COLLEGE of AMERICAN PATHOLOGISTS

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Examining the State of Health Care's Private Payers and the Adverse Impact of Insurance Interference

Contents

Introduction

Patients expect insurers to pay for their medical care, not control it.

Just as a patient should be able to see the surgeon, cardiologist, or other physician of their choice without excessive insurance interference, that physician should be able to work with their trusted/preferred "home team" pathologist to provide the best possible care for their patients. It should be up to the patient and their doctor – not corporations – to determine where diagnostic services occur, with the common goal of delivering the healthiest outcome.

Although patients may never meet the pathologist on their care team, they can be assured that these experts deliver quality and care at every step. On any given day, pathologists impact nearly all aspects of patient care, from diagnosing cancer to managing chronic diseases such as diabetes through accurate laboratory testing. Pathologists ensure laboratory quality so that diagnostic testing is safe and accurate. Often, they guide primary care and other doctors, determining the right test, at the right time, for the right patient. During the COVID-19 crisis, pathologists were on the frontline, responsible for ensuring prompt and accurate testing for patients and health care providers alike. **The influence of pathology services on clinical decision-making is pervasive and constitutes a critical infrastructure and foundation of appropriate team-based care.**

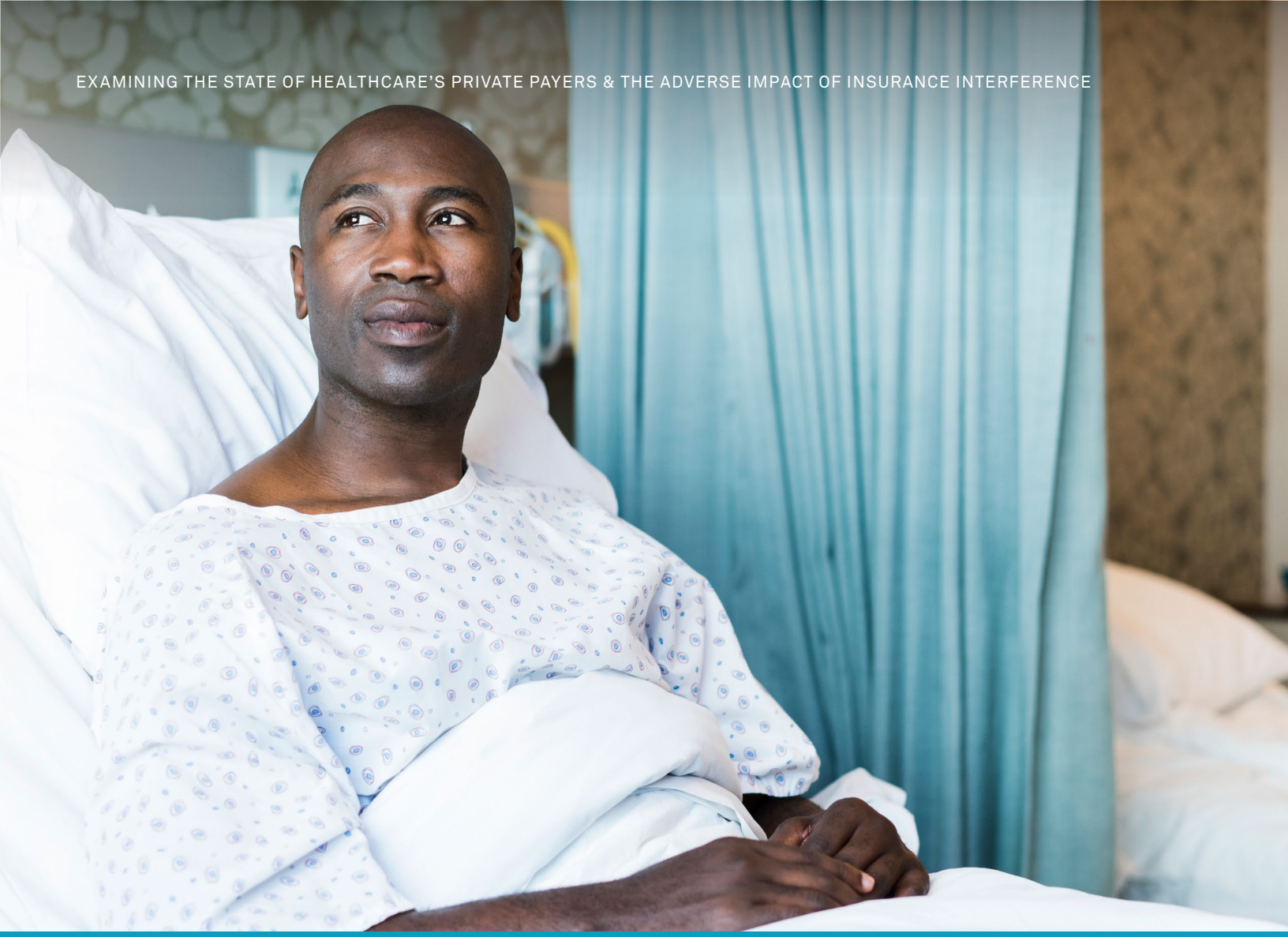
Unfortunately, private health insurers are increasingly interfering in patient-physician and physician-physician relationships, by inappropriately limiting the number of in-network physicians, or exclusively contracting with particular providers/facilities. Two-thirds of the country's population is covered by private health insurance, yet the coverage provided is less and less meaningful.[i] Pathologists are seeing increasing instances of insurance companies dictating medical decisions with the goal of boosting revenue under the guise of controlling costs. While cost is certainly a factor in health care decisions, it's not the only factor and should never be the primary driver of decision-making. In the end, care decisions must be left to patients and their physicians.

