AMERICAN ACADEMY OF FAMILY PHYSICIANS

STRONG MEDICINE FOR AMERICA

July 24, 2014

Karen Ignagni, President and CEO
America's Health Insurance Plans
601 Pennsylvania Avenue, NW
South Building, Suite 500
Washington, DC 20004

Dear Ms. Ignagni,

On behalf of the American Academy of Family Physicians (AAFP), which represents 115,900 family physicians and medical students across the country, I write to ask for information concerning narrow or high-value networks. Over the last several months, there have been many calls from our members, news articles, and reports on these networks which cause us great concern. The AAFP believes primary care is the most cost-effective access point for care; therefore reducing access at this entry point would be shortsighted. The AAFP also believes—if done correctly—narrow/high-value networks can save money for patients when family physicians have wider leeway to coordinate a patient's care with specialists, other providers and hospitals.

The AAFP is growing increasingly concerned with current practices being deployed by health insurance companies whereby they arbitrarily eliminate physicians from their network forcing patients to identify and secure the services of a new physician. This so-called "network optimization" is disruptive to patients and their physicians and, in our opinion, a violation of the core tenants of quality primary care.

While the practice of "network optimization" is not new, the disruptive manner in which it is being executed currently is deeply troubling to the patients, their family physicians, and the AAFP. Decades of peer-reviewed studies have shown that there are two factors that contribute to better health outcomes for individuals – health care coverage and having a usual source of care. We also know from research that patients that have a continuous and longitudinal relationship with a primary care physician have better health care outcomes at lower costs than those who do not have such a relationship.

We recognize that insurers have a responsibility to align networks of physicians and hospitals to maintain affordable premiums while ensuring quality and efficiency. However, we feel that disruptions to the patient-primary care physician relationship such as those being implemented by UHC Community Care, are contrary to both of these goals. Primary care is relatively inexpensive as compared to specialty or hospital care. It also benefits from continuity and trusting relationships. We are baffled by statements made by insurers that support patients having a continuous relationship with a primary care physician when their actions which make this impossible

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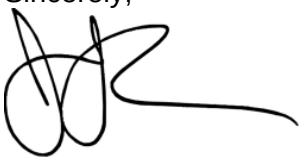
Accordingly, we would like to set up an ongoing dialogue to better understand the current state, determination, and effects of narrow or high-value networks. We have attached a list questions regarding narrow/high-value networks. If possible, we would like AHIP's response within three weeks from the date of this letter. The AAFP looks forward to a continued spirit of collaboration between our organizations to reach tangible health care improvements. Accordingly, if there are questions you may have concerning family physicians, or if you have any questions regarding our request for information, please contact Milack Talia, Senior Strategist for the Practice Environment, at (913) 906-6000, x4175 or mtalia@aafp.org.

Sincerely,



Jeffrey J. Cain, MD, FAAFP
Board Chair

Questions on Narrow/High-Performing Networks

On Physicians:

1. How many family and primary care physicians are currently participating in narrow and ultra-narrow networks?
2. How many family and primary care physicians have been dropped from narrow and ultra-narrow networks since January 1, 2012? Can you create a list from the top ten payors and their states?
3. Could AHIP share data concerning the extent to which narrowed networks have terminated contracts with family physicians in terms of:
    a. The sizes of family medicine practices (solo-physicians, small group of 2-5 physicians, medium group of 6-25 physicians, and large group of more than 25 physicians),
    b. The location of family medicine practices in urban and rural areas,
    c. The employment status of family physicians (whether they were employed or independent),
    d. The ratio of primary care physicians to specialists?

On Networks:

1. In creating narrow and ultra-narrow networks, what criteria/methodology do payors use for selecting providers to be included in those networks? If payors use quality, cost, and effectiveness metrics, what were the specific metrics used and how do they use them in their determination?
2. Have payors documented any meaningful performance difference between broad and narrowed exchange networks based on key CMS hospital metrics, such as, but not limited to:
    a. The composite value-based purchase (VBP) score of outcome, patient experience, and clinical process measures,
    b. The 30-day mortality rate from heart failure,
    c. The likelihood that a patient would recommend a hospital (as measured by the Hospital Consumer Assessment of Healthcare Providers and Systems), and
    d. The rate of antibiotic delivery to surgical patients?
3. Have payors studied the potential impacts of reduced competition and restraint of trade regulations stemming from narrowed networks reducing members' access to health care services and impeding on physicians' freedom to conduct business?

On Policyholders:

1. How many member complaints have the top ten largest payors received related to provider access for out-of-network policies?
2. How many member complaints have the top ten largest payors received related to financial issues/costs they faced when they sought medical necessary care out-of-network?
3. How are payors educating their members on provider lists and increasing transparency with its insurance product offerings and network breadth?