AMA
AMERICAN MEDICAL ASSOCIATION

JAMES L. MADARA, MD
EXECUTIVE VICE PRESIDENT, CEO

ama-assn.org
t (312) 464-5000

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J.P. Weiske
Chair of the Network Adequacy Model
Review (B) Subgroup
National Association of Insurance
Commissioners
701 Hall of the States
444 North Capitol Street, NW
Washington, DC 20001-1509

Jolie H. Matthews
Senior Health and Life Policy Counsel
National Association of Insurance
Commissioners
701 Hall of the States
444 North Capitol Street, NW
Washington, DC 20001-1509

Re: AMA recommendations for quantitative evaluation of network adequacy

Dear Mr. Weiske and Ms. Matthews:

On behalf of our physicians and student members, the American Medical Association (AMA) appreciates the opportunity to provide comments with respect to quantitative evaluation of network adequacy to ensure patients receive the greatest value for their premium dollar. As noted on the September 11, 2014 Subgroup conference call, the AMA supports strong regulatory oversight of provider networks as well as increased transparency about those networks.

As policymakers move forward in determining how to approach new standards and monitoring strategies in the most effective manner for their unique state, the AMA has provided recommendations, with the intent of supporting themes outlined by state medical associations, other provider groups and the consumer representatives.

We offer the following examples of quantitative criteria simply as starting points for discussion among the many experts engaged in this National Association of Insurance Commissioners (NAIC) process, with the recognition that a movement away from insurer self-attestation and subjective network adequacy standards is absolutely necessary.

Quantitative standards for evaluating, monitoring and reporting network adequacy

The AMA encourages regulators to take a multi-pronged approach to quantitative measurement. No individual measurement will ensure access, and in fact, if used alone, may provide a false assessment of adequacy. For example, a network may have four contracted cardiologists 10 miles away or 15 minutes from an enrollee, meeting the hypothetical time and distance standards for that state. However, if two of the cardiologists are only part-time and do not have appointments available for 45 days, one does not have admitting privileges to an in-network hospital, and the remaining cardiologist is not accepting new patients, the network for the enrollee should not be considered adequate.

The AMA suggests the following quantitative measures for your consideration:

- Maximum travel time and distance (will vary, but generally no more than 30 minutes and/or 30 miles in non-rural areas for a full time equivalent provider).
- Maximum appointment wait times (2-3 weeks maximum).
- Provider capacity and admitting of new patients (should be reassessed monthly).
- Minimum providers available to meet the needs of patients with limited English proficiency, diverse cultural and ethnic backgrounds, and with physical and mental disabilities.
- Provider hours.
- Availability of technological and ancillary services.
- Physician admitting privileges.

Additional considerations:

- Quality measurement is essential to evaluation of provider networks, especially narrower and tiered networks.
- Assessment of tiered networks should be based on providers available in the lowest cost-sharing tier.
- Network evaluation should include specific attention to the availability of primary care physicians and commonly accessed specialists.
- If a provider is listed in multiple networks, we encourage regulators to consider that fact when assessing the availability and capacity of that provider.
- Patient feedback is essential to monitoring network adequacy. Regular patient surveys should be conducted for each network plan offered by a health insurer, and the results be made publicly available to consumers on the Department of Insurance's webpage or other relevant website.
- We encourage regulators to offer and require complete and total transparency of network requirements, monitoring, evaluation, and results.

Draft Statutory Language

The AMA offers the following draft statutory language for your consideration:

Section 5. *Network Adequacy*

A. *For the purposes of this section, a carrier's network is sufficient if the carrier meets specific quantitative standards to be defined in regulation by the Department of Insurance ("Department") of this state. The regulations shall establish requirements for provider networks that address the following:*

   a. *Maximum travel time and distance standards in miles by county to access a full time equivalent primary care physician, specialty physician and other health care provider.*
   b. *Maximum allowable wait times for primary care physician, specialty physician and other health care provider.*
   c. *Minimum number of full time equivalent physicians and healthcare providers needed in a network to meet the needs of patients with limited English proficiency, diverse cultural and ethnic backgrounds, and with physical and mental disabilities.*
   d. *Maximum time and distance standards in miles by county to access full time equivalent technological and ancillary services, including imaging and laboratory services.*
   e. *Maximum time and distance standards in miles by county to access general hospital services with emergency care.*

B. *The Department shall incorporate the following factors into the access standards identified in Section 5(A):*

   a. *Monthly assessment of provider capacity, including the availability of providers to accept new patients.*
   b. *The variation in hours of operation for network providers.*
   c. *The quality measures used to evaluate providers for network inclusion.*
   d. *The ability of physicians to admit patients to in-network hospitals.*

C. *All requirements of the regulations to be issued under Section 5(A)-(B) shall be applied to the lowest cost-sharing tier of any tiered network.*

D. *The Department shall conduct quarterly patient surveys to help inform its monitoring of network adequacy and shall make the results publically available.*

E. *The Department shall require full public disclosure of all criteria used by carriers to select network providers.*

Conclusion

As mentioned above, we offer these suggestions as a starting point for discussion and look forward to feedback from regulators and interested parties. However, we again reiterate the need to move toward quantitative assessment of networks to ensure true adequacy and access for patients. We very much appreciate this opportunity to provide input to the subgroup and look forward to continuing our work with you. Please contact Emily Carroll, Senior Legislative Attorney, Advocacy Resource Center at emily.carroll@ama-assn.org or (312) 464-4967 with any concerns or questions.

Sincerely,

James L. Madara, MD