Position on protecting patients' access to care through adequate physician provider networks

Support:

- Comprehensive patient access to specialty care
- Up-to-date and user-friendly provider directories and information, provided to plan participants on in-network physicians[1]
- Clear inclusion criteria for physician participation in provider networks
- Timely appeals processes for physicians who have been excluded from provider networks
- Establishment and enforcement of state and federal network adequacy standards, including minimum time and distance standards[2,3]

Oppose:

- Mid-term terminations of providers
- Provider networks where patients can't access timely specialty and geographically appropriate-care, due to a lack of qualified or regionally-balanced physicians
- Inadequate information to patients, whose insurers fail to keep provider directories accurate and up-to-date
- Network inclusion decisions that are solely based on cost
- Cumbersome, hidden or slow appeals processes for physicians who have been excluded from provider networks or have been recently dropped

The American Society for Dermatologic Surgery Association (ASDSA) continues to consistently receive reports from physicians whose patients are unable to access their ongoing specialty care because the physician has been dropped from the provider network, often without warning or explanation. This has been especially true for skin cancer specialists, who often treat our most vulnerable patients who are recipients of Medicare or Medicaid.

Patients deserve the care they were promised and have paid for, so insurance companies must be timely and transparent, in communicating with patients when they are being denied access to their physicians. Provider terminations without cause should be made prior to the enrollment period so patients can select their health plan based on their existing physician and health needs.[4]

---

[1] A better approach to regulating provider network adequacy. September 14, 2017. https://www.brookings.edu/research/a-better-approach-to-regulating-provider-network-adequacy/.
[2] Plans, providers split on easing Medicaid network adequacy standards. January 15, 2019. https://www.modernhealthcare.com/article/20190115/TRANSFORMATION04/190119947/plans-providers-split-on-easing-medicaid-network-adequacy-standards.
[3] Network adequacy under the Trump Administration. September 14, 2017. https://www.healthaffairs.org/do/10.1377/hblog20170914.061958/full/.
[4] Georgia Society of Dermatology and Dermatologic Surgery. Summary of Physician Profiling Bill. Accessed March 17, 2014.

Patients deserve care based on their unique, comprehensive and complex health needs, not based on insurance companies' economic rationales to exclude physician providers. Inclusion criteria for provider networks or reimbursement purposes should be based on evaluation criteria developed in collaboration with physicians. Quality of care evaluation must be based on recognized, consensus-based guidelines. Such guidelines should be standardized and contain specialty-specific measures. Cost of care evaluation must compare physicians within the same specialty, and when applicable, within the same subspecialty, and the same geographical market. These evaluations should use a statistically valid number of patient episodes of care and statistically valid risk adjustment, and determine appropriate rules for attribution for cost-efficiency. Ratings should not be adversely affected by patient noncompliance, nor should they disincentivize preventive care, or treatment of sicker, economically underprivileged or minority patients.[5]

Insurers have a responsibility to patients to provide comprehensive and timely access to specialty care. Provider networks that do not have an adequate number of physically present contracted board-certified dermatologists in each geographic region deprive patients' access to contractually entitled benefits.

Patients need accurate directories of in-network physicians. All patients deserve access to an up-to-date provider directory enabling them to make optimal decisions regarding their health care insurance coverage. Similarly, physicians and other health care providers need to be included in a provider directory updated in real time, reflecting their network participation status.[6]

Approved by the ASDSA Board of Directors: December 2014
Updated August 2019
Updated September 2023

---

[5] American Medical Association. Meaningful Access to Physicians and other Health Care Providers: Network Standards Act Model Bill. Accessed March 17, 2014.
[6] New American Medical Association Policy Works to Protect Patient Choice and Access to Care, November 10, 2014.

Related AMA Policy:

H-285.908 Network Adequacy

1. Our AMA supports state regulators as the primary enforcer of network adequacy requirements.

2. Our AMA supports requiring that provider terminations without cause be done prior to the enrollment period, thereby allowing enrollees to have continued access throughout the coverage year to the network they reasonably relied upon when purchasing the product. Physicians may be added to the network at any time.

3. Our AMA supports requiring health insurers to submit and make publicly available, at least quarterly, reports to state regulators that provide data on several 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 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.

4. Our AMA supports requiring health insurers to indemnify patients for any covered medical expenses provided by out-of-network providers incurred over the co-payments and deductibles that would apply to in-network providers, in the case that a provider network is deemed inadequate by the health plan or appropriate regulatory authorities.

5. Our AMA advocates for regulation and legislation to require that out-of-network expenses count toward a participant's annual deductibles and out-of-pocket maximums when a patient is enrolled in a plan with out-of-network benefits, or forced to go out-of-network due to network inadequacies

6. Our AMA supports fair and equitable compensation to out-of-network providers in the event that a provider network is deemed inadequate by the health plan or appropriate regulatory authorities.

7. Our AMA supports health insurers paying out-of-network physicians fairly and equitably for emergency and out-of-network bills in a hospital. AMA policy is that any legislation which addresses this issue should assure that insurer payment for such care be based upon a number of factors, including the physicians' usual charge, the usual and customary charge for such service, the circumstances of the care and the expertise of the particular physician.

8. Our AMA provides assistance upon request to state medical associations in support of state legislative and regulatory efforts, and disseminate relevant model state legislation, to ensure physicians and patients have access to adequate and fair appeals processes in the event that they are harmed by inadequate networks.

9. Our AMA supports the development of a mechanism by which health insurance enrollees are able to file formal complaints about network adequacy with appropriate regulatory authorities.

10. Our AMA advocates for legislation that prohibits health insurers from falsely advertising that enrollees in their plans have access to physicians of their choosing if the health insurer's network is limited.

11. 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.

12. Our AMA supports requiring that health insurers that terminate in-network providers: (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 if necessary the letter prior to its distribution. (CMS Rep. 4, I-14 Reaffirmation I-15 Reaffirmed in lieu of Res. 808, I-15 Modified: Sub. Res. 811, I-15 Reaffirmed: CMS Rep. 03, A-17 Reaffirmed: Res. 108, A-17 Appended: Res. 809, I-17 Reaffirmed: Res. 116, A-18 Reaffirmation: A-19)