"Whether its through third-party entities like Multiplan or using tactics such as narrow provider networks and restrictive prior authorization policies, insurers have the perverse incentive to boost revenue over offering adequate payment for adequate patient care under the guise of 'controlling costs.'"

Donald Karcher, MD, FCAP, College of American Pathologists President
Letter to the Editor, The New York Times, April 28,2024

As for physicians, they are increasingly being forced out of network. That's devastating in areas of the country where insurers have consolidated and represent large portions of the local patient population.

Patients and their treating physicians should be able to rely on the expertise of pathologists and the availability of appropriate testing. Pathologists are guiding hospitals and health systems to make decisions that ensure testing and diagnostic accuracy, improve patient care for better patient outcomes, mitigate risks, and ensure quality.



RECOMMENDATIONS AT-A-GLANCE

1. Require adequate networks that include hospital/facility-based physicians (e.g. anethesiologist, hospitalist, pathologist, radiologist, emergency room physician)

2. Restrict in-network steering/tiering and prohibit economic/cost-only network criteria. Physicians should not be inappropriately constrained in their referrals and integrated care delivery should be strengthened in the best interests of the patient, not the insurers.

3. Maintain physician-led team-based care. The best way to support high quality care and lower costs is to keep physicians as the leader of the health care team.

4. Include regular monitoring/audits and meaningful enforcement. Requirements must include a mechanism by which providers and enrollees are able to file formal complaints about network adequacy with regulators.

5. Increase antitrust scrutiny. Reversing the trend toward consolidation in health insurance markets is needed to cut health care costs, improve outcomes, and increase the quality of care.

How did we get here?

Insurance consolidation.

