The Wait Is Over: Health Reform in Action

MATTHEW J. ROWAN
PRESIDENT & CEO

January 1 marked a turning point for the Affordable Care Act, as we’re now starting to see health reform’s effects in real-time. This Executive Briefing highlights several areas receiving particular scrutiny that affect provider operations, access to care, and the supply chain.

A primary ACA goal is to increase healthcare price transparency, which is difficult if doctors don’t realize how their work contributes to industry costs. The article, “How Much Does a New Hip Cost? Even the Surgeon Doesn’t Know,” explains how providers are educating physicians on implantable medical device costs to help lower Medicare’s $20 billion annual spend for these items.

Providers are improving average patient wait times with better health IT and process efficiencies, described in the article, “To Schedule a Doc Visit, Get in Line.” Yet some worry this trend will reverse if fewer doctors accept Medicaid patients while more Americans sign up for insurance coverage. Of concern is whether more patients will choose higher-cost care options as a result, such as hospital emergency rooms.

Early adopters of Medicaid expansion and coordinated care are already seeing positive results. The article, “Report: Fewer ER Visits for Ore. Medicaid Patients,” suggests that more care flexibility and limited funding encourages provider innovation to find new ways to reduce avoidable hospital visits.

I look forward to discussing these and related topics in-depth at HIDA’s Executive Conference, March 18-21, Austin, TX.

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### Healthcare Reform Dashboard

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<th>TRENDS</th>
<th>COMMENTS</th>
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<tbody>
<tr>
<td>ACOs</td>
<td>Medicare Accountable Care Organizations (ACOs) and Pioneer ACOs have saved more than $380 million total since 2012, according to the Centers for Medicare and Medicaid Services (CMS). Early cost savings are encouraging since the ACO model is designed to save money over multiple years.</td>
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<td>Device Tax</td>
<td>During the government shutdown and debt ceiling debate this past fall, a repeal of the 2.3% medical device tax was brought into discussion. Although the medical device tax repeal was not included in the final compromise, the issue received bipartisan support, giving hope to repeal in the future.</td>
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<td>Health IT</td>
<td>In 2013, 69% of office-based physicians reported that they intended to participate in Medicare’s “meaningful use” initiative, according to the Centers for Disease Control and Prevention. About 13% reported that they intended to participate and already had EHR systems capable of supporting the Stage 2 meaningful use objectives necessary to receive incentive payments.</td>
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<td>Community Health Centers</td>
<td>Community health centers received approximately $156 million in government funding to double the number of staff assisting Medicaid and to double the size of staff to help Medicaid to be more efficient and effective in delivering care. States with federal-run exchanges that haven’t expanded Medicaid received $58 million from HHS to support health center staff.</td>
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<tr>
<td>Gift Disclosure</td>
<td>CMS announced that registration and data submission for applicable manufacturers (APs) will begin in a two-phased approach beginning Feb. 18, 2014. Beginning May 2014, APs will be able to report payments and/or gifts made to physicians or teaching hospitals for the Aug. 2013 – Dec. 2013 time period via the Open Payments system.</td>
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### Key Markets

| HOSPITALS | CMS recently announced that it will not enforce its “two midnight rule” until October that would have reimbursed hospitals for inpatient procedures where the patient stays less than two nights at the lower outpatient reimbursement rate. |
| PHYSICIANS | Congress is close to finding a long-term solution to fix Medicare’s current sustainable growth rate (SGR) formula, and have until March to repeal and replace it. The biggest hurdle is the approximately $150 billion cost of the legislation over the next decade. The SGR calculates the reimbursement amount physicians receive under Medicare. |
| Long-term Care | In January, MedPAC approved recommendations to freeze payments for LTCHs, IRFs, HHAs, and hospice providers in 2015. The commission also recommended creating a readmissions reduction policy for HHAs and freezing SNF payments in 2015. |

