Narrow Networks: How to Stay Part of the Plan

BY LAURA B. KAUFMAN, CONTRIBUTING WRITER
INTERVIEWING JODI BLACK, BRETT JOHNSON, CYNTHIA MATTOX, MD,
AND ROBERT E. WIGGINS JR., MD, MHA

With the advent of the Affordable Care Act's health insurance exchanges, narrow networks are increasingly prevalent. How will this impact your practice, and what can you do to make sure you're included on the trimmed-down panels of providers that insurance companies offer to enrollees?

The Use (and Abuse) of Profiling

"Insurance companies will do what they need to do, financially, by channeling access to certain physicians they deem low cost," said Cynthia Mattox, MD, vice chair of ophthalmology at Tufts University School of Medicine. "But the way they are doing their analysis is flawed for ophthalmologists. Does the low cost equal good care?"

A lack of transparency. According to Robert E. Wiggins Jr., MD, MHA, Academy senior secretary for ophthalmic practice, criteria used to profile physicians vary from plan to plan. "Measures out there now are not necessarily reliable or transparent," he said.

Dr. Mattox pointed out that in Massachusetts, where some of this started years ago, "the profiling system for insurance products marketed to state employees was terribly flawed—and proprietary. There was very little divulged then, and that is still the case."

Failure to differentiate subspecialists. "Your work is more costly when you are treating the sickest of the sick," said Dr. Mattox. "Insurers see all ophthalmologists as equal, with no differentiation if you are a subspecialist in retina or glaucoma, for instance."

Out-of-network referrals. Jodi Black, senior director of the California Medical Association (CMA) Center for Economic Services, said that one area plans look at is out-of-network referrals. "In most cases, the plan will say it is unnecessary unless the physician had a prior authorization."

Impact on physicians. Dr. Wiggins described two scenarios that an ophthalmologist could face in terms of narrow networks. First, insurers might say, "We'll put you in a limited network, at lower pay, in exchange for a higher volume of patients." Practices are then faced with the question of whether or not to participate. "Those not fully utilizing their resources may consider increased volume for less compensation, but if they are at capacity or close to it, they may see this as less valuable." Second, insurers might drop an ophthalmologist from a plan's network. The Academy is continuing to lobby against insurance companies' use of inaccurate physician profiling and their resultant failure to ensure network adequacy. In the meantime, here's how you can make your case.

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ACA's Impact

"The Affordable Care Act will certainly have an impact in the coming year, which will be rapidly apparent," said Dr. Mattox. "In the insurance exchanges for individuals, products in these offerings are allowed to have narrow networks as a way of controlling costs, as well as extremely high deductibles. A lot of ophthalmologists have no idea if they are included in these networks. And the patient's plan will dictate payments within the deductible period, which makes accounts receivable and billings that much more complex."

What You Can Do

Learn what criteria are being used for tiering. "It's a real challenge to get transparency on why you aren't included in a panel," said Dr. Wiggins. "But you've got to try and find out how your performance is evaluated. One thing you can do is to look at the 'cousins' of narrow networks—tiered networks—designed with 'top-tier' physicians equaling a lower cost for the patient. See what criteria insurers use to put you in a particular tier. For instance, for UnitedHealthcare's Premium Designation program, go to the website, and

look at the tiering program. Though time-consuming, it shows how they measure cost and quality."

Challenge your classification if necessary. The growing importance of narrow networks makes it even more crucial to challenge an improper classification in a tiered network. "You must request your own individual data if you feel you were incorrectly classified," said Dr. Mattox, suggesting that you fight the battle early on. "The initial letter telling you about your tiering level may be pretty incomprehensible, just outlining how the statistics are done, and without specifics on ophthalmology. You really want to get your patient-level info, including patient name, data that were used to measure costs of care, then attribution to you. If you can get to that level, you can try to point out the flaws and mistakes. It's a lot of work! But if patients are disincentivized to see you, that eventually has a cost to the practice. And the linked risk of being dropped from a network in the future may make understanding the process now helpful. Follow the instructions in the letter exactly—sometimes just asking the questions about my data was enough for certain plans to change my tier."

Appeal if you are cut from a plan. Most insurers allow for an appeal, said Brett Johnson, the CMA associate director for the Center for Medical and Regulatory Policy. "If you have concerns about network adequacy, they should be raised at the regulatory level, that is, with the Department of Managed Health Care or the Department of Insurance."

"Recently, UnitedHealthcare's Medicare Advantage plans rather suddenly dropped a lot of practitioners," said Dr. Mattox. "CMS is looking into it. It does seem that perhaps not all criteria about network adequacy were followed. There is new proposed language from CMS strengthening the rules for how insurers can change their networks."

Instruct staff to share paperwork with physicians. Ms. Black reminds ophthalmologists that, as part of their office processes, it's essential to make sure that staff route important documents to the physicians—who might otherwise be unaware of critical communication from health plans.

Share your story with organized medicine. "There is definitely strength in numbers," said Dr. Mattox, who urges you to contact the Academy, your state medical association, and state ophthalmological society when problems crop up. (E-mail the Academy at healthpolicy@aaodc.org; state ophthalmological society contact information is available at www.aao.org/member/related/state_directory.cfm.)

Patients Caught Off Guard

Physicians are very concerned about costs being reassigned to patients, as well as the confusion surrounding the new plans.

"There are many, many complaints from patients who are now having difficulty finding specialists," according to Ms. Black. She also said many patients aren't aware that some of the new insurance products have narrower networks than before. Dr. Mattox has a telling example: "A monocular patient I'd treated for 15 years for aphakic glaucoma, through surgery and other procedures, came in with a new health plan. We discussed a procedure he needed. He said, 'If you do it, it costs me $500. If the other place does it, it's $50.' I said, 'It's your choice, but I've dealt with your eyes for a long time, and you have a complex condition.' I really felt bad. Patients don't always understand what they're signing up for. His plan disincentivized him from being seen at a tertiary care ophthalmic practice. Why did he sign up? He said simply that it was less expensive. Counseling patients about insurance coverage is complex. They don't necessarily understand Medicare, coinsurance, deductibles, and other factors, and they look to us to explain it sometimes. Patients often don't understand the financial implications until they're in need."

The Future

Moving toward a more balanced future. "Physicians feel that something has to improve," said Mr. Johnson. "You can't raise overhead, reduce rates, and expect things to remain the same. Physicians say they're at their breaking point. Administrative requirements on physicians will need to become more unified, and administratively simplified."

Seeds of change. "Insurers *are* starting to get the message," said Dr. Wiggins. "UnitedHealthcare came out and said that if you're a subspecialist in ophthalmology, you can ask to be removed from the profiling evaluation and can make a case for it."

The IRIS Registry (Intelligent Research in Sight), the comprehensive clinical registry developed by the Academy, opened in March and will offer practices more information to provide to insurers about quality of care. Those involved say that this tool will expand to include an increasing number of measures and will be a better representation of a practice's quality than insurers' current profiling models. Registration for the IRIS Registry is now closed for 2014 and will reopen next year. For more information, visit www.aao.org/irisregistry. ■

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FURTHER READING. See "Choosing Up Sides: Will You Be Left Out?" (Opinion, May) and "Whither Narrow Networks?" (Current Perspective, July) at www.eyenet.org/archives.