

REPORT 4 OF THE COUNCIL ON MEDICAL SERVICE (I-14)  
Network Adequacy  
(Resolutions 113-A-14, 125-A-14 and 130-A-14)  
(Reference Committee J)

## EXECUTIVE SUMMARY

At the 2014 Annual Meeting, the House of Delegates referred three resolutions pertaining to network adequacy, narrow networks and out-of-network benefits: Resolution 113-A-14, Resolution 125-A-14 and Resolution 130-A-14. This report provides an overview of the network adequacy of both exchange and Medicare Advantage plans, highlights emerging issues associated with out-of-network access to services, summarizes relevant policy and advocacy, and presents policy recommendations.

The Council 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. In some cases, strategies to narrow provider networks can result in networks that are inadequate to provide meaningful, in-network access to all medically necessary care on a timely and geographically accessible basis. It is essential for the American Medical Association (AMA) to continue working on legislation or regulation that prohibits the formation of networks based solely on economic criteria and ensures that, before health plans can establish new panel networks, physicians are informed of the criteria for participating in those networks, with sufficient advance time to permit them to satisfy the criteria. Changes to provider networks should be approved prior to the enrollment period, and health plans should provide patients with an accurate, complete directory of participating physicians through multiple media outlets. Any termination or nonrenewal of a physician's participation contract should follow the processes outlined in AMA policy.

Once provider networks are established, enrollees should be allowed to have continued access to the network they reasonably relied upon when purchasing the product throughout the coverage year. To ensure consistency in provider networks during the plan year, health insurance issuers should be required to submit quarterly reports to state regulators. The Council believes it is critical that state regulators establish themselves as the primary enforcer of network adequacy requirements. In cases in which patients find themselves in networks deemed to be inadequate, patients 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. Health insurers should be required to indemnify patients for any covered medical expenses provided by out-of-network providers incurred over the coinsurance/co-payments and deductibles that would apply to in-network providers. In addition, to promote patient financial protection, such services received out-of-network should count toward the deductible and the annual cap on out-of-pocket costs.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 4-I-14

Subject: Network Adequacy  
(Resolutions 113-A-14, 125-A-14 and 130-A-14)

Presented by: Jack McIntyre, MD, Chair

Referred to: Reference Committee J  
(Melissa J. Garretson, MD, Chair)

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1 At the 2014 Annual Meeting, the House of Delegates referred three resolutions pertaining to  
2 network adequacy, narrow networks and out-of-network benefits. The Board of Trustees assigned  
3 these items to the Council on Medical Service for a report back to the House of Delegates at the  
4 2014 Interim Meeting.

5  
6 Resolution 113-A-14, “Network Adequacy,” introduced by the American Psychiatric Association,  
7 the American Academy of Child and Adolescent Psychiatry and the American Academy of  
8 Psychiatry and the Law, asked:

9  
10 (1) That our American Medical Association (AMA) study the issue of network adequacy,  
11 including the impact on access to and quality of care, with a report back by the 2014 Interim  
12 Meeting; (2) That our AMA advocate for adherence to existing statutory and regulatory  
13 measures designed to ensure network adequacy, and work with state medical societies to  
14 advocate for the same in states where measures do not currently exist; and (3) That our AMA  
15 support the right of patients and physicians to seek appropriate recourse when and if harmed by  
16 inadequate networks.

17  
18 Resolution 125-A-14, “Expanding Patients’ Choice in the Exercise of Health Insurance Benefits,”  
19 introduced by the Kansas Delegation, asked:

20  
21 (1) That our American Medical Association study the growing problem of restrictions on a  
22 patient’s ability to use their health insurance benefits with the providers of their choice; and  
23 (2) That our AMA report back to the House of Delegates on the extent of the problem, with  
24 recommended strategies to more effectively engage the public on the problem, and to address  
25 the issue with both state and federal government.