### Key Updates

- **HIDA released its second annual State Medicaid Report**, which outlines key policies affecting the post-acute care market.
- **HIDA is providing guidance to the FDA on transferring required information and licensure standards** as they work toward implementation of the Drug Quality and Security Act.
- **HIDA is working with the industry to urge the OIG to provide an in-depth review of the competitive bidding program.**

### HIDA Advocacy Update

**PEDIGREE**

- HIDA has joined the information exchange work group of PDSA to work on traceability implementation. The group is focused on providing recommendations to the FDA on how transaction history, transaction information, and transaction statements should be exchanged by trading partners beginning January 1, 2015.
- HIDA is also working on providing guidance to the FDA as they work toward implementation of the licensure standards for wholesale distributors of pharmaceuticals included in the Drug Quality and Security Act. While states will continue to license wholesale distributors, they will be required to do so utilizing the federal standards established.

**COMpetitive BIDDing**

- HIDA has partnered with AdvaMed to seek congressional support for a bicameral letter to the OIG requesting a study of Round 2 and the Round 1 recompete of the competitive bidding program and the national mail order program for diabetic testing supplies.
- Among other things, the study would review changes in treatment patterns of enteral nutrition patients residing in SNFs.

**INNOCENT FREE SELLERS ACT**

- HIDA signed onto a letter urging congressional support for H.R. 2746, the Innocent Sellers Fairness Act, which would protect distributors and retailers from unwarranted product liability lawsuits. Alongside HIDA, 10 other organizations, including the U.S. Chamber of Commerce and the National Federation of Independent Business, signed the letter.
- The legislation was introduced in the House of Representatives in July 2013 by Rep. Blake Farenthold (R-TX). HIDA is encouraging members to contact their representatives and urge support for the bill.

### Regulatory Update

- HIDA released the second annual State Medicaid Report which outlines key policies affecting the post-acute care market. The report captures the most recent comprehensive state-by-state Medicaid expenditure data, explains changes in policies and payment criteria, and offers an outlook on Medicaid’s spending over the next decade. It also details each state’s status with Medicaid expansion and the state health insurance exchanges.
Electronic Health Records (EHR) Incentive Program
Stage 2 Extended

Background
To incentivize the use of EHRs in a meaningful way that builds toward interoperability, the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009 included Medicare and Medicaid bonuses for hospitals and physicians to implement EHRs. The Office of the National Coordinator of Health Information Technology at the Department of Health and Human Services issues regulations that have set up a certification process for vendors meeting the specific criteria for achieving Meaningful Use. CMS issues regulations that set forth criteria that must be met by providers to receive bonuses. There are three stages of Meaningful Use and providers are currently in Stage 2.

Delayed Implementation
CMS recently announced significant changes to the Meaningful Use timeline. Specifically, the agency has extended Stage 2 by one year to 2016 and has delayed the start of Stage 3 until 2017. The delay comes as welcome news to providers who have been struggling to achieve Meaningful Use and is important to many providers who were likely to come up short. Out of the 395,059 eligible physicians/professionals and 4,425 eligible hospitals, only 51.5% of the physicians and 86.1% of the hospitals enrolled in the program have met the standards to receive incentive payments. So far, hospitals participating in the program have received $8.9 billion in incentive payments total and participating physicians/professionals have received $5.8 billion total.

Post-Acute Market Exclusion
The HITECH Act did not provide monetary incentives to long-term and post-acute care (LTPAC) providers. However, there are various measures in place and/or under consideration to encourage adoption of health information technology in LTPAC settings.

