

GUIDE 03

What to do when a payor says its network is closed

Closed usually means closed to new applicants on standard terms. How to make the case, at the right level, in the right order.



Closed usually means closed to new applicants on standard terms, not closed. A payor (also spelled payer) opens its network for a provider that fills a gap it has to fill: members with no nearby option in your specialty, access standards it cannot meet without you, or a service its network lacks. Here is how to make that case, at the right level, in the right order.

This guide covers what a closed network actually means, why payors close networks and what opens them, how to get in, what single case agreements tell you, how to appeal a participation denial, and how to write the letter of interest.

01

What does a closed network actually mean?

Three different things get called closed, and they call for different responses.

Narrow is network design. A narrow network plan limits the number of providers on purpose, usually to lower premiums. These are a minority of employer plans: in KFF's 2025 survey, 8 percent of firms with 50 or more employees that offer benefits offered a plan they considered a narrow network, and 15 percent included a tiered or high-performance network in their main plan ([KFF, 2025](#)). Narrow plans are more common on the individual market than among employers.

Closed is participation access. The payor is not adding providers of your type in your service area on standard terms, because it believes the network is saturated or because it has preferred relationships. This is what you hear in the letter. It is a business decision, it is reviewed, and it is the one this guide is about.

Benefit design decides what closed costs you. Before you spend a year on the case, check the out-of-network benefit on the products you want. A PPO member can still see you out of network at a higher cost share; an HMO or EPO member usually cannot. What you are paid out of network today, and how many of the payor's members can reach you that way, is the floor your in-network offer has to beat.

The reason a closed door matters this much is concentration. In PayrHealth's analysis of commercial enrollment by payor as of January 2026, three parent companies held 69 percent of Texas's 16.1 million commercial lives and five held 85 percent. Across Texas, Florida, California, New York and Illinois, the top three payors held between 57 and 81 percent

THE SHORT VERSION

Closed means closed on standard terms. Document the gap, ask one level up, set a date.

Closed is a business decision. It is reviewed, and it can be reopened.

of each state's commercial lives. A closed network at the top payor alone shuts you out of a quarter to more than half of the commercial market, depending on the state. (Method in Sources.)

Three payors hold 57 to 81 percent of commercial lives in five large states

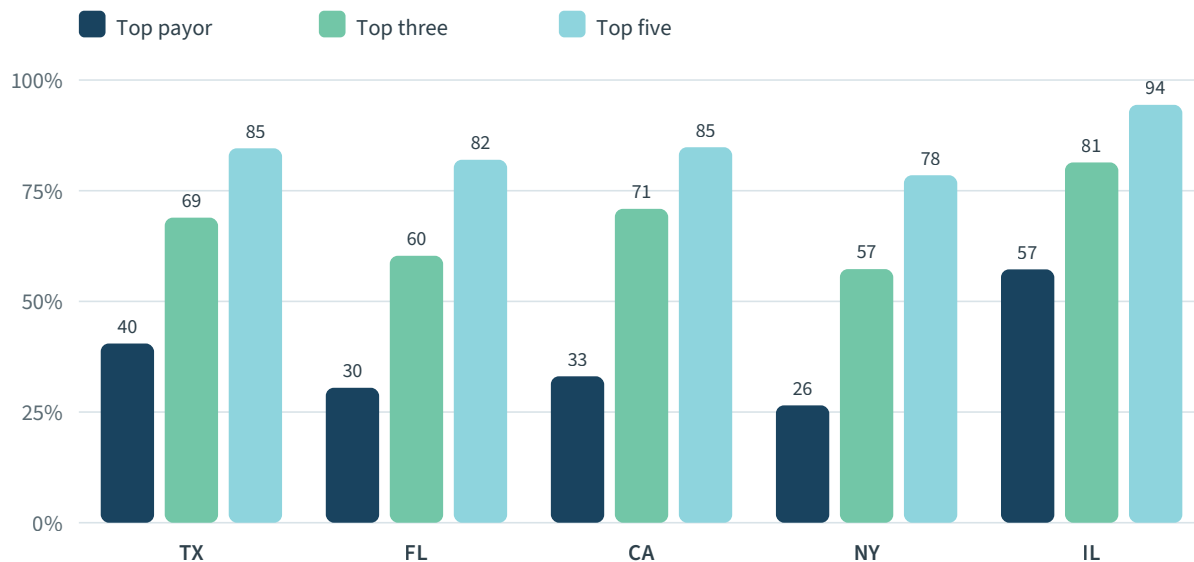


Figure 1. Share of each state's commercial covered lives held by the top payor, the top three and the top five parent companies, January 2026 snapshot, fully insured and self-insured, all product types. PayrHealth analysis of commercial enrollment by payor.