26  
27 Resolution 130-A-14, “Ensuring Affordable Care,” introduced by the New York Delegation, asked:

28  
29 That our American Medical Association advocate for regulation and legislation to provide that  
30 insurers give reasonable credit for out of network expenses based on Fair Health toward a  
31 participant’s annual deductibles and out of pocket maximums.

32  
33 This report provides an overview of the network adequacy of both exchange and Medicare  
34 Advantage plans, highlights emerging issues associated with out-of-network access to services,  
35 summarizes relevant policy and advocacy, and presents policy recommendations.

## 1 NETWORK ADEQUACY AND EXCHANGE PLANS

2  
3 The Affordable Care Act (ACA) requires that qualified health plans maintain provider networks  
4 that are sufficient in number and types of providers to ensure that all services, including mental  
5 health and substance use disorder services, are accessible to enrollees without “unreasonable  
6 delay.” The term “unreasonable delay” is not defined in the law or regulations; therefore, there is  
7 much variation in how the “without unreasonable delay” standard is implemented by health plans  
8 and states. Provider networks of exchange plans also must include “essential community  
9 providers,” which predominantly serve low-income and medically underserved individuals. A  
10 plan’s provider directory must be accurate and available online and in hard copy upon request. Plan  
11 provider directories are also required to identify providers that are not accepting new patients.  
12

13 In an effort to control costs, health insurers offering plans in the exchanges appear to be relying  
14 heavily on tiered and narrow network strategies in some communities. For example, a survey  
15 conducted from early April to early June 2014 found that 54 percent of adults with new coverage  
16 said that their plan includes all or some of the physicians they wanted. The survey also found that  
17 20 percent of individuals with new coverage looked for new primary care physicians, and 39  
18 percent did not know which physicians are included in their network.<sup>1</sup> Another survey conducted  
19 from early April to early May 2014 found that, among individuals previously insured in the non-  
20 group market who switched to a new, ACA-compliant plan, 32 percent reported less choice of  
21 primary care physicians in their new plan, and 24 percent reported less choice of specialists in their  
22 new plan.<sup>2</sup> In addition, a recent study concluded that qualified health plans with narrowed hospital  
23 networks are available to 92 percent of individuals eligible to purchase plans on the exchanges.  
24 The study also found that narrowed hospital networks make up approximately half of all exchange  
25 plan networks.<sup>3</sup> In the employer-based health insurance marketplace, approximately one-quarter of  
26 plans had narrow networks in 2012, which is an increase from 15 percent in 2007.<sup>4</sup>  
27

28 A poll conducted in February 2014 found that 51 percent of patients prefer a more expensive,  
29 broader provider network, whereas 37 percent prefer a narrower network plan that is less  
30 expensive. There were differences in preferences for broader network plans based on age and  
31 income: older individuals and those with higher incomes showed a greater preference for more  
32 expensive plans with broader provider networks. Importantly, respondents who reported being  
33 either uninsured or having to purchase their own coverage were more likely to prefer more  
34 affordable plans with narrower provider networks. Individuals with employer-based insurance  
35 coverage were more likely to prefer more expensive, broader network plans. Preference for narrow  
36 network plans declined once respondents were told that enrolling in a narrow network meant that  
37 they couldn’t access their usual providers. On the other hand, preference for broader network plans  
38 declined once respondents were told that they could save up to 25 percent on their health care costs  
39 by choosing plans with narrower networks.<sup>5</sup>  
40

41 Individuals who have enrolled in qualified health plans through exchanges have few options during  
42 the plan year if their plans have unduly narrow networks, potentially impeding access to their long-  
43 time physicians and hospitals. Enrollees have the opportunity to file a complaint with the  
44 appropriate regulatory authorities, as well as file an appeal with the health plan in which they are  
45 enrolled. Patients facing network inadequacies as a result of inaccurate provider directories being  
46 listed during open enrollment have had additional opportunities to access the care of physicians  
47 listed in the directory. If enrollees affected by such inaccuracies receive care from a provider who  
48 was listed in the version of the provider directory as of the date of enrollment in the health plan, but  
49 who is in fact not in the plan’s network at the time of service, the Centers for Medicare & Medicaid  
50 Services (CMS) strongly encouraged health insurance issuers to consider such services as subject  
51 to in-network coverage and cost-sharing standards. In addition, health insurance issuers were