Additional Resources
Center for Medicare and Medicaid Services
Office of the National Coordinator of Health Information Technology
Center for Disease Control Report

Meaningful Use Timeline

2011 – 2012
Stage 1 – Data Capture and Sharing
• Data standardization
• Clinical conditions tracked
• Clinical quality measured
• Patient engagement

2014 - 2016
Stage 2 – Advance Clinical Processes
Unlocking “Meaningful Use” Criteria
• Family history
• E-doc notes
• State registry
• Patient accessibility
• HIE
• Imaging
• E-prescribing

2015
Penalties begin for all eligible providers regardless of participation

2017
Stage 3 – Improving Outcomes (criteria not finalized but expected to build on existing)
• Increase quality, safety and efficiency
• Increase patient access
• Increase population health
• Link Unique Device Identification to EHRs

2018
Incentive payments are phased out
Weighing Hospital Mergers and Acquisitions with Community Benefit

The Center for Healthcare Economics and Policy undertook a comprehensive study of hospital mergers and acquisitions that shows the industry can still remain competitive and benefit local communities due to the size and nature of transactions.

The Center determined how many hospital transactions there have been since 2007 and how many hospitals have remained in a local area following those transactions to provide options for patients in need of hospital care. It also measured the impact of these transactions by Metropolitan Statistical Area (MSA), which is a geographic region with a relatively high population density at its core and close economic ties throughout the area.

• Between 2007 and June 2013, 607 hospitals (approximately 12% of community hospitals) have been involved in a transaction (merger or acquisition).
• The transactions themselves have been modest: the average number of hospitals acquired in a transaction was between 1 and 2.
• Of those hospitals that have been involved in a transaction, all but 22 have occurred in areas where there were more than 5 independent hospitals. That means there were plenty of hospitals left following the transaction to maintain a competitive marketplace.
• Looking more closely at hospitals included within the group of 22, the stories about how the transaction benefited the community are compelling:
  » Nine of the transactions involved small hospitals (50 or fewer beds), the type of hospitals that often struggle without a larger partner to supply essential capital or specialized expertise.

Acquired Hospitals

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Transactions</th>
<th>Total Hospitals</th>
<th>Average Number of Hospitals Per Transaction</th>
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<tbody>
<tr>
<td>Total</td>
<td>348</td>
<td>607</td>
<td>1.7</td>
</tr>
<tr>
<td>2007</td>
<td>45</td>
<td>111</td>
<td>2.5</td>
</tr>
<tr>
<td>2008</td>
<td>46</td>
<td>52</td>
<td>1.1</td>
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<tr>
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<td>36</td>
<td>61</td>
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<td>2010</td>
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<td>2011</td>
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<tr>
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<td>72</td>
<td>131</td>
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</tr>
<tr>
<td>2013</td>
<td>31</td>
<td>55</td>
<td>1.8</td>
</tr>
</tbody>
</table>

• From 2007 to 2012, there were 317 transactions,* with an additional 31 transactions in the first half of 2013, for a total of 348 transactions involving 607 acquired hospitals
• The average number of acquired hospitals per transaction was between 1 and 2

Frequency of Transactions by Number of Acquired Hospitals • 2007 - June 2013

• The majority of transactions between 2007 and 2013 involved a single acquired hospital

http://www.aha.org/content/13/13mergebenefitcommty.pdf
Adoption of EHR Systems Varies Widely Across States

- In 2013, the percentage of physicians who had an electronic health record (EHR) system meeting the criteria for a basic system ranged from 21% in New Jersey to 83% in North Dakota (Figure 2, below).
- The percentage of physicians who had a system meeting the criteria for a basic system was significantly lower than the national average (48%) in eight states (Connecticut, Maryland, Nevada, New Jersey, Oklahoma, Vermont, West Virginia, and Wyoming) and significantly higher than the national average in nine states (Iowa, Massachusetts, Minnesota, North Dakota, Oregon, South Dakota, Utah, Washington, and Wisconsin).
- In 2013, the percentage of physicians using any type of EHR system ranged from 66% in New Jersey to 94% in Minnesota (data not shown).

Percentage of office-based physicians with a basic EHR system, by state, 2013

* Washington, D.C. estimate does not meet standards of reliability or precision.

NOTES: Significance tested at p < 0.05.

SOURCE: CDC/NCHS, National Ambulatory Medical Care Survey, Electronic Health Records Survey.