The health insurance industry is a highly consolidated one, and in recent years insurers have increasingly used their market power to impose rate cuts and other burdens on pathologists. According to an American Medical Association (AMA) report on competition in health insurance, in 90% of metropolitan service area markets, at least one insurer had a commercial market share of 30% or greater, and in 48% of markets, a single insurer's share was at least 50%.[ii] The American Hospital Association (AHA) has emphasized that consolidation has "undoubtedly contributed to the industry's proclivity for anticompetitive conduct."[iii] Relatedly, in a recent survey of members, the AHA found that 78% of hospitals and health systems' experience working with commercial insurers was getting worse, not better. Similarly, two US Senators wrote to the Federal Trade Commission (FTC) with concerns that "[d]ecades of consolidation by health insurance brokers has primed the industry for abuse, allowing insurers to exert market power in order to raise premiums, restrict competition, and deny consumers choice."[iv]

This consolidation and improper conduct leaves physicians with little negotiating/bargaining room to secure appropriate contracts. As the AMA states in the above report, most health insurance markets are ripe for the exercise of health insurer market power, which harms consumers and providers of care. Increased market consolidation gives insurers more leverage to lower the payments they provide to physicians "while allowing insurers to impose administrative requirements on physician practices in a whole host of ways, including increased prior authorization demands and heavier burdens of paperwork and electronic health record documentation."[v] According to a recent report published by the Healthcare Financial Management Association (HFMA), about 84% of health system CFOs cited lower reimbursement rates from payers as the top cause of low operational margins.[vi]

"The DOJ is also looking into another element of UnitedHealth's vertical consolidation that can make the strategy very lucrative for insurers. Payers are motivated to acquire physician practices because their parent company can essentially pay itself for providing care, allowing them to sidestep regulations capping how much in members premiums they can retain as profit."

Rebecca Pifer, Senior Reporter
Health Care Dive, February 28, 2024

Additionally, the recent Department of Justice (DOJ) antitrust investigation into UnitedHealth Groupv[ii] highlights the concern that, as insurers acquire financially vulnerable physician practices, they are incentivized to steer members to owned providers, which allows them to keep more health care dollars in-house, and at the same time shrink rivals' networks by restricting access to owned providers, while hurting non-participating physicians.

Consolidation may further have created a situation where this kind of practice acquisition is made even easier: as highlighted in a recent congressional hearing, UnitedHealth Group's Optum is leveraging the financial emergency created by UnitedHealth Group's Change Healthcare cyberattack to accelerate its acquisition of physician practices.[viii] Optum is now the country's largest employer of physicians, with 90,000 on staff.[ix]

"The ongoing Change Healthcare episode reminds us of the perils of consolidation and its potential for harm to patients, physicians, physician practices and our entire health care system."

Jesse M. Ehrenfeld, MD, MPH, President of the American Medical Association "Change Healthcare hack shows need for more competition." May 1, 2024

No Surprises Act implementation.

Continued issues around the implementation of the federal No Surprises Act appear to have emboldened insurers in their efforts to impose rate cuts and other burdens on physicians, ultimately pushing providers out-of-network to further reduce payments.[x] For example, in 2021, BlueCross BlueShield of North Carolina sent letters to in-network physician practices in the state threatening contract termination and the physicians' in-network status unless the physicians immediately agreed to payment reductions ranging from 10% to over 30%.[xi] A 2023 survey found that 36% of in-network contracts were terminated, with a remarkable 81% of providers in hospital-based specialties having at least one contract terminated by an insurer.[xii] And once physicians are out-of-network, the same survey found that payments were cut 52%, with 94% of providers receiving payments priced at or below Medicare rates.

"The No Surprises Act has emboldened many payers to pull certain tricks on us, like narrowing the networks, denying claims, and making us jump through hoops with laboratory benefit managers, prior authorization, et cetera. Payers are in the driver's seat. They can challenge us, and if we don't like it, they don't mind if we go out of network, which gives them the upper hand when it comes to payment. They know it's time-consuming, laborious, and costly if we want to contest it, go through the negotiation period, and go to arbitration. They have deeper pockets and figure they can outlast us."