1 encouraged to adopt policies to prevent disruptions in treatment of episodes of care, such as cancer  
 2 treatment. To prevent treatment disruptions, CMS urged health insurance issuers to consider  
 3 treating providers as in the plan’s network for an acute episode of care at the start of the plan year.

4  
 5 The evaluation of network adequacy standards in state-operated and federally facilitated exchanges  
 6 varies widely. Addressing the network adequacy of health plans offered on federally facilitated  
 7 exchanges, the Center for Consumer Information and Insurance Oversight (CCIIO) stated that it  
 8 intends to collect plan provider lists and review them to determine whether providers are available  
 9 without unreasonable delay. Its focus areas will include access to hospital systems, mental health  
 10 providers, oncology providers and primary care providers. CCIIO also stated it will eventually  
 11 develop time and distance or other standards to guide network review.

12  
 13 Methods to ensure network adequacy on the state level vary based on existing state laws and  
 14 regulations. Thirteen states and DC, operating their own exchanges, have outlined additional  
 15 standards to supplement federal requirements on provider networks.<sup>6</sup> Some states rely on health  
 16 insurers attesting to network adequacy requirements, whereas others use private accreditation to  
 17 evaluate network adequacy – either the Health Plan Accreditation program of the National  
 18 Committee for Quality Assurance (NCQA) or URAC Health Plan Accreditation Program.  
 19 However, NCQA and URAC have stressed that their accreditation should not be viewed as a  
 20 substitute for an insurance commissioner’s oversight of the adequacy of a network.

21  
 22 *Relevant AMA Advocacy*

23  
 24 AMA advocacy on the issue of network adequacy in plans offered on health insurance exchanges  
 25 has included in-person meetings and consistent communications with the Administration, as well as  
 26 formal comments. Responding to complaints from the AMA, other provider groups, and consumer  
 27 groups, the final 2015 letter to issuers in federally facilitated exchanges adopted stronger  
 28 requirements for network adequacy and provider directories.

29  
 30 On the state level, the Advocacy Resource Center (ARC) has created an ACA state implementation  
 31 toolkit, which contains four model bills on tiered and narrow networks and access to accurate  
 32 provider directories. In addition, the AMA has a model bill titled “Meaningful Access to  
 33 Physicians and other Health Care Providers: Network Standards Act” to ensure network adequacy.  
 34 The AMA also is an active participant in a National Association of Insurance Commissioners  
 35 (NAIC) subgroup that is reviewing the Managed Care Plan Network Adequacy Model Act, and has  
 36 submitted comments to the NAIC outlining suggested revisions and updates. Finally, pursuant to  
 37 Policy D-165.989, the AMA has been supportive of state medical association efforts advocating  
 38 that states issue more stringent network adequacy standards than what is outlined in federal  
 39 requirements.

40  
 41 **NETWORK ADEQUACY AND MEDICARE ADVANTAGE**

42  
 43 The Council notes that many Medicare Advantage plans have limited networks and more than one  
 44 in four Medicare beneficiaries are enrolled in Medicare Advantage plans.<sup>7</sup> In Medicare Advantage,  
 45 plans must meet network adequacy criteria related to minimum number of providers and facilities,  
 46 and maximum travel time and distance. The Council is concerned with some strategies used to  
 47 narrow provider networks in Medicare Advantage plans, especially the significant modifications  
 48 that a number of Medicare Advantage plans made to their provider networks in late 2013 during  
 49 the Medicare open enrollment period for coverage effective in 2014, without adequately notifying  
 50 beneficiaries and many providers of the network changes.