Uncommon Cures for the Cold: Cold Weather Scenario Planning for Supply Chain Managers

WRITTEN BY ELIZABETH HILLA, EXECUTIVE DIRECTOR, HIDA EDUCATIONAL FOUNDATION  I JANUARY 30, 2014

Winter is upon us, yet too often cold weather scenario planning is an afterthought for supply chain managers. But blizzards and ice storms are relatively common occurrences with a number of solutions to overcome challenges. Recent arctic blasts serve as reminders that proper preparation for the cold can help you be ready not only for winter’s worst, but for other natural disasters that might occur.

An ounce of prevention

Winter storms can knock out both power/communications and deliveries. To deal with the power and phone outages, you’ll need back-up generators and satellite phones — but the best way to deal with road closures and other delivery challenges is to avoid them altogether. Work with your distributor to set up weather alerts and to arrange for advance deliveries when winter weather threatens.

When in doubt, take a dose of data

Most suppliers can prepare usage reports by month (even by day) and by department so that if ordering systems are down, they can deliver the right items and amounts based on your historical usage. Talk through a worst-case scenario so it’s clear what an "automatic order" will be and which fail-safe delivery routes are already planned.

Stockless programs won’t leave you out in the cold

Many supply chain managers like the idea of saving money and space through low-inventory programs like stockless or just in time, but worry that a weather event or epidemic could leave them with stock-outs. Those who use these programs, however, say that planning and communications can prevent shortages even during natural disasters. Distributors handle emergency orders and often agree to set aside allocated reserves to ensure a guaranteed supply of needed products.

Inoculate against the flu

With winter comes the flu, and with the flu comes increased demand for many products, from test kits to needles and syringes. Work with your supplier to analyze both historical data and up-to-the-minute trends so you’re prepared as the flu season hits.

There’s no one-size fits all plan, but there are customized options built around your facility and various scenarios, not just winter weather. Whether you’re a large medical center in "tornado alley" or a river-town integrated delivery network that must be prepared for power outages and flooding, plan ahead so that you’re ready for the worst.

Elizabeth Hilla is executive director of the HIDA Educational Foundation, an affiliate of the Health Industry Distributors Association. The Foundation is devoted to education and research that increases efficiency and effectiveness within the healthcare supply channel. She also serves as a senior vice president at HIDA.


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MUST READ NEWS

How Much Does A New Hip Cost? Even The Surgeon Doesn’t Know

JANUARY 6, 2014

BY JENNY GOLD

What will a gallon of milk set you back? How about a new car? You probably have a rough idea.

But what about a medical device — the kind that gets implanted during a knee or hip replacement? Chances are you have no clue. And you are not alone: The surgeons who implant those devices probably don’t know either, a just-published survey shows.

Medicare spends about $20 billion each year on implantable medical devices — nearly half of it for orthopedic procedures. And as the population ages and more Americans get joint replacements, that number is only going up, which will have a bigger and bigger impact on the nation’s health care spending.

But orthopedic surgeons don’t know much about how much their work contributes to that spending. They were only able to correctly estimate the cost of a device 21% of the time, according to a survey of 503 physicians at seven major academic medical centers published this week in Health Affairs. Their guesses ranged from 1.8% of the actual price to 24.6 times the actual price. Researchers could not release the actual costs, because they signed nondisclosure agreements with the hospitals.

And residents were worse at guessing — they were correct only 17% of the time. Estimates within 20% of the actual cost were considered correct. The study did not look at what patients know about cost.

“In orthopedic surgery, we’re never told how much things cost. We never see the cost displayed anywhere, and even if you were interested, there’s no great way to find it,” says Dr. Kanu Okike, lead author of the Health Affairs study and an orthopedic surgeon at Kaiser Permanente Moanalua Medical Center in Honolulu (Kaiser Health News is not affiliated with Kaiser Permanente).

