family Physicians, the Missouri State Medical Society, the Missouri Dental Association, the Metropolitan Medical Society of Greater Kansas City, the Missouri State Board of Registration for the Healing Arts, and the Missouri Pharmacy Association, to name a few, each supported HB 335 (written statements and testimony on file with the author).

87. Zelman, *supra* note 18, at 159.

88. Zelman, *supra* note 18, at 158.

89. *Some States Already Enforcing Rights for Consumers Enrolled in Managed Care*, 5 HEALTH CARE POLICY REPORT 1 (1997).

managed care Consumer Bill of Rights,⁹⁰ Congress,⁹¹ and many state legislatures.⁹² In Missouri, the “assault” led to the passage of HB 335.

B. Network Adequacy in HB 335

Reflecting the concerns of consumers and health care providers, the General Assembly made an adequate network of health care providers one of its chief concerns when passing HB 335.⁹³ The legislation requires that an HMO “provide its enrollees with adequate access to health care providers.” The bill inserted this provision in the list of requirements for issuance of a certificate of authority to do business in the state.⁹⁴ Similar language⁹⁵ requires that an HMO show that it has a sufficient number of providers in its application for a certificate of authority.⁹⁶

Substantially more detailed language was adapted from the NAIC Model Act, with a few significant modifications.⁹⁷ First, whereas the Model Act states that the adequacy of the network may “be established by reference to any reasonable criteria used by the [health] carrier,”⁹⁸ HB 335 states that the adequacy of the network “shall be determined by the director [of the Department of Insurance] . . . and by reference to any reasonable criteria.”⁹⁹ Second, where the Model Act grants the commissioner rulemaking authority,¹⁰⁰ HB 335 does not contain an additional grant of rulemaking authority for purposes of HMO-related provisions.¹⁰¹ Finally, the legislation requires an HMO to “make its

90. ADVISORY COMMISSION ON CONSUMER PROTECTION AND QUALITY IN THE HEALTH CARE INDUSTRY, *Consumer Bill of Rights and Responsibilities, Report to the President of the United States* (Nov. 1997).

91. See, e.g., HR 1415, 105th Session of Congress, 1st Session, sponsored by Representative Norwood et al.

92. Zelman, *supra* note 18, at 158.

93. RECOMMENDATIONS TO THE MISSOURI GEN. ASSEMBLY, FINAL REPORT OF THE JOINT INTERIM COMMITTEE ON MANAGED CARE I (Nov. 1996).

94. MO. REV. STAT. § 354.410.1 (Supp. 1997).

95. MO. REV. STAT. § 354.405.3(13) (Supp. 1997) (“Evidence demonstrating that the health maintenance organization has provided its enrollees with adequate access to health care providers . . .”).

96. MO. REV. STAT. § 354.405.3 (Supp. 1997).

97. MO. REV. STAT. § 354.603.1 (Supp. 1997).

98. MANAGED CARE PLAN NETWORK ADEQUACY MODEL ACT § 5A (Nat’l Ass’n of Ins. Commr’s 1996) (emphasis added).

99. MO. REV. STAT. § 354.603.1 (Supp. 1997) (emphasis added).

100. MANAGED CARE PLAN NETWORK ADEQUACY MODEL ACT § 11 (Nat’l Ass’n of Ins. Commr’s 1996).

101. See MO. REV. STAT. § 354.600-354.636 (Supp. 1997).

entire network available to all enrollees unless a contract holder has agreed in writing to a different or reduced network.”¹⁰²

In order for the Department of Insurance to enforce network adequacy standards consistently and fairly, it must be able to use “a statement of general applicability that implements, interprets, or prescribes law or policy”¹⁰³ and must, therefore, promulgate rules to define its policy.¹⁰⁴ No new rulemaking authority was granted the Department of Insurance specific to the network adequacy provisions of HB 335.¹⁰⁵ However, HB 335 requires that an HMO be “able to provide its enrollees with adequate access to health care providers” as a condition of licensure.¹⁰⁶ Because the Department of Insurance has rulemaking authority over licensure provisions,¹⁰⁷ it should be able to promulgate rules defining an adequate network and require that such a network be a condition of licensure.