1 Issues with network adequacy in Medicare Advantage plans highlighted by the AMA have  
 2 prompted CMS to require Medicare Advantage plans in 2015 to provide CMS with 90 days notice  
 3 of any significant changes to their provider networks, and establish best practices for Medicare  
 4 Advantage plans to follow when they make significant changes to their provider networks. Also in  
 5 2015, Medicare Advantage plan enrollees will be eligible for a special enrollment period and to  
 6 switch plans when they are affected by significant provider network terminations that occur during  
 7 the plan year when such terminations are initiated by their Medicare Advantage plan without cause.

8  
 9 *Relevant AMA Advocacy*

10  
 11 In response to the terminations of physicians from Medicare Advantage plan provider networks  
 12 during the 2013 open enrollment period, the AMA circulated a sign-on letter that urged CMS to  
 13 take immediate action to ensure that Medicare Advantage plan enrollees had accurate and reliable  
 14 provider network information to make informed health insurance elections for the 2014 plan year,  
 15 and to address a lack of Medicare Advantage plan transparency on network adequacy. The AMA  
 16 also joined more than 30 medical associations and physician groups in a friend-of-the-court brief in  
 17 support of upholding a preliminary injunction barring UnitedHealthCare from terminating  
 18 thousands of physicians from its Medicare Advantage plan in Connecticut. In addition, the AMA  
 19 prioritized the issue of network transparency and adequacy in comments to and meetings with  
 20 CMS regarding Medicare Advantage. The AMA also has been working with members of Congress  
 21 on legislation to enhance beneficiary protections. For example, the AMA has worked with Rep.  
 22 Rosa DeLauro (D-CT) and Sen. Sherrod Brown (D-OH) on HR 4998/S 2552, the Medicare  
 23 Advantage Participant Bill of Rights Act of 2014, and has formally supported the legislation.

24  
 25 TREATMENT OF OUT-OF-NETWORK SERVICES

26  
 27 While tiered and narrow networks of plans offered through the exchanges may provide patients  
 28 with access to plans with lower premiums and cost sharing when compared to broader network  
 29 plans, the Council recognizes that patients with narrow network plans who need to seek care from  
 30 out-of-network providers face the potential of significant out-of-pocket costs. Plans that do cover  
 31 out-of-network services often do so with higher patient cost-sharing requirements (coinsurance,  
 32 co-payments and deductibles). Regardless of whether a plan covers out-of-network services, the  
 33 annual cap on patient out-of-pocket costs outlined in the ACA (\$6,350 for an individual and  
 34 \$12,700 for a family) does not apply to services obtained out-of-network. Depending on the plan,  
 35 there is either a separate deductible or out-of-pocket maximum for out-of-network services, or the  
 36 cost of services obtained out-of-network does not count toward the deductible or out-of-pocket  
 37 maximum. Patients who seek care out-of-network can also be billed for any charges not covered by  
 38 their health plans. The ACA prohibits insurers from charging consumers out-of-network cost-  
 39 sharing for emergency services, even if those services are delivered by out-of-network providers.

40  
 41 *FAIR Health*

42  
 43 FAIR Health Inc., a nonprofit entity created as part of settlements between the New York State  
 44 Office of the Attorney General and major health insurers in 2009 concerning the transparency of  
 45 out-of-network payment, houses and provides access to an independent database comprised of  
 46 more than 16 billion claims dating back to 2002 of more than 60 contributors and other payors,  
 47 which represent 140 million covered lives.<sup>8</sup> The FAIR Health database helps to ensure that health  
 48 plans do not use proprietary databases to artificially reduce their payments to out-of-network  
 49 physicians. FAIR Health also offers free online comparison tools that publicly report rates for any  
 50 given out-of-network services and help patients estimate out-of-pocket medical costs.