Unlike pretty much every other consumer industry, health care costs are not transparent, even for the surgeons. Each hospital system and purchasing group negotiates deals with device manufacturers and signs a nondisclosure form, promising not to share the details of those prices with anyone else. That’s because “medical device manufacturers strive to keep their prices confidential so that they can sell the same implant at a different price to different health care institutions,” the study authors write.
But costs matter: for a total knee replacement, the actual piece of machinery that gets implanted can cost anywhere from $1,797 to $12,093, depending on the negotiated price. And there’s little evidence that one particular device is any better than another for the patient, says Okike.

The hospital actually has a financial incentive to use cheaper devices — it’s paid a lump sum for the procedure by Medicare (the government’s health insurance program for seniors and disabled people). That means that if a hospital uses a cheaper device, it ends up with a bigger profit.

But they don’t tend to pressure surgeons to use the cheaper device, says Dr. Kevin J. Bozic, an orthopedic surgeon at the University of California San Francisco, who studies the cost of medical devices. That’s because orthopedic surgeons are big moneymakers. “They don’t want to offend the doctors. They cater to them however they can, which includes not telling them which devices to use,” he explains.

And many orthopedic surgeons are aligned with a particular manufacturer, says Bozic. That makes them even less likely to take cost into consideration. Doctors may be paid as consultants to manufacturers and can also receive royalties when other doctors at other hospitals use a device, if they contributed to the design. (But not when they themselves or their colleagues use them; anti-kickback laws prohibit that.)

Some hospitals are seeking to make the cost of devices more transparent, in the hopes that just knowing what things cost will encourage surgeons to make different choices and lower spending. There are some glimmers of hope, including a national pilot project that makes a surgeon’s payment for each surgery dependent on the cost of the device they use.

“But at the root of it, the biggest problem is the lack of price transparency across the industry,” says Okike, the author of the Health Affairs study. And device manufacturers aren’t in a hurry to change that without some sort of pressure.

Update: This story was updated on 1/9/2014 to explain how anti-kickback laws apply to orthopedic surgeons.

This article was produced by Kaiser Health News with support from The SCAN Foundation.

To Schedule A Doc Visit, Get In Line

JANUARY 29, 2014

BY JENNY GOLD

“We have too few providers, which is creating a significant access problem,” says Travis Singleton, senior vice president of Merritt Hawkins in Texas, which conducted the survey. The health care and physician search consulting firm spoke with 1,399 medical offices between June and November 2013 in five different areas of specialization: cardiology, dermatology, obstetrics/gynecology, orthopedic surgery and family practice. Researchers called the practices and asked for the first available appointments for new patients needing routine care, such as a heart check up or a well-woman visit.

The good news is that wait times actually decreased slightly, down from an average of 20.4 days when the survey was last conducted in 2009, and down from 20.9 days in 2004. Singleton attributes the slight improvement to practices employing more midlevel providers like nurse practitioners, better health care IT to help with scheduling and an increase in the number of urgent care centers.

Even Boston, which has eye-popping wait times, has gotten better. The city’s average wait time dropped from nearly 50 days in 2009 to 45.4 days in 2013. That nearly brings it closer to its of about 39 days in 2004 before Massachusetts adopted its version of health care reform.

The bad news is that fewer doctors are accepting Medicaid: An average of 45.7% of physicians surveyed take Medicaid coverage, down from 55.4% in 2009. Acceptance rates varied widely, however, ranging from 73% in Boston to 23% in Dallas. An average of 76% of physicians surveyed accept Medicare.

Need to see a doctor? You may have to wait.

A survey of physician practices in 15 metropolitan areas across the country, which was taken before the health law expanded coverage, found that the average wait time for a new patient to see a physician in five medical specialties was 18.5 days. The longest waits were in Boston, where patients wait an average of 72 days to see a dermatologist and 66 days to see a family doctor. The shortest were in Dallas, where the average wait time is 10.2 days for all specialties, and just 5 days to see a family doctor.
The rates of Medicaid acceptance are likely to prove problematic as more and more Americans sign up for Medicaid under the Affordable Care Act. “At the end of the day, it doesn’t matter how many physicians you have,” says Singleton. “If no one will take your insurance, you’re going to end in the same place, and that’s probably the ER.” And with more patients covered both by Medicaid and private insurance, he says, wait times are likely to get worse.

