Network Adequacy Position Paper

The Leukemia & Lymphoma Society (LLS) is the world’s largest voluntary health agency dedicated to curing leukemia, lymphoma, Hodgkin’s disease and myeloma, while improving the quality of life of patients and their families. Treating cancer involves accessing a complex and extensive set of health care services including chemotherapy and prescription drugs, among others. As the U.S. healthcare system evolves, LLS is committed to ensuring access to and compliance with the most appropriate, evidence-based treatments for all blood cancer patients.

The Affordable Care Act (ACA) requires the Secretary of Health and Human Services (HHS) to establish regulations for the certification of Qualified Health Plans (QHPs) that are sold in the ACA’s health insurance exchanges. To receive certification, a QHP must at a minimum meet the federal requirements for network adequacy. However, the regulations only require insurers to maintain a network that is sufficient in number and types of providers to assure that all services will be accessible without unreasonable delay. This standard is ambiguous and does not provide the specificity that is necessary to ascertain whether a QHP has a network that allows meaningful and timely access to appropriate care or medically necessary treatment.

Recommended Network Adequacy Standards

LLS recommends that CMS amend and strengthen the federal network adequacy regulations for qualified health plans. LLS supports the changes, delineated below, to ensure cancer patients can access medically necessary cancer care, without unnecessary delays.

**LLS Recommendations: Adequate Numbers and Types of Providers**

- Ensure that all QHP networks include an adequate mix and number of health care providers to meet the healthcare needs of the enrolled populations. For cancer patients, networks must include providers in each area of specialty found on the American Board of Medical Specialties list of approved medical boards, specifically those specializing in oncology.
- Ensure that each QHP’s contracted providers treating cancer patients have “admitting” or “referral privileges” to in-network hospitals, ambulatory surgery centers or other specialty treatment facilities, as needed.
- Ensure each QHP network includes in-network coverage for at least one NCI-designated cancer center and at least one transplant center within 30 miles of an urban area or 60 miles of a rural area, where available.
- Ensure at least one pediatric hospital is in network within a thirty-mile radius in an urban area or sixty-mile radius in a rural area of the plan’s service area due to the specialized nature of caring for children with acute conditions. If there is no pediatric hospital within the specified geography of the plan’s service area, ensure the network contains at least one pediatric hospital.
- Ensure transparency by requiring QHPs to make publically available on-line and in print, directories of in-network providers and institutions.

**Notification Requirements**

- Require plans to notify the state, and enrollees, before any negative changes can be made to the provider networks.
- Require that regular updates be made to provider network directories and made available via the QHP’s website, or send directly to patients via email or hard copy every six months.
- Require network providers to notify the health plan, in a timely manner, if they are no longer taking new patients to enable health plans to keep their provider networks up-to-date and ensure patients’ access to timely care.

**Patient Costs for Out-of-Network Services**

- Adopt a robust and transparent “referral process” whereby patients can access medical services from an out-of-network provider at the same cost-sharing levels they pay for services from an in-network provider, when those services are deemed medically necessary by the referring physician. These costs shall be calculated as part of a patient’s annual limitation on cost-sharing under 45 CFR § 156.130.
- If providers leave the network mid-plan year, patients should not be penalized and their out-of-pocket liabilities shall remain at the in-network rate for 90 days until an alternative arrangement can be made.
  - Further, patients must be notified directly, in writing, of this change to enable them to identify another in-network provider.

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