1 *Relevant AMA Advocacy*

2

3 In response to health insurance exchange regulations and letters to issuers, the AMA has raised  
 4 concerns about the potential adverse effects on patients as a consequence of narrow networks. In  
 5 particular, AMA comments have noted that out-of-network costs can impose a significant financial  
 6 burden on patients, as out-of-network services are often not covered by insurance or have greater  
 7 cost-sharing requirements. They are also excluded under the ACA’s cap on out-of-pocket costs. To  
 8 minimize the financial burden to patients, the AMA has prioritized the need for health plans to be  
 9 transparent in providing prospective enrollees critical information addressing network adequacy  
 10 and out-of-network provider access, including the number of visits to out-of-network providers per  
 11 thousand enrollees in the last year; the percent of services received from in-network providers as a  
 12 percentage of total services received by enrollees; and the percentage of total costs for in-network  
 13 and out-of-network services received by enrollees which were paid for by the health insurance  
 14 issuer. In addition, for health plans that use either a charge-based or non-charge-based  
 15 methodology to determine payment due to an out-of-network physician, the AMA has stated that  
 16 these plans should provide patients, including prospective enrollees, with additional information so  
 17 they would have a greater understanding of their financial responsibilities and payment obligations.

18

19 On the state level, the AMA has worked with state medical associations to support state out-of-  
 20 network transparency legislation. In addition, the AMA has a model bill titled “Truth in Out-of-  
 21 Network Healthcare Benefits Act,” which aims to ensure that out-of-network benefits are conveyed  
 22 in clear, transparent, simple, and accurate terms so that patients understand their rights and  
 23 responsibilities.

24

25 **RELEVANT AMA POLICY**

26

27 Policy H-285.911 states that health insurance provider networks should be sufficient to provide  
 28 meaningful access to all medically necessary and emergency care, at the preferred, in-network  
 29 benefit level on a timely and geographically accessible basis. Policy H-285.984 states that health  
 30 care plans or networks that use criteria to determine the number, geographic distribution, and  
 31 specialties of physicians needed be required to report to the public, on a regular basis, the impact  
 32 that the use of such criteria has on the quality, access, cost, and choice of health care services  
 33 provided to patients enrolled in such plans or networks. Policy H-285.924 states that health plans  
 34 should provide patients with their current directory of participating physicians through multiple  
 35 media outlets, including the Internet. Policies H-450.941 and D-285.972 support monitoring the  
 36 development of tiered, narrow or restricted networks to ensure that they are not inappropriately  
 37 driven by economic criteria by the plans and that patients are not caused health care access  
 38 problems based on the potential for a limited number of specialists in the resulting network(s).  
 39 Policy H-180.952 opposes any penalties implemented by insurance companies against physicians  
 40 when patients independently choose to obtain out-of-network services.

41

42 Policy H-285.991 states that prior to initiation of actions leading to termination or nonrenewal of a  
 43 physician’s participation contract for any reason the physician shall be given notice specifying the  
 44 grounds for termination or nonrenewal, a defined process for appeal, and an opportunity to initiate  
 45 and complete remedial activities, except in cases where harm to patients is imminent or an action  
 46 by a state medical board or other government agency effectively limits the physician’s ability to  
 47 practice medicine. The policy also outlines requirements for an appeals process for physicians  
 48 whose health insurance contract is terminated or not renewed.

49

50 Policy H-385.989 supports a pluralistic approach to third party payment methodology and affirms  
 51 that physicians have the right to establish their fees at a level which they believe fairly reflects the

1 costs of providing a service and the value of their professional judgment, and should have the right  
 2 to choose the basic mechanism of payment for their services, and specifically to choose whether or  
 3 not to participate in a particular insurance plan or method of payment, and to accept or decline a  
 4 third party allowance as payment in full for a service. The policy also supports establishing  
 5 additional limits on the amount or the rate of increase in charge-related payment levels when  
 6 appropriate.

