



# Improving the Health Insurance Marketplace

## Network adequacy

The AMA recognizes that, in an effort to hold down costs, many health insurers offering plans in the exchanges, Medicare Advantage, and to employers are relying on tiered and narrow networks, which may provide patients with access to plans with lower premiums and cost sharing. However, in some cases, strategies to narrow provider networks can result in networks that are inadequate to provide meaningful access to timely, convenient and quality care.

To ensure network adequacy, the AMA supports: state regulators as the primary enforcer of network adequacy requirements; quarterly reporting by health insurers on network adequacy measures; additional financial protections to patients who seek care out-of-network; accurate, complete and up-to date provider directories; and publicly available health plan criteria on how a health plan chooses which physician participate in a network.

The AMA believes that an adequate provider network is a critical attribute of health insurance coverage. Patients are more likely to seek medical care from physicians and other health care providers who are part of the network. Inadequate networks could prevent patients from being able to see the physicians that they know, trust and depend upon throughout their lives. Patients who lose their usual physicians, including specialists, due to inadequate networks or network changes implemented after the enrollment period may experience interruptions in care, delayed care and undue harm. They can also prevent patients who are newly insured from being able to access the physicians that suit their needs in a timely manner.

### Federal provisions addressing network adequacy

- The Affordable Care Act (ACA) requires that qualified health plans maintain provider networks that are sufficient in number and types of providers to ensure that all services, including mental health and substance use disorder services, are accessible to enrollees without “unreasonable delay.”
- Provider networks of exchange plans also must include “essential community providers,” which predominantly serve low-income and medically underserved individuals.
- A plan’s provider directory must be accurate and available online and in hard copy upon request. Plan provider directories are also required to identify providers that are not accepting new patients.
- In Medicare Advantage, plans must meet network

adequacy criteria related to minimum number of providers and facilities, and maximum travel time and distance.

### The patchwork of current monitoring and enforcement of network adequacy standards

- The term “unreasonable delay” is not defined in the ACA or related regulations. Therefore, there is much variation in how the “without unreasonable delay” standard is implemented by health plans and states.
- Addressing the network adequacy of health plans offered on federally facilitated exchanges, the Center for Consumer Information and Insurance Oversight (CCIIO) stated that it intends to collect plan provider lists and review them to determine whether providers are available without unreasonable delay. CCIIO also stated it will eventually develop time and distance or other standards to guide network review.
- In state-based exchanges, there have been only limited efforts to adopt comprehensive network adequacy standards or requirements.
- Some states rely on health insurers attesting to their own network adequacy requirements, whereas others use private accreditation to evaluate network adequacy – either the Health Plan Accreditation program of the National Committee for Quality Assurance (NCQA) or URAC Health Plan Accreditation Program. However, NCQA and URAC have stressed that their accreditation should not be viewed as a substitute for an insurance commissioner’s oversight of the adequacy of a network.

- Provider directories may contain inaccurate or misleading provider information, preventing patients from making informed decisions and creating misperceptions of the networks' adequacy.
- Changes to existing insurance products to rely on increasingly narrow and tiered networks are being implemented without adequate or meaningful notice to patients or physicians.
- Insurers may use inaccurate or misleading data to select network physicians, or evaluate physicians based on cost alone, which undermines patient access to quality care.
- Patients who need to seek care from out-of-network providers face the potential of significant out-of-pocket costs.

## Strategies to foster healthy markets

### Support state regulators as the primary enforcer of network adequacy requirements

The AMA has long advocated for states issuing strong network adequacy standards. While some states have strong network adequacy standards to supplement federal requirements on provider networks, others rely on insurer self-attestation or private accreditation to evaluate network adequacy. While health plan self-assessment and private accreditation are key components of ensuring network adequacy, it is critical that state regulators take a more active role to ensure that network adequacy requirements are evaluated, monitored and enforced.

### Require health insurers to submit quarterly reports to state regulators on network adequacy measures

To ensure consistency in provider networks during the plan year, the AMA believes that health insurers should submit and make publicly available quarterly reports to state regulators, including such measures as the number and type of providers that have joined or left the network; the number and type of specialists and subspecialists that have left or joined the network; the number and types of providers who have filed an in-network claim within the calendar year; total number of claims by provider type made on an out-of-network basis; data that indicate the provision of Essential Health Benefits; and consumer complaints received. Such reporting would increase patient confidence in provider networks, and build on existing efforts of health plans to monitor their networks internally.

### Provide additional financial and other protections to patients who are forced to seek care out-of-network

When patients find themselves in networks that are inadequate, the AMA believes they should have access to adequate and fair appeals processes to ensure they are able to receive the care they need at the in-network rate. If a provider network is inadequate and access to an out-of-network provider is required, health insurers should be required to indemnify the patient for any covered medical expenses provided by the out-of-network provider incurred over that which would apply to in-network providers. In addition, such services received out-of-network should count toward the patient's deductible and the annual cap on out-of-pocket costs.

### Ensure provider directories are accurate, complete and up-to-date

To help ensure that patients have the ability to select the health plan that provides covered access to the physicians they want and need, the AMA believes that health plans should provide patients with an accurate, complete directory of participating physicians through multiple media outlets. It is essential that provider directories identify providers that are not accepting new patients. Provider directories should also detail the education and training of the physicians and other health care professionals within a plan's network. The AMA stresses that provider terminations without cause be done prior to the enrollment period, thereby allowing enrollees to have continued access to the network they reasonably relied upon when purchasing the product throughout the coverage year.

### Require health plans to inform physicians of criteria to participate in provider networks

The AMA believes that insurers must publicly provide the criteria and methodology used to evaluate a physician for network inclusion, with sufficient time to permit physicians to satisfy the criteria. If the methodology includes cost considerations, it must also incorporate quality data, and must include proper safeguards (e.g. risk adjustment, adequate sample size, etc.) to ensure the integrity of the data. The AMA strongly opposes the formation of provider networks based solely on economic criteria.

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