02

Why do payors close networks, and what opens them?

A payor runs its network to two numbers: medical expense ratio and market share. The network is a cost tool. It needs enough providers to meet access standards and sell the product, and few enough to steer volume and hold rates. Once a provider type is "adequate" in a service area, every added provider is cost without benefit, so the standard answer to a new application is no.

That logic also tells you what opens the door. In PayrHealth's experience, networks open when one of these is true:

- 1. Network adequacy deficiencies.** The payor cannot meet an access standard for your specialty in your service area without you. These standards are now quantitative: marketplace plans on the federal exchange have had to meet time and distance standards since plan year 2023 and appointment wait time standards since plan year 2025 ([45 CFR 156.230](#)), and Medicare Advantage and Medicaid managed care carry their own. A gap you can document is the case payors answer.

Once a provider type is adequate, every added provider is cost without benefit.

2. **Service area expansions.** A payor moving into new areas needs providers it does not have.
3. **New product rollouts.** A new exchange, Medicare Advantage or narrow product needs its own network, built on a schedule. The door that is closed for the PPO may be open for the product launching next year.
4. **Disadvantage to a competitor.** If you are in the competing payor's network and not theirs, employers and brokers notice. A practice that is the reason a group chooses the other plan is a practice the payor wants.
5. **Cost savings and actuarial trend.** You lower the payor's cost against the providers it already has: a lower site-of-service cost, fewer ER visits, fewer readmissions, shorter episodes.
6. **Risk delegated to third parties.** Where the payor has delegated the network to an IPA, MSO, management company or specialty benefit manager, the payor's own contracting team may have no door to open; the delegate does. Ask who holds the network for your specialty before you write.

Employer demand is the seventh, and it is the one most practices ignore. A self-funded employer whose employees want you can ask its carrier or administrator to add you. Sixty-seven percent of covered workers are in self-funded plans ([KFF, 2025](#)), and a benefits manager's request carries weight a provider's letter does not.

03

How do you get into a closed network?

There is no quick path, and persistence without a case is just persistence. The play is a case, delivered at the right level, escalated when the answer is no.

First, make sure the no is the no you think it is. Get the denial in writing with the stated reason. A credentialing denial (an incomplete application, a licensing or accreditation question) is a different problem from a network denial, with its own appeal path. A network denial that cites adequacy is the one this guide addresses.

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Precision Medical Products

Three commercial payors said their networks were closed. Escalated to the people who could decide, all three contracted, opening access to more than 6 million lives. Case study

Second, do the self-evaluation. A plain SWOT, from three perspectives: yours, the payor's and the patient's. Most practices write the first and skip the other two. The payor's column is the one that decides the outcome.

Third, build the value proposition in the payor's terms. Payors buy five things, and your case should lead with the one or two you can prove:

Access. Geography the network does not cover, or a delivery model it lacks (extended hours, telehealth, home-based care, a language the service area needs). Count the covered lives in your service area who have no in-network option within the payor's time and distance standard, and the wait for the nearest one.

Clinical quality. Better outcomes, with evidence the payor can verify: registry data, accreditation, published measures.

Short-term cost. You are price competitive against the providers the payor already has, or you deliver the same service at a lower site-of-service cost.

Longitudinal cost. You prevent downstream spend, with a number attached: avoided admissions, ER visits, readmissions, complications.

Patient experience. Happier members complain less and stay with the plan longer. Member satisfaction and retention are things a payor's account team cares about even when its contracting team does not.

Fourth, ask at the right level, in order. A closed-network request moves up a ladder, and each rung gets a shorter, sharper version of the case:

1. The provider relations representative, who can only relay.
2. The network or contracting manager for your market, who can say yes to standard terms.
3. The contracting director, who can make an exception.
4. The market or regional network vice president, who owns adequacy and growth for the service area.
5. Other departments when the case warrants it: the medical director for a clinical case, the account team when an employer is asking, sales when a product is launching.

Set a date for a reply at each step (two weeks is reasonable), and when the answer is no, ask who makes the decision above them and write to that person. Keep the trail; it is also the record for the next review cycle.

