



October 9, 2018

Ms. Margaret E. O’Kane  
President, National Committee for Quality Assurance  
1100 13<sup>th</sup> Street, NW, Third Floor  
Washington, DC 20005

Dear Ms. O’Kane:

We are writing in concern that current National Committee for Quality Assurance (NCQA) health plan network adequacy standards are deficient in ensuring that health plan enrollees have reasonable and timely access to in-network hospital-based providers. We hope that this letter can lead to NCQA action on standard setting in this area, or a dialogue on this issue as the oversight of network adequacy is critical to the patients we serve.

Specifically, NCQA should be mindful that a national coalition of physician medical societies and patient advocacy groups are calling upon state and federal regulators to scrutinize health plans for hospital-based physician network adequacy. (See: Attached Declaration). We urge NCQA to consider the following public policy actions in this area that should help inform your review and consideration of this matter:

### **Policy of the American Medical Association**

Current policy of the American Medical Association (AMA) policy (Network Adequacy-H.285.908), states:

Our AMA advocates that health plans should be required to document to regulators that they have met requisite standards of network adequacy including hospital-based physician specialties (i.e. radiology, pathology, emergency medicine, anesthesiologists and hospitalists) at in-network facilities, and ensure in-network adequacy is both timely and geographically accessible.

### **State Regulatory Requirements Based on NAIC Model Act**

It should also be noted, the 2015 national model legislation/regulation on network adequacy “Health Benefit Plan Network Access and Adequacy Model Act,” of the National Association of Insurance Commissioners (NAIC), placed a clear obligation on health insurance payers to declare, as part of their regulatory submission to a state, their “process for monitoring access to physician specialist services in emergency room care, anesthesiology, radiology, hospitalist care and pathology/laboratory services at their participating hospitals” (Section 5 – Network Adequacy (F) (11)).

This network adequacy provision of the NAIC model was adopted in the State of Oregon (OAR 836-053-0320 (l)), the State of Colorado (3 CCR-7024-Reg 4-2-54 Section 6 (g)) under rules promulgated by the Insurance Departments of these respective states and in the State of Connecticut (Conn. Gen. Stat. § 38a-472f (h) (2) (j)).

Furthermore, in March 2016, the State of California adopted new rules to assess the sufficiency of health plan networks for the provision of hospital-based physician providers. Specifically, the new state rule (California Code of Regulations (CCR) Title 10, Section 2240.5 (d) (14)) provides that health plans submit prior to approval:

(14) A report describing, for each network hospital, the percentage of physicians in each of the specialties of (A) emergency medicine, (B) anesthesiology, (C) radiology, (D) pathology, and (E) neonatology practicing in the hospital who are in the insurer's network(s).

### **Federal QHP Application Standard**

An NAIC analog requirement is also now embedded in the "Network Adequacy" application standard for the Centers for Medicare and Medicaid Services (CMS) Qualified Health Plan (QHP) Issuer Application Instructions for 2019 (issued April 9, 2018) applicable to QHPs seeking entry into the federally facilitated exchanges. Under this application, a QHP must include an access plan, which specifies: "The health carrier's process for monitoring access to physician specialist services in emergency room care, anesthesiology, radiology, hospitalist care, and pathology/laboratory services at their participating hospitals." ("Qualified Health Plan Issuer Application Instruction," April 9, 2018, p.39)

### **State Laws on Hospital-Based Physician Network Adequacy**

The State of Louisiana establishes in law (RS 22:1019.2) a network adequacy requirement that: "each health insurance issuer shall maintain a network of providers that includes but is not limited to providers that specialize in mental health and substance abuse services, facility-based physicians, and providers that are essential community providers."

Under this section of Louisiana law a: "Facility-based physician" means a physician licensed to practice medicine who is required by the base health care facility to provide services in a base health care facility, including an anesthesiologist, hospitalist, intensivist, neonatologist, pathologist, radiologist, emergency room physician, or other on-call physician, who is required by the base health care facility to provide covered health care services." (see 1019.1. definitions).

Most recently, the State of New Hampshire, in 2018, enacted RSA 420.J:7 II(e): "Standards for addressing in-network access to hospital-based providers, such as anesthesiologists, radiologists, pathologists, and emergency medicine physicians." This provision imposes a network adequacy review of hospital-based providers under any insurance plan subject to Department of Insurance oversight in that state.

### **State Legislation**

In addition to these state laws and regulations, state legislation in 2018 to require hospital-based physician network adequacy assessments by state regulators was also considered in Washington (HB 2114) and Tennessee (SB 2640/HB 2353). We anticipate, in 2019, further state legislative action to ensure health plans meet requisite standards for hospital-based physician network adequacy.

## **Health Insurance Plan Network Narrowing**

Under a research report issued this summer (July 2018), Avalere, a leading healthcare research firm, evaluated the state of health plan network adequacy.<sup>1</sup> They concluded: In 2017, 68% of healthcare plans in the exchange market offered restrictive networks, compared with 48% in 2014. In addition, Avalere found:

- Nearly 41% of silver plan physician networks in 2015 were defined as small or extra small.
- Insurance plans offered in exchange markets in 2017 covered between 34% to 66% fewer providers than plans available in other markets.
- In 2015, nearly 15% of insurance plans in exchange markets were “specialist-deficient” lacking any in-network provider for at least one specialty, like radiologists.

## **Request to NCQA**

As should be noted, states now recognize the need to review and assess this important aspect of network adequacy as part of their routine state oversight responsibility of health plan adequacy. However, we do not see NCQA as including any standard that is germane to ensuring hospital-based physician network adequacy. Specifically, we are not aware of any NCQA standard to assess health plans for hospital-based physician network adequacy or to require that plans meet any standard germane to this issue.

Accordingly, in concert with the actions at the state level now being undertaken and given the critical importance of this issue to seamless, transparent and economically efficient health care delivery, on behalf of the physician and patient community, we urge adoption of NCQA standards in this area. We look forward to further dialogue or a response that addresses our concerns. We are amenable to meet if further dialogue can facilitate adoption of NCQA standards.

Thank you for your courtesies and consideration.

Sincerely,



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<sup>1</sup> “The High Cost of Healthcare: Patients See Greater Cost-Shifting and Reduced Coverage in Exchange Markets 2014-2018” (July 2018), Avalere Research conducted for *Physicians For Fair Coverage*.