REMAPPING DEBATE
Asking "Why" and "Why Not"

Out-of-network coverage in New York? We left it up to the insurers

Original Reporting | By Craig Gurian | Health care, Insurance

Oct. 30, 2013 — New York's health insurance exchange (called "NY State of Health") offers individuals and families numerous insurance plan options at various "metal" levels. What it doesn't offer in most parts of the state are plans that provide coverage for non-emergency out-of-network care. In a sample Manhattan zip code, for example, there are 62 plans available at all metal levels. Not one of those plans pays for out-of-network care (see graphic).

This outcome is not a "glitch," a State Department of Health official has confirmed to Remapping Debate. Instead, it is a function of New York's decision to permit insurers to elect whether or not to sponsor plans that include out-of-network coverage. That decision, some worry, will have a negative impact on patient choice and patient care.

"We left it up to the insurers"

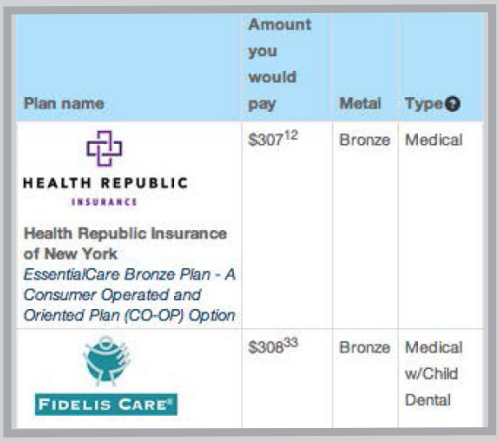
Out-of-network coverage had, until recently, commonly been available via employer-based plans (albeit with ever-increasing deductibles and co-payments). And a state establishing an exchange pursuant to the Affordable Care Act certainly has the authority to require coverage of out-of-network physician services. Indeed, in the small business part of the exchange ("SHOP" plans), New York requires a participating provider to include a plan with out-of-network coverage if it offers such coverage in the commercial insurance market (see bottom box for the limitations of that policy). But, on the individual and family side, the state decided not to use its authority.

Randi Imbriaco, director of plan management for the Department of Health (DOH), said she didn't think anything was lost by not having an exchange option for individual and family plans that provides out-of-network coverage. Pointing to a process of state review of each plan for access to and adequacy of both specialists and primary care providers, Imbriaco said that insurers are required "to allow their members to go to the out-of-network provider" if "there's a specialty lacking or they don't have enough providers."

Mo Auster, the vice president of legislative and regulatory affairs for the Medical Society of the State of New York, a physician advocacy organization, said that the lack of a requirement to cover of out-of-network care would reduce patient choice and increase insurance company leverage.

Mark Scherzer, a health insurance attorney for patients and legislative counsel to the advocacy organization New Yorkers for Accessible Health Coverage, characterized the absence of the requirement as a lack of a "fundamental consumer protection," and asserted that the theoretical right to go out of network when there is not an "appropriate" in-network provider is enormously difficult to achieve in practice. The burden of proof, he said, is on the patient, and it is not enough for the patient to show simply that her out-of-network choice would be better.

OUT-OF-NETWORK TALLY



Plan name	Amount you would pay	Metal	Type
HEALTH REPUBLIC INSURANCE Health Republic Insurance of New York *EssentialCare Bronze Plan - A Consumer Operated and Oriented Plan (CO-OP) Option*	$307.12	Bronze	Medical
FIDELIS CARE®	$308.33	Bronze	Medical w/Child Dental

A print-out from the NY State of Health website of the 62 individual and family plans available in an Upper West Side Manhattan zip code. The list indicates whether a plan covers out-of-network care.

▸ VIEW PDF

If "you have a choice between a doctor who's in the network who has done the procedure you need done three or four times and who is board-certified in the specialty that typically treats your disease, your plan is going to say that person is 'appropriate,' even though there may be someone down the street, who is out-of-network, who does 20 of these procedures a week and is a recognized expert [and with whom] it's going to be far safer for you, far better outcomes for you. But the burden on you to get to that person is to prove that the person in the network is inadequate for your needs…And that's a really hard case to make."

Why then did New York State not require out-of-network coverage? "We left it up to the insurers," said DOH's Imbriaco, and the insurers, she continued, arguing that "a closed network helps keeps costs low," chose not to provide out-of-network coverage in most of New York State, including New York City (some plans in the western part of New York State do offer such coverage).

Wouldn't it be a useful option for New Yorkers to be able to select a plan with out-of-network coverage, even if that plan were more expensive than one without such coverage? Imbriaco had the same answer: "Well, that was a choice made by the insurers, and they decided not to."

Increased leverage for insurance companies

The Medical Society's Mo Auster said that the idea that insurance companies and individual doctors engage in a genuine negotiation — whether concerning fees or medical decisions — is a fiction. Since the insurer's terms are "pretty much 'take it or leave it,'" he said, a doctor's only influence over the process was his or her ability to run a practice without signing up with a network. "The extent to which that ability is minimized," Auster said, "further enhances the negotiating leverage of the health insurance company to basically take the clinical control away form the doctor."

Dr. Andrew D. Coates is an internist based in upstate New York who is president of Physicians for a National Health Program (PNHP), an organization that advocates for a single-payer health insurance system. Coates, who was speaking during the interview for himself and not as a representative of PNHP, agreed with the idea that the lack of out-of-network options would enhance the ability of insurance companies to engage in cost cutting, regardless of whether patients were harmed, as, for example, in a push for doctors to see more and more patients each day.

