

## Opinion

# Choosing Up Sides: Will You Be Left Out?

**I**t happened first at summer camp. The two team captains took turns selecting teammates from the pool of campers who were standing around, hands in pockets, pretending not to be paying attention. The sorting process continued until the captains had made all the choices they wanted. The camp counselor pointed out that I had not been selected by either team, and so he would assign me to a side. “Do we have to take him?” moaned one captain as his team groaned in unison like stair treads under tiptoes. Not that I blamed them, for I had already distinguished myself in camp baseball as being a sure out at the plate and a sure error in the field. I was a skinny runt who never played catch with my dad as all the other boys had. So my athletic abilities were not up to the standards of Lake Wobegon, where all the children are above average.

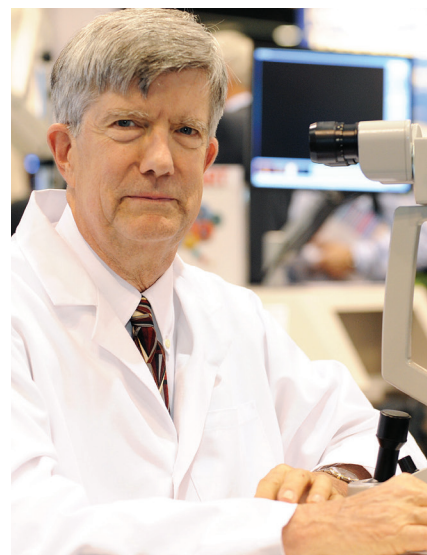
Déjà vu! Here we are in 2014, and health insurance companies are choosing up sides just as if we were still in camp. But it isn't baseball this time—now it's the health insurance game, and the stakes are much higher: the professional livelihoods of those who aren't chosen. The insurers are putting together panels that include only the most cost-effective providers and hospitals (according to their definitions). This isn't the first time we have seen insurance companies attempting to control costs by limiting access. It was only two decades ago that managed

care networks tried to do the same thing, based almost entirely on cost, but backlash from patients and government sent them whimpering back to more open panel structures.

It's different now, claim the insurers. They are able to rank providers according to adherence to evidence-based practice (the new proxy for quality), and they pledge to use this measure first, and cost only secondarily, to decide which providers and hospitals to include in the networks. They have little choice but to try this network-limiting strategy again. The Affordable Care Act mandates that every insurance plan cover essential health benefits (no more excluding maternity), have guaranteed issue provisions (no more excluding preexisting conditions), and adhere to community rating standards (no more denying individual coverage). There is scant room to compete on premium price except through savings gleaned from pruning the networks of providers.

It's a shock for an ophthalmologist to get a letter from a major insurance company saying that he or she is being dropped from the network because of costs higher than a peer group—or for no stated reason. It's a helpless feeling, especially since the daunting appeals process seems rigged in favor of the insurer. The Academy, the American Medical Association, the American Society of Retina Specialists, and other medical societies complained to the

Centers for Medicare & Medicaid Services (CMS) that wholesale provider terminations by Medicare Advantage plans violate the promise of adequate patient access to care. In a victory for federal advocacy, CMS is considering rule changes to limit significant changes to networks that threaten patient access. But commercial insurance plans are governed by the laws of each state and may take widely differing approaches. Write to us about your experiences with unjustified terminations by insurers in your area so we can compile a list of strategies to deal with this problem and include them in a future issue. Help turn “I've been left out” to “I'm back in.”



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