100%

PathNet

A national payor's Utah lab network had been closed for over a year. A months-long appeal overturned the denial at 100 percent of Medicare for commercial claims. Case study

The request moves up a ladder, and each rung gets a shorter case



Figure 2. Who can say what at each level of a payor's network organization. Set a reply date at each step and write to the next rung when the answer is no.

Fifth, use the alternative doors as context. Complementary payors (regional plans, third-party administrators), physician organizations that hold delegated contracts, letters of agreement and single case agreements are not substitutes for participation, but they shape the case and they shape your fallback. The next section covers the one that matters most.

04

What do single case agreements tell you?

A single case agreement (SCA) is a one-patient, one-episode contract between a payor and an out-of-network provider at a negotiated rate. Payors use them when the network cannot serve a member: no in-network provider within the access standard, a specialty the network lacks, or continuity of care for a patient already in treatment.

Each SCA a payor approves for your patients is a written admission that its network has a gap for that member. That makes SCAs evidence, and it makes them part of your fallback position:

Track them. Count the SCAs by payor, reason and service area over the past 12 to 24 months. Ten SCAs for the same specialty in the same service area is evidence of a gap the payor itself recognized, and it belongs in your letter.

Price your out-of-network position. What you collect through SCAs and the out-of-network benefit, against the volume and administrative cost, is the floor your in-network offer has to beat. Knowing that number keeps you from accepting a participation offer that pays less than being out of the network.

Each single case agreement is a written admission that the network has a gap.

Do not build the practice on them. SCAs are episodic, negotiated one at a time, and the first thing a payor cuts when it tightens out-of-network policy. They are leverage for the participation case, not a strategy for revenue. Out-of-network billing is also constrained: the federal No Surprises Act limits balance billing for emergency and certain facility-based services, and many states limit it further.

PayrHealth does not negotiate single case agreements for clients. We use them for what they are: proof of a gap, and part of the alternative the payor has to compare its offer against.

05

How do you appeal a participation denial?

Most network denials have no formal appeal, because they are business decisions rather than credentialing decisions. What they have is a reconsideration process, and it works more often than practices expect.

1. **Get the reason in writing.** “Network adequate for your provider type in your service area” is the usual one. Ask the payor which standard it applied and which product lines the denial covers. Some states require payors to give a written reason, and some have any-willing-provider laws for certain provider types; know which apply to you.
2. **Separate credentialing from network.** If the denial cites qualifications, it is a credentialing decision with appeal rights under the payor’s credentialing plan and, in many states, state law. Appeal it on those terms.
3. **Answer the stated reason with evidence.** If the payor says adequate, show the gap: the covered lives in your service area with no in-network option within time and distance, current wait times at the in-network alternatives, your SCA count, employer requests. If it says saturated, show what you do that the network does not.
4. **Offer a narrower yes.** A single product line, a defined service area, a term with a review, a rate at or below the network’s current level. A narrow yes becomes a full contract at the next renewal; a broad no stays a no.
5. **Escalate the request to leadership.** Ask the contracting manager to send it up for further evaluation, in those words. Reconsideration and escalation are what moved the Missouri case below.
6. **Use the member’s voice where it is real.** A patient’s complaint to the plan about access, or an employer’s request to its administrator, is heard in a different department from yours. Where adequacy is the

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Integrated Respiratory Solutions

No contract with Missouri’s top commercial payor and a closed DME network. A written specialty case, reconsideration requests and escalation to leadership produced the agreement.
Case study

issue, the state insurance department takes complaints too. Use these when the facts support them; they are not a substitute for the case.

7. **Calendar the next review.** Networks are reassessed when products are recertified and when service areas change. Ask when the payor will next evaluate your specialty in your service area and reapply then, with the file you have built.

06

How do you write a letter of interest to a payor?

Assume you have already applied and been told the network is closed. The letter acknowledges that, states your value in one sentence, proves it in three short paragraphs, and sets a date. One page.

Subject: Request for reconsideration of network participation, [Practice name], [specialty], [service area]

Your [date] letter indicated that your [product] network is closed to [provider type] in [service area]. [Practice name] serves [number] of your members in that area today and will [one-sentence value proposition: close a documented access gap, lower your cost for these services, or improve outcomes for your members]. We ask that you reconsider our participation based on the information below.

Access. [Covered lives in your service area with no in-network option within your time and distance standard; current wait times at the nearest in-network provider; single case agreements approved for our patients in the past 12 months.]

