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Should Insurance Regulation Be Used to Promote Nontraditional Goals?

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Three policies to revamp insurance consumer protections for health care delivery are explored, with highlighted areas for improvement being maternal health coverage and loosening of network adequacy requirements.

The past 2 years have seen calls from stakeholders and experts to revise insurance consumer protection regulations to alter the landscape of health care delivery. Consumer advocates such as myself generally view insurance regulation's role as defending existing, organic patterns of health care delivery from insurer encroachments. Network adequacy requirements and coverage mandates, for example, ensure that consumers receive what they reasonably expect from a health plan: access to medically necessary care when a medical condition arises.

Should regulations go beyond this to vindicate other policy objectives? This commentary discusses 3 recent proposals, one of which has been implemented.

Loosening Network Adequacy Requirements to Counteract Provider Consolidation

Martin Gaynor, a prominent health care cost containment and antitrust enforcement advocate, includes loosening of network adequacy regulations on a long list of policy options to improve the competitiveness of health care markets. He argues that "network adequacy regulation can undermine attempts by insurers to promote competition via selective contracting [and] should therefore be narrowly tailored to achieve its goals, and should take account of impacts on competition." Not surprisingly, this view has been endorsed by deregulation advocates such as the Cato Institute.

Perhaps it's the quantitative nature of some network requirements—that is, time and distance standards—that gives rise to the idea of a consumer protection "dial" that can be modulated: Change the travel time requirement from 20 to 30 minutes so that x fewer providers are needed and prices can be cut accordingly. The floating of such a concept for a consumer protection law is unique to this context. One does not hear suggestions that, say, the Real Estate Settlement Procedures Act, which prohibits kickbacks, ought to permit kickbacks below $30 in order to increase competition among mortgage brokers.

Historically, consumer protections have been dichotomous, not continuous: a business practice is either unfair and deceptive or not unfair and deceptive; a network is either adequate or inadequate. A 50-mile drive does not become shorter as the Herfindahl–Hirschman Index rises. The statutory provision governing Medicare Advantage network adequacy requires plans to have sufficient providers that beneficiaries can access services with reasonable promptness. This requirement is unqualified, with no suggestion that it can be balanced against other considerations.

Loosening Network Adequacy Requirements to Discourage Utilization of Overused Services

In the Medicare Advantage proposed rule for contract year 2021, issued in February 2020, CMS introduced another novel goal for network adequacy rules to address: discouraging utilization of services deemed "overused." Then–HHS Secretary Alex Azar believed that overcapacity of brick-and-mortar dialysis facilities was leading to an excessive proportion of patients with kidney issues receiving treatment in these centers, rather than at home. The Trump administration decided that removing time-and-distance standards for dialysis facilities would encourage home dialysis treatments.

Of course, health policy analysts have posited that a number of medical procedures are overused (eg, spine surgery). This was the first time a regulator viewed network adequacy regulation as a tool to curb overuse. But given that the entire structure of managed care is geared toward avoiding overused services, adding this tool seems unnecessary. Health plans can use primary care gatekeeping and prior authorization to nudge patients toward less-invasive treatments. In the case of dialysis, plans can limit nephrologist credentialing to champions of home modalities or deploy case managers to ensure patients are fully informed of all treatment options. This is a belt-and-suspenders approach in which the redundant belt cinches consumer convenience.

Coverage Mandates to Address the Maternal Health Crisis

Consumer advocates have generally thought of insurance coverage mandates as a means of preserving or promoting care that has become, or is becoming, standard medical practice as ordered by most physicians. For instance, one controversy that emerged during the managed care backlash of the 1990s was so-called "drive-through deliveries." In that case, shortened hospital lengths of stay were being driven by health maintenance organizations, not by medical professionals, and clinicians joined with consumer advocates to secure regulations mandating a minimum postpartum stay.

But what if the existing medical landscape doesn't protect consumers? Should insurance regulation be used as a sword, rather than as a shield, to reshape the delivery system? The question is provoked by the deficient and deplorable state of maternal health in the United States. Experts at the Center for American Progress (CAP) argue that birth outcomes could be improved through increased use of certified professional midwives (CPMs) and doulas. One policy option CAP proposes is a coverage mandate for these categories of providers.

CAP cites evidence that these practitioners can reduce overall health expenditures. This, in turn, points up the complexity of this case: Ordinarily, states enact mandates when insurers won't cover physician-recommended care because it's costly (eg, infertility treatments, autism therapy). Here, it's believed that doctors have declined to recommend less costly care due to institutionalized racism or professional territoriality, bolstered by licensure restrictions. Would it be helpful for expectant mothers to pick these practitioners out of a provider directory on a fee-for-service basis? Or should they be integrated into a team and compensated as part of an episode-based alternative payment model? Would coverage and credentialing of CPMs and doulas result in "medicalization" of their care—something many community-based practitioners resist? Although it's clear that states' attention is warranted here, the thorny specifics seem beyond the competency of insurance regulation to resolve, especially as state-regulated insurers pay for relatively few deliveries.

It is tempting for advocates who lack clinical expertise to lobby government officials rather than health plan medical directors or clinical guidelines committees who speak a different language and are less amenable to political influence. Similarly, it must be hard for insurance regulators to resist an opportunity to address festering quality, efficiency, and equity deficits. But not every health care problem is a health insurance problem, and there will always be plenty of old-fashioned health insurance problems to keep policy makers busy.