A. Joe Saad, MD, CPE, FCAP, Chair CAP Council on Government and Professional Affairs CAP TODAY, April 2024

The only real backstop for out-of-network physicians is the federal independent dispute resolution (IDR) process, yet pathologists have reported significant difficulties in resolving payment disputes due to the burdensome process, high administrative costs, significant backlog/delays, and continuing confusion. Still, even if you successfully navigate this process and are the prevailing party, you are not assured payment. In fact, the CAP has heard directly from pathologists who have not received payment from insurers within the 30-day statutorily required timeframe. The AMA has similarly reported hearing from physicians who are not receiving payment from insurers as required.xiii These kinds of problems will only worsen if insurers continue to face no adverse consequences for non-compliance with payment determinations and other federal IDR requirements, as such apparent impunity encourages insurers not to engage in serious and realistic efforts to negotiate participating provider agreements.

While the use of limited networks is prevalent across all kinds of plans, it has become increasingly common in Medicare Advantage, Medicaid managed care, and Affordable Care Act marketplace plans.xiv Especially for the most vulnerable populations, adding unnecessary burdens to receiving laboratory testing can interrupt continuity of care, exacerbate issues around social determinates of health, and lead to increased costs down the road.

The threat of network expulsion is particularly real for pathology – according to recent FAIR Health data, while other specialties are seeing an increase in in-network utilization, pathology in-network claims peaked in 2022 and has been declining ever since.xv In fact, recent data from a CAP-conducted survey shows that, in 2023, 19% of practice leaders reported their practice had been denied continued participation in a commercial health plan or insurer network in which it had previously been a participating provider, up from 9% in 2021. An additional 17% reported their practice attempted to join a commercial health plan or insurer network but was denied or unable to reach agreement, up from 12% in 2021.

Insurer profits and third-party consultants.

At the same time, insurers are continuing to turn substantial profits, despite increased utilization of medical services in the United States. The revenues of six for-profit parent companies of insurers made up nearly 30% of total US health spending in 2023 – compared with less than 10% in 2011.[xvi] For 2023, UnitedHealth Group brought in $22.4 billion in profit.[xvii] Meanwhile, physicians face constant decreases in reimbursement for their services while still making efforts to improve quality of care to the patients they serve.

"As a result of ongoing Medicare funding pressures, there are adjustments we can make to partially offset these rate pressures and reduction for a particular period. For example, we can seek to intensify our medical and operating cost management, make changes to the size and composition of our care provider networks, adjust member benefits and implement or increase the member premiums supplementing the monthly payments we receive from the government."

UnitedHealthcare (source: UNH 10-Q)

Whether it is a data analytics firm or a laboratory benefit management (LBM) company, third-party consultants are marketing their business as a way to help insurers lower costs and thereby increase profits. The New York Times reported on one such firm, MultiPlan, "which sells data to help insurance companies determine how much they should pay providers for out-of-network medical care, and how much of that cost is passed directly to patients."[xviii] EviCore, which "partners" with insurers, promotes "proprietary analytics" that can "highlight areas of low-value spend and pinpoint opportunities to improve care and increase savings."[xix] Kentmere Healthcare Consulting, as another example, claims to deliver "proprietary claims analysis" that "paints a clear picture for health plan executives of where their issues are and how they can save tens of millions of dollars annually."[xx] These third-party arrangements do nothing to improve care for patients –they are solely focused on improving an insurance company's bottom line.

What is the problem?

The College of American Pathologists has identified four distinct but related categories illustrating how insurers are interfering with physician services and patient care at the local level: network manipulation, reduced reimbursement, nonstandard coding requirements, and restricting patient care through prior authorization and other utilization management measures.

Steering, tiering, and other network manipulation.

Health insurance plans are increasingly relying on narrow/tiered and often inadequate networks of contracted physicians, hospitals, and other providers to shift medically necessary health care costs onto their enrollees. According to a recent Kaiser Family Foundation survey, more than a quarter (26%) of insured adults reported that an in-network physician they wanted to see in the last year did not have appointments available and 14% of respondents said their insurance did not cover the particular physician or hospital they needed.[xxi] Anticompetitive insurer-imposed policies that steer services for patients may disrupt coordination, add burdens, or lead to lower quality care. This is a particular concern for the most vulnerable patient populations, including those with low income and/or chronic conditions – as mentioned above, the use of limited networks has become increasingly common in Medicare Advantage, Medicaid managed care, and Affordable Care Act marketplace plans.