Cost. [Our rates against the network's current level for the same codes; site-of-service or episode cost savings; avoided admissions or ER visits, with numbers.]

Outcomes and experience. [Verifiable quality measures, accreditation, patient satisfaction, continuity for members already in our care.]

We would like to review our participation with you and anyone else you would involve in the decision. Please let us know by [date within two weeks] whether a call can be scheduled, and who at [Payor] owns network adequacy for [specialty] in [service area].

Acknowledge the no, state the value in one sentence, prove it in three paragraphs, set a date.

Attach the one-page value summary, a service area map with covered lives, and your outcomes data. Nothing else. If the reply is no, the same letter goes to the next rung with the new information added and the previous reply attached.

If you would rather hand the case and the escalation to a team that does this every day, see our [payor contracting services](#). And for the contracts you already hold, a free rate review compares each with the best-paid quarter of practices like yours, for the same codes, in your market, and shows what each could pay. [See if you qualify](#).

Frequently asked questions

What does it mean when a payor says the panel is closed?

It usually means the payor is not adding providers of your type in your service area on standard terms, because it considers the network adequate or has preferred relationships. It is a business decision that is reviewed, not a permanent status. A documented access gap, a cost advantage or employer demand can reopen it, and the request can be escalated above the person who said no.

How do I get on insurance panels when they are closed?

Get the denial in writing with its reason, build a value case in the payor's terms (access, cost, outcomes), and ask for reconsideration at the next level up, with a date for a reply. Escalate from the provider relations representative to the contracting manager, the director and the market vice president, adding evidence at each step. Offer a narrower yes, such as one product or service area, if a full contract is refused.

What is a single case agreement?

A single case agreement is a one-patient, one-episode contract between a payor and an out-of-network provider at a negotiated rate, used when the network cannot serve a member. Each one a payor approves is evidence that its network has a gap for that patient, which makes SCAs useful proof in a participation request and part of your fallback position, not a revenue strategy.

How long does it take to get into a payor network?

Months, and sometimes more than a year for a closed network, because the request has to move up the payor's decision ladder and may wait for a product or service area review. Credentialing after a contract is agreed adds its own time. Start with the written denial and the value case, set a reply date at each step, and calendar the payor's next network review so a no now becomes a yes at the next cycle.

Can a payor deny participation without a reason?

Often yes, for network reasons: participation in a commercial network is a business decision. State rules vary, though; some states require a written reason for a participation denial, and some have any-willing-provider laws for certain provider types, so check yours. Credentialing denials are different, with appeal rights under the payor's credentialing plan and often under state law. Always ask for the reason in writing; it tells you which path to take and what evidence to bring.

What goes in a letter of interest?

One page: acknowledge the closed network and the date of the denial, state your value in one sentence, prove it in three short paragraphs covering access, cost and outcomes with numbers, and ask for a call by a date within two weeks, naming who owns network adequacy for your specialty. Attach a one-page value summary, a service area map with covered lives, and outcomes data.

Read next

- [When to renegotiate your payor contracts, and how often](#): timing, notice windows and the request letter.
- [An introduction to payor contracting language](#): the contract terms that decide what a rate is worth.

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Sources

- KFF, 2025 Employer Health Benefits Survey, Oct. 22, 2025: narrow and tiered network prevalence among firms with 50 or more employees; share of covered workers in self-funded plans. [kff.org](https://www.kff.org)
- 45 CFR 156.230, provider access standards for network plans: time and distance standards from plan year 2023 and appointment wait time standards from plan year 2025 for qualified health plans on the federally facilitated exchange. [law.cornell.edu](https://www.law.cornell.edu)
- PayrHealth analysis of commercial enrollment by payor, January 2026 snapshot. Method: commercial covered lives (fully insured and self-insured, all product types) by parent company for Texas, Florida, California, New York and Illinois; each state's top three and top five parent companies as a share of that state's commercial lives. Texas: 16,057,828 commercial lives, top three 68.9 percent, top five 84.6 percent. Top-three share across the five states: 57.3 percent (New York) to 81.4 percent (Illinois).
- Armando Cardoso, "Payor Contracting: Narrow and Closed Networks," presentation to the Brain Injury Association of America, Jan. 23, 2020, and a

presentation on payor contracting strategy to the Cencora SPN Vision Exchange, Nov. 15, 2025.

FREE RATE REVIEW

See what your contracts could pay

A free rate review compares each of your contracts with the best-paid quarter of practices like yours, for the same codes, in your market, and shows what each could pay.

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