> Now that there is a mandate for individuals to purchase health insurance, said Mark Scherzer, "what a stupid time to eliminate the consumer protection."

He thought that doctors were increasingly being put in an "ethical bind" where their medical instincts might tell them in a particular instance to recommend an out-of-network physician — the "one oncologist that you can think of that should really evaluate what to do next" in the case of a rare cancer — even as they knew that following that recommendation would be financially ruinous for the patient.

More broadly, in Coates' view, the greater empowerment of insurance companies was accelerating a turn towards "a corporate medical model that threatens to squeeze the humanity out of our interaction with our patients."

Remapping Debate asked Imbriaco whether DOH was concerned about doctors not having sufficient leverage to negotiate the terms of their services with insurance companies. "We try not to get involved in the negotiations between insurance companies and providers," she replied. "The only time we get involved is when consumers end up being put in the middle of this feud. And then we try to talk to the two of them to work it out."

Imbriaco did agree with the premise that only having to deal with in-network doctors makes it easier for insurance companies to control their costs (and, conversely, that having to cover out-of-network care makes it more difficult). She said that, from the point of view of the marketplace, more cost control was a good thing, describing the closed networks as a "contributory factor" to what New York is touting as a 53 percent reduction in individual market premiums from their current, pre-exchange rates. ("We'll see," Imbriaco noted as a caution elsewhere in the interview, whether the closed-network-keeping-costs-down theory "actually plays out the way it's supposed to.")

Small business plans and out-of-network coverage

Using the same Manhattan zip code as we did for individual plans, we found that only one of three providers — UnitedHealthcare's Oxford — offered out-of-network coverage in the SHOP market. And, it turns out, these plans (available at the "silver" and "platinum" levels, not the "bronze" or "gold") also have limits. They do not offer Oxford's broadest (Freedom) network of doctors, and they require a written referral before a plan member is permitted to see a specialist.

We asked Maria Gordon-Shydlo, a spokesperson for UnitedHealthcare, why an "ungated," Freedom plan wasn't being offered. Her emailed response said that UnitedHelalthcare was "offering state standard options" but did not answer why an ungated Freedom plan was not being offered.

Could "the marketplace" have done better?

Bill Schwarz, the director of the public affairs group for DOH, participated in the interview with Imbriaco, and later clarified in a follow-on email exchange that the principal reasons for the large reduction in individual market premiums from pre-marketplace status quo are an anticipated more than 36-fold explosion in the size of the individual market (from 17,000 to a projected 615,000), making for an enrolled population that is, on average, healthier.

Schwarz didn't, however, answer two of Remapping Debate's inquiries made in the course of that follow-on email exchange: Isn't getting rid of out-of-network coverage a material factor in cost reduction? And, if not, why not have required insurance companies to provide plans with an out-of-network option?

Notably, the small individual market in New York had until this year required insurers to provide out-of-network coverage, but the market had faced one species of "adverse selection," the problem attracting primarily the sickest people. In New York's individual market, Mark Scherzer said, there was not adverse selection of one carrier as compared with others (since all were required to participate) but rather of the entire market. Scherzer attributed the adverse selection problem to the fact that New York had "a voluntary market, which took sick people and didn't give anybody else the financial capacity to participate. And that's what the Affordable Care Act is supposed to resolve."

A conflict of interest?

The Community Service Society of New York (CSS) was founded in 1939 and describes itself on its website as "an informed, independent, and unwavering voice for positive action on behalf of more than 3 million low-income New Yorkers."

We reached out to the vice president of health initiatives for CSS to speak with her about the choices that the New York exchange has brought and not brought to New Yorkers. An initial willingness to proceed was superseded when Jeffrey N. Maclin, director of public relations for CSS, explained in an email that we could have an interview as to CSS's role as one of the many "navigators" with whom New York State has contracted to help New Yorkers seeking health insurance on the exchange, but questions about plans offered in the marketplace should be directed to the Department of Health.

We did want to know what CSS (as a navigator) says to individual New Yorkers who ask for assistance in purchasing a plan on the exchange that covers out-of-network physician services ("We inform them," Maclin emailed back, "that there are no out-of-network options on the exchange and help them select a plan that has most of the client's providers.")

But we also wanted to know why CSS was not willing to speak to the consequences of the choices that are and are not available, what we understood to be a traditional advocacy role for CSS. So we asked via email. And we asked whether "the lack of out-of-network options are a concern of CSS or, by contrast, does CSS view the absence of those options as a sensible cost-containment measure?" Did CSS have any thought as to why marketplace competition didn't yield individual plans with out-of-network options? None of these questions were answered.

What if New York had required out-of-network coverage as the price of admission to a new pool of almost 600,000 projected enrollees? Scherzer said, “There was no imperative” to remove the requirement of out-of-network coverage. On the contrary, he said, it would now “not adversely affect the market to require that.”

“It has adversely affected the market up ‘til now to have generous benefits that sick people could buy only because the sick people were the only ones who bought it,” said Scherzer. That’s no longer the case. Now we have a mandate for everybody to buy it. So you’ve eliminated the problem that [the insurance companies were] running away from.”

Scherzer’s conclusion: “What a stupid time to eliminate the consumer protection.”

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