



Patient Access to Specialty Care – Surprise Medical Bills

Issue:

Qualified Health Plans are being sold on the Exchanges with very limited networks (Exclusive Provider Organizations), often restricting patient access to qualified specialists. These inadequate networks are also partially to blame for the increase in patients receiving bills for out-of-network services.

Plans argue that these narrow networks help drive down costs. Unfortunately, it appears that the effect of this selective contracting is that Health Plans are also discouraging patients with certain chronic diseases (i.e. allergies, asthma, COPD, etc.) from enrolling in that Health Plan because their Allergist is not in-network.

Background:

While ensuring that individuals have the ability to pay for their healthcare needs is an important public policy objective, ensuring that these individuals have access to the appropriate provider is an equally important public health objective.

There have been numerous reports noting that many plans being offered on the Exchanges have so-called skinny networks or Exclusive Provider Organizations (EPOs). These are networks that are smaller than those typically available in that market. EPOs began appearing on the Health Exchanges a few years ago and their use by Health Plans has gotten more pronounced.

A recent article in [Modern Healthcare](#) highlighted this phenomenon:

The trend toward narrow-network plans and away from health plans with a broader selection of doctors and hospitals has persisted since the inception of the Affordable Care Act exchanges in 2014”

“Narrow network plans like health maintenance organizations and exclusive-provider organizations often provide no coverage for patient visits to out-of-network providers.”

While Health Plans maintain that such smaller networks are necessary to keep costs lower, some patient groups have raised the concern that these Network decisions are also a way for Health Plans to avoid certain high cost patients. It is also fueling the “surprise bill” concerns that are currently being debated in Congress and state legislatures.

Many patients – particularly parents of children with Asthma – will choose a Health Plan because their Allergy/Immunology physician or Children’s Hospital is in-network. If their Allergist or hospital are not “in-network” then they won’t choose that plan.

Despite dramatic advances in diagnosis, treatment and overall management of Asthma, the incidence of the disease has increased significantly over the past few years. Vast numbers of asthma patients – including a disproportionate number of children – do not receive adequate care to control their disease. This serves to further discourage Health Plans from enrolling these patients.

Discussion:

Allergists have consistently shown that they can provide effective, economical asthma management. Asthma patients under the care of an allergist have better outcomes at lower cost because of:

Fewer ER visits	Improved quality of life	Fewer hospitalizations
Reduced Length of Stay	Fewer sick care office visits	

Unfortunately, we are seeing the early signs of a shortage of A/I physicians causing more and more Health Plans to try to manage Asthma patients using physicians who may not have the necessary training to properly manage these patients.

Even where A/I physicians are available, we are seeing increasing evidence that Health Plans are excluding Allergists from their networks.

Whether it is a lack of supply or a desire by the Plans to avoid certain high cost patients, the end result is that patients are not receiving the care they need or deserve.

Recommendations:

As part of legislative initiative to address “surprise billing” Congress should direct CMS to establish specific network adequacy standards, including:

- An adequate number of primary care physicians in the Health Plans Network;
- An adequate number of specialist physicians in the Health Plans Network;
- Patient appointment wait time standards for primary care and specialist care;
- Permit patients a “life event” open enrollment period if the patient’s physician or hospital is removed from the network after the close of the regular open enrollment period.