But Ken Hertz of the MGMA Health Care Consulting Group, which consults with physician practices, says wait times don’t always increase in proportion to patient volume. As plan deductibles and copays have gone up in recent years, patient volume in outpatient settings have actually declined, he says.

And long wait times can be attributed to many things other than patient volume, he adds, including operators not understanding the scheduling system. “Most practices are working diligently to see patients and see them in a timely manner, but there are a lot of moving parts,” he says.

“The successful practices will figure out new ways and approaches to shortening wait times. This isn’t going to be acceptable” in the long term, says Hertz.

This post was updated to correct information in the graph about Boston’s overall wait times. The current wait averages 45.4 days, while it was nearly 50 days in 2009 and 39 days in 2004.

SALEM, Ore. -- People on the Oregon Health Plan are making fewer visits to the emergency room and more visits to primary care clinics, according to a new report on Oregon's year-old coordinated care organizations.

The Oregon Health Authority says the report shows Gov. John Kitzhaber's overhaul of the state Medicaid program is achieving its goals in reducing unnecessary use of the emergency room.

But the figures don't allow for a definitive conclusion about whether the coordinated care organizations are responsible for the shifts. The report looked only at Medicaid patients, so it's unclear if the results were substantially better than other segments of the health care market.

Oregon Health Plan members made 13% fewer ER visits in the first nine months of 2013 when compared with 2011. Every coordinated care organization saw a reduction, although the level varied widely. Hospitalizations for chronic conditions also dropped by 32% for heart failure, 46% for chronic obstructive pulmonary disease and 18% for adult asthma.

The number of primary-care visits jumped 16% in the year after coordinated care organizations launched.

Kitzhaber persuaded Oregon lawmakers to create coordinated care organizations to oversee physical health, mental health and dental care for patients in their area. The Obama administration gave Oregon nearly $2 billion over five years to keep the Medicaid system afloat while the coordinated care organizations ramp up their operations. In exchange, the state has promised to save at least as much money over the following five years.

The 16 coordinated care organizations have more flexibility to care for patients, but they must stick within strict funding limits. Proponents hope the combination of more flexibility and limited funding will encourage the coordinated care organizations to find new ways to reduce avoidable hospital visits. Some are hiring case workers to actively ensure patients are following treatment plans or to intervene with patients who frequently visit emergency rooms.

The report looked at the use of ERs by Medicaid patients before and after the coordinated care organizations were created.

A study published last month found that patients newly covered under Oregon's Medicaid program made 40% more emergency room visits in the first two years compared with others who didn't gain coverage. The study by researchers at Harvard University, the Massachusetts Institute of Technology and elsewhere looked at a period before Oregon created coordinated care organizations.

Insurers Face New Pressure Over Limited Doctor Choice

Regulators, Lawmakers Look at Ways to Increase Number of Providers

BY ANNA WILDE MATHEWS AND CHRISTOPHER WEAVER

UPDATED FEB. 6, 2014 1:28 A.M. ET

Insurers are facing pressure from regulators and lawmakers about plans that offer limited choices of doctors and hospitals, a tactic the industry said is vital to keep down coverage prices in the new health law's marketplaces.

This week, federal regulators proposed a tougher review process for the doctors and hospitals in plans to be sold next year through HealthCare.gov, a shift that could force insurers to expand those networks.

Meantime, regulators in states including Washington and New Hampshire are ramping up their own scrutiny, and lawmakers in Mississippi and Pennsylvania, among others, are weighing bills that could force plans to add more hospitals and doctors.

The moves come amid complaints by some consumers that they don't have access to a broad enough range of care—such as specialists at top academic medical centers, which tend to charge insurers higher fees and aren't included in many of the new networks.