For example, in 2021 UnitedHealthcare tried to roll out a "benefit design" that requires laboratories to meet UnitedHealthcare-determined efficiency and quality requirements in order to become a "Designated Diagnostic Provider" or DDP. Facilities that did not meet these requirements (non-DDP facilities) would "remain in network," but UnitedHealthcare would not cover outpatient diagnostic laboratory services provided by

these facilities, leaving patients "liable for charges." Even with recent modifications, the CAP believes UnitedHealthcare policies that subject patients to an increased payment for services received at in-network, but non-DDP facilities, is counter to efforts to protect patients and eliminate surprise medical bills.

In New Jersey, Horizon is strictly enforcing a policy for managed care members that hospital-based pathologists are only "credentialed" and reimbursed for diagnostic services performed on patient specimens obtained in the hospital setting, while all other specimens must be sent to a "preferred" laboratory in the Horizon managed care network. These kinds of requirements prevent the local pathologist from participating in care coordination at the time of initial diagnosis or correlating these critical initial findings with subsequent surgical specimens obtained in the hospital. The CAP is committed to improving care and addressing health care costs, but disrupting care coordination can negatively affect a patient's timely diagnosis, treatment, and outcome.

"CalOptima, the Medi-Cal managed care insurer in Orange County, has eliminated four key safety net hospitals - those that care for people experiencing homelessness, substance use disorders, chronic health conditions, and more - from its network... Whatever the reason CalOptima has for dropping these hospitals, we do know that this is being done by an insurer that is holding tight to a nearly $700 million surplus that the State Auditor has reported should be used for patient care and expanding access.

Unless this situation is resolved quickly, everyone in Orange County — not just those covered by CalOptima - will face significant challenges in accessing the health care they need and deserve. With CalOptima cutting off access to these four hospitals, the burden of caring for Orange County's most vulnerable patients is now shifting to remaining local hospitals, at a time when they are already challenged with limited emergency department and inpatient capacity. This unnecessary barrier will lead to harmful delays in access to medically necessary care and to additional overcrowding in emergency departments."

Carmela Coyle, President & CEO of the California Hospital Association
Capitol Weekly, February 28, 2024

In response to our request for an explanation of Anthem's referral requirements and an opportunity to discuss our concerns further, we were told that in Virginia there is a single exclusive participating laboratory for HMO, commercial, Medicare, and Medicaid programs. "The same exclusivity applies to Georgia for HMO and commercial plans, Colorado for commercial and Medicare plans, and Nevada for commercial and Medicare plans," Anthem stated in their response.

Reduced reimbursement and "take it or leave it" contracts.

Insurer-imposed reimbursement policies that inappropriately value pathology services risk limiting access to timely and appropriate services and threaten the ability of pathologists to provide care for patients. Health insurers are slashing reimbursement across the board – or ceasing reimbursement for critical services altogether – without any individual physician/practice consideration, putting many pathologists in serious financial jeopardy across the nation. Pathology services, which often have low reimbursement rates, are especially vulnerable to systematic underpayment.

Blanket rate cuts that lower reimbursement below the cost to provide the services may benefit a few high-volume laboratories and cut costs for the payer, but they threaten the financial viability of many small or rural laboratories and practices. And – as explained above – many pathologists have little leverage or ability to opt out-of-network with powerful insurers as a result of consolidation and insurer control in their health systems and communities. Further, as the AMA recently wrote to the FTC and DOJ, "mergers of market

