NARROW NETWORKS: LET THE BUYER BEWARE

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In the current, post-PPACA world, the term "narrow network" is often heard and, at times, is a strategy deployed by employers and insurers. There are a variety of ways to describe narrow networks, such as carve-out network, exclusive provider network, select network, tiered network…you get the idea.

From a covered member's standpoint, this strategy involves limiting the number of contracted providers plan members can seek care from and, in return, receive the best benefits and lowest out-of-pocket costs. From the standpoint of the insurer or employer, narrow networks mitigate risk and reduce expenses.

Those who have been around the healthcare scene since the 1980s might recall the introduction of narrow networks, albeit presented at the time as HMO Lite, a PPO/HMO hybrid or, more commonly, exclusive provider organization, replete with its very own acronym—EPO!

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These narrow-network plans from the 80s, lasting well into the 2000s, sometimes included something called a "gatekeeper." A gatekeeper was an assigned or selected primary care physician whose responsibility it was to determine whether a patient needed to see a specialist for their particular ailment. And the associated health insurance plan would provide a higher level of benefits only if this gatekeeper referral process was adhered to. Eventually, insurance companies figured out the expense associated with administering the gatekeeper model was more than the savings it delivered. While the gatekeeper concept went the way of the cassette tape, the idea of a smaller, more tightly managed network of contracted providers remained.

2014 was the year the bulk of PPACA-related insurance reforms was set to become effective. In turn, we saw more narrow PPO networks associated with health insurance

plans offered both on and off the public healthcare exchanges. Since a good number of health insurance plans received delayed, or what has been termed "grandmothered" status, the full impact of PPACA has yet to unfold for individuals insured by such plans. However, plans offered on the public exchanges, and non-grandmothered plans, were required to conform to all of the otherwise mandatory PPACA provisions, effective as plans renewed on or after January 1, 2014. One of the strategies many insurance companies and employers chose to mitigate the risks associated with offering plans on a guaranteed-issue basis, with no preexisting condition limits, priced at community rates, offering a minimum of 10 essential health benefits was…the use of narrow PPO networks.

A 2013 McKinsey study found that 70% of the public healthcare exchanges offered plans with narrow networks. The same study found premium savings of 26% between plans offering broad and narrow networks, underscoring the efficacy of this cost-reducing strategy. Of great concern is that a number of the nation's leading hospitals are not included in many of these narrow-network plans. For example, Mayo Clinic in Minnesota, Cedars-Sinai in Los Angeles and Children's hospitals in Seattle, Houston and St. Louis are considered out of network on most health plans sold on the public exchanges. As more "off exchange" plans are forced into full compliance with PPACA in the coming years, it is widely anticipated that the use of narrow networks will increase dramatically.

Narrow networks and the resultant reduction in choice of healthcare providers have grabbed the attention of lawmakers at both the state and federal level. According to the Wall Street Journal, some state legislatures are considering bills that could force insurers to offer more hospitals and doctors on their plans. And federal regulators have proposed that the review process for plans offered on HealthCare.gov include tougher criteria pertaining to provider access and

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networks. Clearly, narrow networks, while reducing healthcare costs, come with a trade-off that can be difficult to swallow.

Which brings us to the question "What is the down side to seeking care from an out of network provider?" While folks tend to focus primarily, or only, on the reduced level of health insurance benefits associated with out-of-network care, there are actually several ways such care can penalize an insured member:

1. Higher Out-of-Pocket Costs—The majority of health plans nowadays provide some level of coverage both in and out of their PPO network (unlike HMO plans that often times provide NO coverage for care received out of network). A general rule of thumb is to double or even triple the in-network benefit levels to arrive at the out-of-network exposure. For example, a plan with in-network deductible/coinsurance/out-of-pocket maximum equaling $1,000/90-10%/$2,500 could have out-of-network coverage equaling $3,000/70-30%/$7,500, respectively.
2. Out-of-Pocket Maximums Accumulate Separately—The higher out-of-pocket exposure/expense associated with using out-of-network providers is in addition to the out-of-pocket exposure/expense applicable to in-network provider use. In other words, the in-network and out-of-network expense "buckets" within a health plan generally accumulate separately. So if a patient receives care from both in- and out-of-network providers in the same plan year, he has to satisfy two, separate out-of-pocket maximums in order to reach the point where the plan pays all (or 100%) of covered expenses for care provided by any provider. Using the example above, the grand, out of pocket maximum total for both the in and out of network buckets would be $2,500 + $7,500 = $10,000!
3. Balance Billing—Care provided by in-network providers is billed at pre-negotiated, contracted rates. This means a patient cannot be billed additional charges beyond the contracted amount, which the provider is required to accept from the insurance company/administrator. Care provided by out-of-network providers is neither negotiated, nor contractually binding. Consequently, out-of-network providers can charge any amount they deem appropriate, which the insurance company/administrator may not agree to pay. If the insurance payer refuses to pay the billed amount based on a standard known as "usual, reasonable and customary," the provider has, in effect, two options: excuse the patient from having to the pay the difference or bill the patient for the "balance of the bill" not covered by insurance.
4. Spending Account Depletion—If a patient has a tax-preferred spending account, or multiple accounts, associated with his health insurance plan, such as a Flexible Spending Account, Health Savings Account or Health Reimbursement

Arrangement, he can use funds from these accounts to pay for his out-of-network care. The downside to this, of course, is the depletion of these accounts, leaving the patient with fewer available dollars to pay for additional care received by in-network providers for the balance of the calendar year.

5. Pre-certification Penalties—Most health insurance plans include a provision requiring the patient to contact their insurance company/administrator prior to receiving certain, generally expensive types of care. Examples include an overnight hospital admission, surgery and MRI. In- network providers usually take care of this administrative requirement, and may even be contractually required by the health plan to carry out this duty. If such care, which is usually specified in the health insurance certificate or summary plan description, is not pre-certified, a penalty applies to the patient. The penalty can be either a flat-dollar amount, such as $250 or $500, or a percentage of the cost of care, usually capped at some amount. An out-of-network provider is not contractually obligated to perform this function and, if they fail to do so, the insurance company/administrator can impose the pre-certification penalty on the patient.

IMPORTANT: Most health insurance plans waive the out-of-network, plan-related penalties in the event of an emergency (see numbers 1, 2 and 5 above). However, many plans stipulate that once the patient is stable, he must be transferred to an in-network provider in order to avoid penalties.

So to quote the old expression, "let the buyer beware" when selecting a health plan and seeking care from providers that may or may not be contracted by the health plan. As more employers opt to provide their employees with dollars rather than benefits (defined contribution) to purchase their own coverage, newly armed health insurance shoppers will need to pay close attention to the provider network associated with the various plan options under consideration. HIU

COBRA CONUNDRUMS

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COBRA. In this scenario, he could have been eligible for Marketplace coverage since he had not yet elected COBRA and was still within the 60-day Marketplace special-enrollment period.

As you can see, coordinating coverage is a complex business! Be sure to share this article with your employer clients so then can convey accurate information to their COBRA-eligible individuals. Also, make sure clients are sending all the appropriate notices on a timely basis as COBRA compliance continues to be essential. HIU

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This column discusses potential COBRA conundrums and their possible outcomes. The information contained in this column should not be construed as legal advice. Always follow state and federal COBRA rules and seek the advice of an attorney when confronting your company's COBRA conundrums.