HB 335 was a legislative response to a consumer and health care provider “assault” on managed care. Although much of the bill, and the network adequacy provisions in particular are based on NAIC Model Acts, the General Assembly determined that the Department of Insurance, rather than each individual HMO, was the appropriate entity to determine what constitutes an adequate network. Because the General Assembly required that HMOs give enrollees “adequate access to health care providers,”¹⁰⁸ the Department of Insurance has broad authority in regard to network adequacy.

IV. DISCUSSION

HMOs object to regulation of networks on the grounds that rigid requirements designed by government will lead to “cookie cutter” health care plans and stifle the creativity of the market.¹⁰⁹ However, the fact that the legislature determined that the Department of Insurance should establish the adequacy of an HMO’s network rather than a health carrier¹¹⁰ clearly suggests that the legislature had limited faith that the marketplace could address the issue.

102. MO. REV. STAT. § 354.603.1(4) (Supp. 1997).

103. MO. REV. STAT. § 536.010 (4) (1994).

104. MO. REV. STAT. § 536.021.1(8) (1994).

105. *See* MO. REV. STAT. §§ 354.600-354.636 (Supp. 1997).

106. MO. REV. STAT. § 354.410.1(10) (Supp. 1997).

107. MO. REV. STAT. § 354.485 (1994) gives the director of the Department of Insurance rulemaking authority for Missouri Revised Statute Sections 354.400 to 354.550 (1994), and the licensure requirements pertaining to network adequacy are in MO. REV. STAT. § 354.410.1(10) (Supp. 1997).

108. MO. REV. STAT. § 354.410.1(10) (Supp. 1997).

109. Letter from Michael G. Winter, Executive Director of the Missouri Association of Health Plans, to Tom Bixby, Director of the Division of Consumer Affairs, Department of Insurance (Jan. 8, 1998) (on file with author).

110. MO. REV. STAT. § 354.603.1 (Supp. 1997).

The question then becomes under what circumstances the Department of Insurance should rely on regulation, as opposed to relying on the marketplace, to protect consumers from inadequate networks of health care providers.

Network adequacy is, in part, a quality of care issue. Although large employers have begun to consider quality issues in the marketing of health care coverage,¹¹¹ “[f]ew purchasers have ever terminated an HMO contract because the quality of the plan’s care . . . was poor.”¹¹² In addition, quality issues have failed to approach the significance of price as a factor in purchasing.¹¹³ Smaller employers are less likely to be involved in addressing quality issues than larger employers.¹¹⁴ Smaller employers are also more likely to be covered by state-regulated plans than large employers,¹¹⁵ and smaller employers are increasingly moving to managed care products.¹¹⁶ For purposes of state-regulated managed care plans, therefore, quality of care does not seem to be adequately addressed by market forces.

Market forces probably have some impact on the number of providers in an HMO’s network: one factor positively affecting consumers’ choice of HMOs is a broad network of health care providers.¹¹⁷ But, to the extent employer groups have attempted to get HMOs to address these issues, the results have focused on primary care and preventive services¹¹⁸ rather than the needs of the least healthy. As noted above, HMOs have the “perverse incentive” to “displease high-cost enrollees”¹¹⁹ and, at the same time, they have the incentive to encourage healthy people to become members.¹²⁰ HMOs, therefore, have very strong financial incentives to offer a less than adequate network of specialty care providers—who provide care to high-cost enrollees, and have at least a moderate market incentive to develop a broad primary care provider network, which would provide services predominately to healthy patients. Although market forces are arguably beginning to address network adequacy issues, then, the needs of the least healthy are not being addressed. As a result, whereas market creativity may be able to address consumers’ desire to have a large network of primary care providers, it is unlikely to address the needs of the five percent of HMO enrollees who are responsible for sixty percent of the costs.¹²¹

111. Gray, *supra* note 1, at 44.

112. Michael H. Bailit, *Ominous Signs and Portents: A Purchaser’s View of Health Care Market Trends*, 16 HEALTH AFFAIRS 85, 86 (1997).

