Health Plan Network Adequacy

Access to physicians, hospitals, and other health care providers depends on a range of factors, including the breadth, size, and distribution of a health plan's provider network. Network adequacy refers to a health plan's ability to provide access to in-network physicians and hospitals to meet enrollee's health care needs. Inadequate networks create obstacles for patients seeking new or continued care and limit their choice of physicians and facilities. For physicians, inadequate networks can negatively impact a practice's negotiating power, lead to excessive appointment wait times, and contribute to increased physician burnout.

Although network adequacy must be monitored across all types of health plans, the use of narrow networks has become increasingly common in Medicare Advantage (MA), Medicaid, and ACA marketplace plans. MA plans, which enroll more than half the total Medicare population, are subject to federal regulations. Although plans offered in individual and small group markets may also be subject to federal requirements, states are primarily responsible for regulating them. In accordance with federal standards, states also regulate network adequacy in Medicaid and generally have broad discretion to oversee Medicaid managed care organizations (MCOs). Self-insured plans are exempt from most state insurance laws but must comply with a limited set of federal regulations. Although midlevel providers may be in a provider network if permitted under state law, health plans must meet network adequacy requirements for physicians and measurement should be limited to physicians for physician services.

A multilayered approach is essential

The AMA supports state regulators as the primary enforcer of health plan network adequacy. However, because many states have not updated their network adequacy requirements, especially in light of narrowing networks, the AMA advocates for the establishment of a strong national floor of quantifiable standards. The AMA maintains that regulators should take a multilayered approach to ensuring the adequacy of provider networks that includes:

Establishment and enforcement of a minimum network adequacy standard requiring all health plans to contract with sufficient numbers and types of physicians and other providers, including for mental health and substance use disorder (SUD), such that both scheduled and unscheduled care may be provided without unreasonable travel or delay.

Use of multiple criteria to evaluate the sufficiency of physician networks, including but not limited to:

- ✓ **Minimum physician-to-enrollee ratios** across specialties and subspecialties, including mental health and substance use disorder providers who are accepting new patients
- ✓ Minimum percentages of non-emergency physicians available on nights and weekends
- ✓ **Maximum time and distance standards**, including for enrollees who rely on public transportation
- ✓ **A clear standard for network appointment wait times** across specialties and subspecialties, developed in consultation with appropriate specialty societies, for both new patients and continuing care
- ✓ **Sufficient physicians** to meet the care needs of people experiencing economic or social marginalization, chronic or complex health conditions, disability, or limited English proficiency

Development and promulgation of network adequacy assessment tools that allow patients and employers to compare plans and make informed decisions when enrolling in a plan.

Requirements for health plans to report to regulators annually and prominently display network adequacy information so that it is available to consumers shopping for plans, including:

- ✓ The **breadth of a plan's provider network**, by county and geographic region or Metropolitan Statistical Area (MSA)
- ✓ **Average wait times** for primary and behavioral health care appointments as well as common specialty and subspecialty referrals
- ✓ The **number of in-network physicians treating substance use disorder** who are accepting new patients in a timely manner, and the type of substance use disorder medications offered
- ✓ The **number of in-network psychiatrists and other mental health providers** accepting new patients in a timely manner
- ✓ **Instructions for consumers and physicians to easily contact regulators to report complaints** about inadequate provider networks and other access problems
- ✓ The **number of physicians versus non-physician providers** in the network overall and by specialty/practice focus
- ✓ The number, geographic location, and medical specialty of any **physician contracts terminated or added** during the prior calendar year

Requirements that health plans report to state regulators and make publicly available, at least quarterly, reports on additional measures of network adequacy, including:

- ✓ 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
- ✓ Total number of claims by provider type made on an out-of-network basis
- ✓ Data that indicate the provision of Essential Health Benefits and complaints received.

Use of claims data, audits, secret shopper programs, complaints, and enrollee surveys or interviews to monitor and validate in-network provider availability and wait times, network stability, and provider directory accuracy, and to identify other access or quality problems.

A mechanism by which enrollees are able to file formal complaints about network adequacy with regulators.

Prohibitions against health plans falsely advertising that enrollees have access to physicians of their choosing if the plan's network is limited.

Holding health plans accountable for network inadequacies, including through use of corrective action plans and substantial financial penalties.

Network adequacy and telehealth

The AMA does not support counting physicians who only offer telehealth services towards network adequacy requirements and urges caution when integrating telehealth into network adequacy standards, which could potentially lead to fewer in-person physicians in a network and thereby limit access to in-person care. Additionally, the AMA believes that in-network physicians who provide both in-person and telehealth services may count towards network adequacy requirements on a limited and ideally temporary basis when their physical practice does not meet time and distance standards, based on regulator discretion, such as when there is a documented shortage of physicians in the needed specialty or subspecialty within the community served by the plan.

Parameters for out-of-network care

When patients find themselves in networks that are inadequate, 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 physician 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 physicians. In addition, such services received out of network should count towards the patient's deductible and annual out-of-pocket cap.

When networks are deemed inadequate, health plans should also pay out-of-network physicians and hospitals fairly and equitably for services provided. Payment for such care should be based on a number of factors, including the usual and customary charge for such service, which should be based upon a percentile for all out-of-network charges for a particular service by a provider in the same or similar specialty and provided in the same geographic area as reported by a benchmarking database. On this topic, the AMA continues its focus on the *No Surprises Act* and remains concerned that implementation of the statute does not support physicians' ability to meaningfully engage in dispute resolution, as Congress intended, because of the Administration's problematic reliance on the qualified payment amount in arbitration, among other issues.

Health plans that terminate in-network providers should be required to: (a) notify providers of pending termination at least 90 days prior to removal from network; (b) give to providers, at least 60 days prior to distribution, a copy of the health insurer's letter notifying patients of the provider's change in network status; and (c) allow the provider 30 days to respond to and contest the letter prior to its distribution.

Provider directory accuracy

To help ensure that patients are able to select a health plan that provides covered access to physicians they want and need, insurers must provide patients with accurate, complete, and up-to-date directories of participating physicians. Because outdated and inaccurate directories are an ongoing pain point for patients and physicians, the AMA believes regulators should take action to improve the accuracy of directories and increase data standardization across plans, and:

- ✓ Require plans to submit accurate network directories each year prior to open enrollment and whenever there are significant changes to the status of physicians included in the network
- ✓ Audit directory accuracy more frequently for plans that have had deficiencies
- ✓ Take enforcement action against plans that fail to maintain complete and accurate directories
- ✓ Immediately remove from directories physicains who no longer participate in the network.

The AMA Council on Medical Service studies and evaluates the social and economic aspects of medical care and recommends policies on these issues to the AMA House of Delegates. For more information, see AMA Council on Medical Service Report 3-I-23, Strengthening Network Adequacy