power health insurers tend to result in lower than competitive payments to health care providers, but there is no evidence the cost savings are passed through to consumers in the form of lower premiums."[xxii] Numerous pathologists have been forced out-of-network due to these tactics. For example, Anthem Blue Cross Blue Shield persists in offering unacceptable take-it-or-leave it contracts to pathologists and the CAP continues to hear about issues with nonpayment despite earlier media attention on the issue.[xxiii] In 2020, the CAP expressed consternation about the basis on which these new rates were calculated, especially during the middle of the COVID-19 public health emergency.[xxiv] In 2021, the AHA wrote to Anthem with concerns including frequent changes to enrollees' coverage, delays in patient care resulting from excessive prior authorization requirements, and growing failure to pay claims in a timely manner.[xxv] In 2022, the Georgia state insurance commissioner fined Anthem $5 million for failing to pay in a timely manner, delays in loading provider contracts, and inaccurate provider directories.[xxvi] **The CAP continues to hear from our members about their frustration, fears, and financial concerns, as they work through difficult business decisions that result from these changes.**

The insurer Cigna, meanwhile, has threatened nonpayment for important laboratory oversight services, known as the professional component of clinical pathology services.[xxvii] These services are critical to the reliable and accurate diagnosis and treatment of patients, particularly in delivery systems increasingly reliant upon care coordination, integration, and population management.

A recent contract negotiation between Anthem Blue Cross and UC Health also exemplifies the extent to which insurers will go to prioritize financial profit over patients.[xxviii] Anthem terminated its agreement with all UC Health locations and initiated a process to transfer tens of thousands of HMO members away from UC Health and reassign them to new health care providers who have no knowledge of their conditions and treatment needs. Though they eventually reached an understanding, this dangerous negotiating tactic disrupted the patient-physician relationship and jeopardized access to care.

"Anthem Blue Cross's decision to withdraw from the agreement with the University of California reflects its willingness to disrupt the provider-patient relationship to enhance financial priorities. Anthem Blue Cross patients may find their surgical plans upended, cancer care fragmented, and the management of chronic illnesses impeded by a lack of timely access to specialty care. The ripple effect of this decision could lead to prolonged wait times for appointments with new care teams at other health systems. This predicament is exacerbated by the existing strain on health care capacities statewide."

Sonia L. Ramamoorthy, MD, chief of colon and rectal surgery at UC San Diego Health The San Diego Union-Tribune, January 22, 2024

For pathology, insurers' prioritization of financial profits has had real consequences – 72% of practice leaders reported that their practice experienced some kind of detrimental effect due to decreased reimbursement rates for pathology services over the last five years. For example:

- 35% reported an inability to fund an adequate number of pathologists and/or other laboratorians,
- 26% reported increased turn-around time for pathology reports, and
- 9% had to decrease or completely discontinue some on-site pathologist services at one or more hospitals.

Non-standard coding requirements.

Non-standard coding and/or reimbursement practices have serious negative consequences for pathologists and laboratories trying to comply with conflicting requirements. For example, guidelines that deviate from or distort standard billing practices not only limit the ability of laboratories to provide care for patients, but this conflict creates fraud concerns, issues with state health plan contracts, and of particular concern to many patients, potential denials from secondary insurance coverage. Unnecessary changes risk interfering with the ability for a patient to receive timely and appropriate services and could negatively affect patients, providers, and the entire health care system.

For example, UnitedHealthcare recently implemented a requirement that molecular pathology claims contain DEX Z-codes, which are proprietary alpha-numeric codes obtained from the Palmetto DEX Registry. The CAP expressed to UnitedHealthcare its concerns with the requirement itself, as we continue to support the use of the CPT code set as the appropriate method to identify services. The CPT code set is universally used by the medical community and transparently developed with broad stakeholder input, including the CMS and other payers who are represented on the CPT Editorial Panel. CPT codes are also recognized by the US Department of Health and Human Services (HHS) as a HIPAA-compliant Level I HCPCS code set. Z-codes, on the other hand, do not fit these criteria or have this level of input and scrutiny. We also strongly advise adhering to the use of CPT for reporting of molecular pathology and genomic procedures, as it does not impose additional requirements and reporting complexity to process claims for medically necessary services, and maintains alignment with the reporting requirements established by other private payers. Finally, the CAP remains apprehensive about the process of obtaining Z-codes and the sharing of information between UnitedHealthcare and Palmetto. Despite UnitedHealthcare's efforts to suggest otherwise, the CAP considers this requirement to be highly disruptive, administratively burdensome, and extraordinarily expensive for pathologists and laboratories, and ultimately, it will impede patient access to medically necessary testing.

