Strategic Discussion
The Use of Market Forces-Power in Negotiating Rates

Background: The board of directors already recognizes that: (a) Voters and policymakers increasingly identify the rising costs of health care and health insurance as a critical problem; (b) The Denver Metro Chamber of Commerce (DMCC) and other chambers/business coalitions will help drive efforts to contain costs in the 2019 Legislature whether or not there is consensus on solutions by other stakeholders; (c) Efforts to increase health care cost transparency and the public publication of meaningful data whether by ballot initiative or legislation will continue if not accelerate as the subject enjoys bipartisan support. In response, the board has appointed a one-time work group to guide CMS efforts to influence reductions in the cost of care, while ensuring quality.

Why the board is having a strategic discussion on market forces: Health plans have privately been making the make the case for several years that sole source providers, both physician groups and hospitals, demand and receive unreasonable commercial rates, while CMS has been publicly vocal about members routinely complaining that health insurers exert and use significant market power over their practices. Now comes Colorado Department of Insurance ("DOI") Interim Commissioner Mike Conway floating a draft, proposed rule that allows health insurance carriers to obtain a waiver from geographic-access network-adequacy requirements under certain circumstances. The Commissioner intends to be responsive to price variation and the use of network adequacy rules by some providers to leverage unreasonable commercial rates. What has been an under-the-radar discussion in the past has now been elevated to a public policy debate in the full view of interested stakeholders and the public.

Current CMS Public Positioning: In responding to Commissioner Conway's draft waiver rule, CMS positioned the organization in the following way:

> Please know that you have our full cooperation and candor as you seek to find a workable means of balancing the legitimate interests of all parties—patients, doctors, and health insurance companies. Colorado, like most states, struggles with how to determine a fair and rational process for setting a subjective standard for physician networks that will assure timely access to cost-effective medical care while also minimizing the risk of exploitation by either provider organizations or health insurance companies. While we cannot support this narrow approach to rule making, we would welcome a complete and thorough review of DOI network adequacy rules including market forces.

Strategic Questions:

1. Now that CMS is positioned, what next?

2. What is the role of CMS as this issue further unfolds in the public policy space?
3. Who owns the problem and who else cares?

Issue Overview:

The Consumer Protection Standards Act ("CPSA") requires health insurance carriers that provide a managed care plan to maintain a provider network that is sufficient to assure that all covered benefits are accessible to their insureds without unreasonable delay. In the case of emergency services, a covered person must have access to health care services 24 hours per day, 7 days per week. The statute identifies the criteria to be used in determining the sufficiency of the network, and DOI has promulgated network adequacy rules as Rule 4-2-53.

When the CPSA was originally enacted, the prevailing thought was that freely negotiated network arrangements would produce market efficiencies that benefited all industry participants and consumers. Commercial health insurance companies would be generally free to select which providers would serve on their panels (i.e., to be "in network") and, conversely, health care providers would be generally free to choose which commercial health insurance plans' networks they would apply to join. Consequently, good faith negotiations on the part of both parties would presumably produce mutually beneficial contract terms that provided for adequate networks and timely, more cost-effective access to quality care for patients.

While health insurance companies do work collaboratively with practices to improve care value, market conditions that influence these relationships have prompted carriers to also adopt a back-to-the-Nineties strategy for mitigating increased costs, including the tiering and downsizing of provider networks and the institution of tighter utilization controls for many of our members. In this new world of narrow provider networks, which by design limit patient choice, network adequacy regulations are purported to being used by both providers and health insurance companies as leverage in rate negotiations. Physicians without the market leverage cannot effectively challenge terms they find disadvantageous since being exiled to out-of-network status can cripple their economic viability and carrier's argue sole source or regionally dominant providers can effectively insist and receive higher commercial rates.