Some consumers say they will have to switch doctors with the new health-law plans. But the issue extends beyond the new policies, as insurers have been trimming the array of doctors in private Medicare Advantage coverage and losing some big health-network providers due to market clashes.

California Insurance Commissioner Dave Jones said he plans to revise his agency's standards for insurers' health networks partly because current regulations don't give him enough power to continue oversight after a health plan goes on the market. The aim would be to "make sure when people purchase health insurance, they have reasonable access to health-care providers," he said.

Under the new federal proposal, insurers selling plans in the federally run marketplace would be required to submit to the Centers for Medicare and Medicaid Services a full list of providers in a network before their plans are approved for listing in the exchanges. In the future, regulators also plan to develop federal standards for the required number of providers. For this year, the federal exchange relied largely on state regulators and third-party organizations to review networks, said Karen Pollitz, a senior fellow at the Kaiser Family Foundation.

"It's a substantial change," said Ms. Pollitz. "It's much more specific, and it's going to involve a lot more direct federal oversight."

Under the proposal, the plans offered in the federally run insurance marketplace also would need to include a larger share than previously required of "essential community providers," which are safety-net hospitals, clinics and others often used by lower-income people.

A spokesman for the Centers for Medicare and Medicaid Services said it is "working to strengthen the network adequacy requirements that took effect for this year."
The American Medical Association said it would monitor any patient-access problems in the exchanges and work "to implement proactive solutions we believe can enhance the public health and welfare by eliminating inadequate networks," which, it said, could "endanger patients' health if they cannot access timely, convenient, quality care."

A spokesman for America's Health Insurance Plans, the industry's main trade group, said narrower provider networks are "one way health plans can help to preserve benefits and mitigate cost increases for consumers" as health-law changes take effect.

Narrower networks can help keep down costs partly because providers agree to lower their fee in exchange for the volume of business they expect with fewer competitors.

Some 70% of new plans under the health law offer relatively narrow networks compared with many current plans, according to a recent report by McKinsey & Co. The consulting firm found that plans with smaller choices of hospitals had significantly lower premiums than similar plans offering a broader choice.

The narrow networks have drawn protests, lobbying and some legal challenges from doctors and hospitals.

In New Hampshire, WellPoint Inc. is the only insurer offering consumer plans on the exchange, and its network leaves out 10 of the state's 26 hospitals. The Legislature is considering a bill that would force health plans to negotiate with all providers, and the state's insurance regulator is planning to review its network standards, with a hearing set for Monday. Frisbie Memorial Hospital in Rochester, N.H., has filed a legal protest about the network, which doesn't include it, and is offering patients transportation to the hearing.

The state regulator has already heard from some, like Josh Kattef, 37 years old, an investor in Hopkinton, N.H. Mr. Kattef said that with any of the new plans he would have to drive about 40 minutes to the nearest hospital, and they don't include his current physicians.

"No one wants to give up their doctor," he said. Mr. Kattef said he currently is on an old plan with a broader network, but he will have to switch in December to a new health-law plan.

A WellPoint spokesman said its health-law plan network "meets and exceeds" New Hampshire standards, and that the plans would cost about 30% more if they didn't have a limited network. "All exchange members would have seen higher premiums," he said.

In Washington state, Seattle Children's Hospital has filed a legal protest against the insurance department's decision to approve networks that didn't include it. The state regulator, which clashed with several insurers over their networks last year, has proposed new standards for reviews that would toughen scrutiny about provider networks and require more disclosure of changes to consumers.

Meantime, legislation proposed in Mississippi would prohibit insurers from turning away most hospitals, doctors or other health providers that agree to prices set by insurers. The bill also would bar insurers from selectively charging higher copayments at some doctors' offices or hospitals as a means of steering patients to lower-fee options.

In Pennsylvania, state Rep. Jim Christiana, a Republican from suburban Pittsburgh, proposed legislation that would block insurers from excluding hospitals in some circumstances after a dispute between two big insurers with affiliated health systems. "We don't believe access should be restricted to lock out competition," he said.

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