7  
 8 Addressing the use of charge-related payment mechanisms, Policy H-385.990 recognizes that  
 9 indemnity reimbursement, as a schedule of benefits, as well as “usual and customary or  
 10 reasonable,” have positive aspects which merit further study. The policy also urges physicians to  
 11 continue and to expand the practice of accepting third party reimbursement as payment in full in  
 12 cases of financial hardship, and to voluntarily communicate to their patients through appropriate  
 13 means their willingness to consider such arrangements in cases of financial need or other  
 14 circumstances. Policy H-385.923 provides a definition of “Usual, Customary and Reasonable.”  
 15 Several AMA policies support balance billing, including Policies H-385.991, D-385.975,  
 16 D-390.986, D-380.996, D-390.985 and D-390.969.

17  
 18 **DISCUSSION**

19  
 20 The Council recognizes that, in an effort to hold down costs, many health insurers offering plans in  
 21 the exchanges, Medicare Advantage, and to employers are relying on tiered and narrow networks,  
 22 which may provide patients with access to plans with lower premiums and cost sharing. However,  
 23 in some cases, strategies to narrow provider networks can result in networks that are inadequate to  
 24 provide meaningful access to all medically necessary and emergency care at the preferred, in-  
 25 network benefit level on a timely and geographically accessible basis. The Council stresses the  
 26 need for the AMA to continue working on legislation and/or regulations that prohibit the formation  
 27 of networks based solely on economic criteria and ensures that, before health plans can establish  
 28 new panel networks, physicians are informed of the criteria for participating in those networks,  
 29 with sufficient advance time to permit them to satisfy the criteria. To ensure that patients select the  
 30 health plan that provides covered access to their usual physicians, changes to provider networks  
 31 should be approved prior to the enrollment period, and health plans should provide patients with an  
 32 accurate, complete directory of participating physicians through multiple media outlets. It is  
 33 essential that provider directories identify providers that are not accepting new patients, which has  
 34 been an issue with both exchange and Medicare Advantage plans. The Council stresses that  
 35 changes to provider networks, including the termination or nonrenewal of a physician’s  
 36 participation contract, should follow the requirements outlined in Policy H-285.991.

37  
 38 Once provider networks are established, enrollees should be allowed to have continued access to  
 39 the network they reasonably relied upon when purchasing the product throughout the coverage  
 40 year. To ensure consistency in provider networks during the plan year, the Council supports  
 41 requiring health insurer issuers to submit quarterly reports to state regulators, including such  
 42 measures as the number and type of providers that have joined or left the network; the number and  
 43 type of specialists and subspecialists that have left or joined the network; data that indicate the  
 44 provision of Essential Health Benefits; and consumer complaints received. The Council believes  
 45 that such reporting would increase patient confidence in provider networks, and build on existing  
 46 efforts of health plans to monitor their networks internally. While health plan self-assessment and  
 47 private accreditation are key components of ensuring network adequacy, the Council believes it is  
 48 critical that state regulators establish themselves as the primary enforcer of network adequacy  
 49 requirements to ensure state network adequacy laws and regulations are followed.

1 When patients find themselves in networks deemed to be inadequate as defined by relevant state  
2 and federal laws and regulations, the Council believes they should have access to adequate and fair  
3 appeals processes to ensure they are able to receive the care they need at the in-network rate. If a  
4 provider network is deemed inadequate and a referral to an out-of-network provider is made, health  
5 insurers should be required to indemnify the patient for any covered medical expenses provided by  
6 the out-of-network provider incurred over the coinsurance/co-payments and deductibles that would  
7 apply to in-network providers. In addition, to promote patient financial protection, such services  
8 received out-of-network should count toward the deductible and the annual cap on out-of-pocket  
9 costs. To ensure that reasonable credit is given for out-of-network expenses when a patient is  
10 enrolled in a plan with out-of-network benefits, or forced to go out-of-network based on network  
11 inadequacies, the Council believes that legislation or regulation is needed to ensure that data from  
12 an independent medical charge database, such as Fair Health, is used.