Prior authorization and other utilization management measures.

Pathologists are acutely aware that the right test at the right time can make all the difference in a patient's diagnosis, treatment, and outcome. Unfortunately, prior authorization often interferes with a patient's ability to receive timely and appropriate services/care, negatively affecting patients, providers, and the entire health care system. Recent AMA survey data show that 93% of physicians report care delays or disruptions associated with prior authorization[xxix], and as was explained in the HHS Office of Inspector General report that highlighted concerns about prior authorization within Medicare Advantage, inappropriate denials may prevent or delay beneficiaries from receiving medically necessary care and can burden providers.[xxx]

According to a recent survey of physicians conducted by Morning Consult on behalf of the AHA, 84% of employed physicians reported that administrative burden from payers — including prior authorization and reporting requirements — has adversely impacted their ability to operate an independent practice.[xxxi] **In the same survey, 81% of physicians reported that commercial insurer policies and practices interfered with their ability to practice medicine.**

Pathologists are confronted with similar challenges from LBMs. Much like PBMs, LBMs are health insurance protocols or programs that are administered by a payer or another entity under contract with the payer. These programs dictate or limit health care provider decision-making relating to the use of laboratory/pathology services. The CAP has argued that regulation of LBMs is fundamentally needed to prevent conflict of interests by entities that administer these programs and to ensure that these programs do not conflict with, subordinate, or unduly encumber the practice of medicine.

Why does this matter?

As we hear from physicians about unacceptable take-it-or-leave it contracts and/or unworkable new payment terms in contracts from insurance companies, it is clear insurers are moving forward with increasingly narrow and often inadequate networks of contracted physicians/hospitals to the detriment of patient care in communities across the country.

Recent data from a CAP-conducted survey shows that in 2023, 19% of practice leaders reported their practice had been denied continued participation in a commercial health plan or insurer network in which it was previously a participating provider, up from 9% in 2021. 17% reported their practice attempted to join a commercial health plan or insurer network but were denied or unable to reach agreement, up from 12% in 2021.

2023 Practice Leaders Survey, College of American Pathologists

Hindering access to local/community pathology services can negatively affect a patient's diagnosis, treatment, and outcome. Especially for the most vulnerable populations, adding unnecessary burdens to receiving laboratory testing can interrupt continuity of care, exacerbate issues around social determinates of health, and lead to increased costs down the road. This has severely disrupted physicians attempting to meet new standards for improving patient care and achieving healthier outcomes.

For example, as explained above, in situations where an initial diagnostic biopsy (for example, an office-based fine-needle aspiration to diagnose cancer) leads to further hospital-based care, restrictive insurer requirements can prevent the local pathologist from participating in care coordination at the time of initial diagnosis or correlating these critical initial findings with subsequent surgical specimens obtained in the hospital. For patients who live further away from their health system/hospital, returning to receive care after these initial results have been returned may be difficult, and more likely to result in delayed care and compromised health outcomes.