113. *Id.*

114. Zelman, *supra* note 18, at 163.

115. Iglehart, *supra* note 35, at 39-40.

116. Jensen, *supra* note 3, at 127.

117. Bailit, *supra* note 113, at 86.

118. Gray, *supra* note 1, at 45.

119. Gray, *supra* note 1, at 45.

120. U.S. GOV’T GENERAL ACCOUNTING OFFICE, HEALTH CARE REFORM: CONSIDERATIONS FOR RISK ADJUSTMENT UNDER COMMUNITY RATING 4 (Sept. 1994).

121. Gray, *supra* note 1, at 45.

Another aspect of network adequacy for which market forces are unlikely to satisfactorily address the needs of enrollees is in physician shortage areas.¹²² These areas have too few health care providers to serve the needs of the population.¹²³ These areas are also less likely to have large employers who purchase health coverage based, at least in part, on quality of care.¹²⁴ As a result, the marketplace is not likely to address the network adequacy needs of individuals living in physician shortage areas.

V. CONCLUSION

Although managed care has effectively brought the cost of health care under control,¹²⁵ many of the strategies employed to do so have come under fire.¹²⁶ As a result of consumer and provider concerns about managed care,¹²⁷ the Missouri General Assembly passed and Governor Carnahan signed HB 335, which provided for extensive reforms in how managed care will operate in the state.¹²⁸ Included among these reforms is the requirement that HMOs "provide its enrollees with adequate access to health care providers."¹²⁹ In HB 335, the General Assembly gave the Director of the Department of Insurance the responsibility for determining what constitutes an adequate network of providers.¹³⁰

Although discussion of the quality of health care provided by HMOs has begun to take place in the marketing of health care coverage,¹³¹ such discussions take place primarily among large employers not affected by state regulation,¹³² and rarely affect purchasing decisions.¹³³ Health insurers, including HMOs, have the incentive to encourage healthy customers to enroll in their network,¹³⁴ and to discourage unhealthy customers from Department of Insuranceng so.¹³⁵

122. Physician shortage areas are geographic regions designated by the Health Care Financing Administration. The agency identifies areas in the country which have an insufficient supply of health care providers to meet the needs of the population. In Missouri, physician shortage areas are primarily rural areas, although inner-city Kansas City and St. Louis are also so designated.

123. *Id.*

124. Zelman, *supra* note 18, at 163.

125. Enthoven, *supra* note 70, at 27.

126. Gray, *supra* note 1, at 37.

127. Moran, *supra* note 5, at 13. *See also supra* note 78.

128. *See supra* note 16.

129. MO. REV. STAT. § 354.410.1(10) (Supp. 1997).

130. MO. REV. STAT. § 354.603.1 (Supp. 1997).

131. Gray, *supra* note 1, at 44.

132. Iglehart, *supra* note 35, at 39-40.

133. Bailit, *supra* note 113, at 86.

134. U.S. Government Accounting Office, *supra* note 121, at 4.

135. Gray, *supra* note 1, at 45.

The greatest need for regulation of network adequacy is in the area of care provided to the least healthy of a plan's enrollees and to those living in physician shortage areas. The Department of Insurance should develop network adequacy standards which focus most heavily on specialized care for unhealthy enrollees, and on ensuring adequate coverage for those in physician shortage areas. To the extent possible, the rules should allow plans flexibility so as to enable market forces to address quality issues. However, market forces are not effectively addressing concerns about network adequacy for those individuals who are most vulnerable in the health care system. Allowing HMOs the flexibility to address those needs—without more—would seem to be abdication of the responsibility given to the Department of Insurance by the General Assembly in HB 335.

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