13

#### 14 RECOMMENDATIONS

15

16 The Council on Medical Service recommends that the following be adopted in lieu of Resolution  
17 113-A-14, Resolution 125-A-14 and Resolution 130-A-14, and that the remainder of the report be  
18 filed:

19

- 20 1. That our American Medical Association (AMA) reaffirm Policy H-285.924, which states that  
21 health plans should provide patients with an accurate, complete directory of participating  
22 physicians through multiple media outlets, including the Internet. (Reaffirm HOD Policy)  
23
- 24 2. That our AMA reaffirm Policy H-285.991, which outlines requirements that must be met prior  
25 to initiation of actions leading to termination or nonrenewal of a physician's participation  
26 contract for any reason, as well as requirements for a meaningful appeals process for  
27 physicians whose health insurance contract is terminated or not renewed. (Reaffirm HOD  
28 Policy)  
29
- 30 3. That our AMA reaffirm Policy D-285.972, which states that our AMA will seek legislation or  
31 regulation that prohibits the formation of networks based solely on economic criteria and  
32 ensures that, before health plans can establish new panel networks, physicians are informed of  
33 the criteria for participating in those networks, with sufficient advance time to permit them to  
34 satisfy the criteria. (Reaffirm HOD Policy)  
35
- 36 4. That our AMA support state regulators as the primary enforcer of network adequacy  
37 requirements. (New HOD Policy)  
38
- 39 5. That our AMA support requiring that provider terminations without cause be done prior to the  
40 enrollment period, thereby allowing enrollees to have continued access throughout the  
41 coverage year to the network they reasonably relied upon when purchasing the product.  
42 Physicians may be added to the network at any time. (New HOD Policy)  
43
- 44 6. That our AMA support requiring health insurers to submit and make publicly available, at least  
45 quarterly, reports to state regulators that provide data on several measures of network  
46 adequacy, including the number and type of providers that have joined or left the network; the  
47 number and type of specialists and subspecialists that have left or joined the network; the  
48 number and types of providers who have filed an in-network claim within the calendar year;  
49 total number of claims by provider type made on an out-of-network basis; data that indicate the  
50 provision of Essential Health Benefits; and consumer complaints received. (New HOD Policy)



- 1 7. That our AMA support requiring health insurers to indemnify patients for any covered medical  
2 expenses provided by out-of-network providers incurred over the co-payments and deductibles  
3 that would apply to in-network providers, in the case that a provider network is deemed  
4 inadequate by the health plan or appropriate regulatory authorities. (New HOD Policy)  
5
- 6 8. That our AMA advocate for regulation and legislation to require that out-of- network expenses  
7 count toward a participant's annual deductibles and out-of-pocket maximums when a patient is  
8 enrolled in a plan with out-of-network benefits, or forced to go out-of-network due to network  
9 inadequacies. (New HOD Policy)  
10
- 11 9. That our AMA support fair and equitable compensation to out-of-network providers in the  
12 event that a provider network is deemed inadequate by the health plan or appropriate regulatory  
13 authorities. (New HOD Policy)  
14
- 15 10. That our AMA provide assistance upon request to state medical associations in support of state  
16 legislative and regulatory efforts, and disseminate relevant model state legislation, to ensure  
17 physicians and patients have access to adequate and fair appeals processes in the event that  
18 they are harmed by inadequate networks. (Directive To Take Action)  
19
- 20 11. That our AMA support the development of a mechanism by which health insurance enrollees  
21 are able to file formal complaints about network adequacy with appropriate regulatory  
22 authorities. (New HOD Policy)  
23
- 24 12. That our AMA advocate for legislation that prohibits health insurers from falsely advertising  
25 that enrollees in their plans have access to physicians of their choosing if the health insurer's  
26 network is limited. (Directive to Take Action)

Fiscal Note: Less than \$500.

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