Further, this kind of interference adds unnecessary time to treatment since it is typical, and often required, that

the hospital-based pathologist confirm the diagnosis and assume responsibility for the patient's treatment. As acquiring outside materials can introduce significant delays in confirming diagnoses, patients may even require a second biopsy in the hospital setting to expedite care, which increases costs that may have been avoided. There are also logistical challenges and risks in dividing increasingly small diagnostic specimens to ensuring complete diagnostic and prognostic evaluation. Additionally, some conditions may require rapid diagnosis for treatment (eg, small cell carcinoma) – not always possible when sending samples to outside laboratories – to prevent serious, even life-threatening complications. Pathologists impact nearly all aspects of patient care and are critical members of the health care team, from diagnosing cancer to participating in multidisciplinary conferences with the treating physicians (eg, oncologists, surgeons) while the care plan is being formulated, to managing chronic diseases such as diabetes through ensuring accurate laboratory testing. Finally, removal of diagnostic material from the treating institution seriously undermines the important continued deliberation and discourse by the pathologists and other physicians involved in a patient's care and impairs continuing education of medical staff and trainees through those activities.

What is the solution?

Patients and their physicians having appropriate access to pathology services makes all the difference in the patient's diagnosis, treatment, and outcome. Yet, the commonly used geographic standards of time and distance do not truly capture network adequacy and community care, especially for pathology. Additionally, a physician being in-network does not mean they can provide a full range of services to all patients in their community.

Therefore, it is critical that the health care community come together to urge adoption of proposals that – taken together – protect coordinated care delivery in the best interests of patients, not insurers. These proposals must account for hospital-based physicians such as pathologists, and ensure meaningful contracts that protect local care; insurers should not unduly limit health care provider decision-making and physicians should not be inappropriately restricted in their referrals. Finally, both state and federal standards must strengthen enforcement of requirements that manage insurer interference and continue to support the physician-led health care team. Specific proposals include:

1. **Require adequate networks that include hospital/facility-based physicians** (eg anesthesiologist, hospitalist, pathologist, radiologist, emergency room physician). In the best interest of the patient, state and federal legislators should pass network adequacy legislation that requires health plans maintain robust networks of physicians to ensure timely access to care for all insured patients. We recommend states and federal agencies evaluate their approved and licensed insurance plans' networks for in-network pathologist participation adequacy as well as the timeliness, proficiency, scope of pathology services provided, including genetic analysis, and utilization of pathology services.

2. **Restrict in-network steering/tiering and prohibit economic/cost-only network criteria.** State and federal legislators/regulators should enact/implement prohibitions on the use of tiered and narrow physician networks that deny patient access to, or attempt to steer patients towards, certain physicians/facilities based primarily on cost of care factors. Prohibitions should include restrictions on anticompetitive "exclusive" or "preferred" contracts

that are in opposition to local, coordinated care in the patient's community. Network criteria should not be inappropriately driven by economic criteria – physicians should not be unduly constrained in their referrals and integrated care delivery should be strengthened in the best interests of the patient, not insurers.

3. **Maintain physician-led team-based care.** The best interests of the patient also include ensuring that care is led by physicians; and the best way to support high-quality care and lower costs is to keep physicians as leaders of the health care team.

4. **Include regular monitoring/audits and meaningful enforcement.** Requirements must include a mechanism by which providers and enrollees are able to file formal complaints about network adequacy with regulators. It is not enough to report network issues to state departments of insurance. There must be meaningful enforcement, which could include:

    a. reviewing plans prior to approval for sale,
    b. reviewing plans during an annual review process and when there are changes to networks,
    c. conducting market examination that includes a review of provider network adequacy,
    d. requiring plans to provide transparent, accessible, and updated provider directories to ensure sufficient enrollee access to health care,
    e. conducting random audits or other random reviews or examinations,
    f. conducting targeted examinations when there are concerns about the adequacy of a plan's provider network, and
    g. conducting outreach to providers regarding difficulties contracting with issuers.

5. **Increase antitrust scrutiny.** Reversing the trend toward consolidation in health insurance markets is needed to cut health care costs, improve outcomes, and increase the quality of care. State and federal officials should rigorously review and scrutinize proposed mergers to determine their effects on patients, physicians, and other health care providers. Policy changes should also place physicians on a level playing field with insurers and hospitals, and allow physicians to collectively negotiate fee schedules and other practice matters with health plans and managed care entities.

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