Insurance Companies Struggle to Balance Medical and Pharmacy Networks

Cost and Access Are Often at Odds; Enrollees Are Caught in the Middle

Stephen Barlas

As of January 1, 2015, the facilities and physicians of the University of Pittsburgh Medical Center (UPMC) are no longer available to members of the Highmark health plans offered on the marketplace exchange in Pennsylvania and through Medicare Advantage. Or maybe they are available, at least in some cases. Highmark and UPMC, which has its own health plan, are going through a messy divorce. The split has left the region’s health insurance customers wondering whose network is a better deal—that is, if they can figure out which physicians and hospitals are “in network” for each plan.

That is the situation confounding Highmark members, especially, in the new year as UPMC facilities, part of UPMC’s health plan, partly depart from the Highmark plans as a result of consent decrees signed by the UPMC and Highmark plans. UPMC decided to pull its 22 hospitals out of the Highmark plans after Highmark in 2011 bought the West Penn Allegheny Medical Center, whose eight hospitals compete with UPMC’s 22 hospitals in several counties in the western Pennsylvania area. Highmark bought West Penn to lessen its dependence on UPMC hospitals, where services presumably cost more. UPMC sought a divorce, but there were legal problems—hence the consent decrees. As of January 1, Highmark patients have access to some UPMC physicians and hospitals in network, but others will be out of network. In fact, some UPMC doctors at UPMC hospitals will be in network for Highmark subscribers, while that same doctor at a different UPMC hospital may be out of network. Some employers have thrown up their hands while that same doctor at a different UPMC hospital may be in network in Pittsburgh could be in network outside of Pittsburgh, except if it’s [a] children’s hospital, psychiatric, oncology, or emergency services. The same physician who is out of network except if it’s [a] children’s hospital, psychiatric, oncology, or emergency services. The same physician who is out of network except if it’s [a] children’s hospital, psychiatric, oncology, or emergency services.

Steven Shapiro, MD, UPMC’s Executive Vice President, explains, “We now are spending a lot of time trying to educate the patients so that they know that, for example, the UPMC doctors within the greater Pittsburgh region are out of the network except if it’s [a] children’s hospital, psychiatric, oncology, or emergency services. The same physician who is out of network in Pittsburgh could be in network outside of Pittsburgh, so you get the point. It’s very confusing.”

Confusion over which physicians, facilities, and pharmacies are in networks put together by insurance companies appears to be an issue among enrollees in marketplace plans under the Patient Protection and Affordable Care Act (PPACA) and Medicare Advantage plans. But signs of uneasiness about networks, which health plans use to control costs and keep premiums from exploding (though rarely for ensuring quality), have spread far and wide. Even members of accountable care organizations (ACOs) are apparently restive. Seniors in Medicare Part B whose physicians are members of ACOs are automatically assigned to an ACO, although they can opt out. But ACO patients are not required to visit the network’s providers; there is no penalty, in terms of copayments or deductibles, for going out of the ACO’s network. Patients who do so make it a lot harder for the ACO to manage patient costs and quality. That flight of ACO patients to non-ACO physicians has made it much more difficult for Pioneer ACOs (which have the strictest requirements from Medicare) and even more conventional ACOs to earn profits, which is why many ACOs are leaving the program.

The dissatisfaction with Medicare Part D drug plan networks has a different nature. The Centers for Medicare and Medicaid Services (CMS), which runs Medicare, reports that seniors are choosing—not departing—plans based on the availability of a preferred network offering lower prices. However, these networks may not include pharmacies convenient for the enrollee, and they may not offer lower prices than pharmacies outside of the preferred network. Often, the Part D plans use mail-order options through pharmacy benefit managers (PBMs) as their preferred option. Pharmacies at mega-retailers such as Walmart are also often included in the preferred tier. Members who want to drive around the corner to their neighborhood pharmacy, or to the on-site pharmacy at their nearby hospital—in effect going out of the preferred tier, which is a second cousin to going out of network—are charged a higher price for the prescription—a second cousin to going out of network—are charged a higher price for the prescription. Groups such as the Consumers Union, Medicare Rights Center, and National Senior Citizens Law Center are supporting congressional legislation that would allow community pharmacies in medically underserved areas to participate in all Medicare drug plan networks, including plans’ discounted or “preferred” networks.

Making Networks More Attractive

Consumer dissatisfaction with networks has registered with some providers. Kaiser Permanente dominates California, for example, handling health care for about 40% of employees in the state. But as a health maintenance organization (HMO), Kaiser offers members limited choice within its network and covers out-of-network services only in certain emergency situations. In September, some of the biggest hospitals in the Los Angeles area announced the formation of a new health plan called Anthem Blue Cross Vivity, which hopes to lure Kaiser patients by giving them more choice. Anthem is a division of WellPoint. The venture will market a new health plan to employers with

Mr. Barlas, a freelance writer based in Washington, D.C., covers topics inside the Beltway.
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no deductible and premiums 10% below competitors, according to Anthem.² So not only will the plan be cost-competitive with Kaiser, it will offer a broader network—this is the important part—that will include two of Los Angeles’ leading academic and research medical centers: Cedars-Sinai Health System and UCLA Health. Those two hospitals are known for their high prices. All the hospitals will assume financial risk, à la ACOs. Whether they will profit in a Vivity network that capitulates payments, to vie with Kaiser, remains to be seen. The California Public Employees’ Retirement System (CalPERS), the state’s giant pension plan, has agreed to include the Vivity network in its HMO plan.

Some health plans are offering a menu of networks, giving subscribers an option to pay higher premiums for more choice. Marc Barclay, Vice President of Provider Networks and Contracting at BlueCross BlueShield of Tennessee, says his company has 90% of the subscribers to marketplace policies in the state. “We do offer a broad network that includes everybody in the state of Tennessee for these members, and we have a smaller network, and then an even smaller network, and there’s a tier premium,” he says. “The one size fits all … is probably not going to work in the future, so we offer our members choices.”

Insurers are generally fine with state and federal laws (more on those in a moment) that allow them to cherry-pick providers when forming networks, within some general boundaries. But what health insurers generally oppose are state efforts to legislate the ability of providers to force their way into a network. On November 4, 2014, voters in South Dakota agreed by a vote of 62% to 38% to allow any provider to be in network if that provider is willing to accept the payment the health insurer gives its preferred providers for a particular service. Such measures are called “any willing provider” (AWP) laws. Opposing the initiative were, among others, the South Dakota Association of Healthcare Organizations, Avera Health System, and Sanford Health System; the latter two are the state’s biggest health insurers.

While AWP laws are in one sense proconsumer, they can also be anticonsumer. Last March, responding to a proposed CMS plan to apply an AWP standard to the Part D program, the Federal Trade Commission wrote:³

> The proposed any willing pharmacy provisions threaten the effectiveness of selective contracting with pharmacies as a tool for lowering costs. Requiring prescription drug plans to contract with any willing pharmacy would reduce the ability of plans to obtain price discounts based on the prospect of increased patient volume and thus impair the ability of prescription drug plans to negotiate the best prices with pharmacies. Evidence suggests that prescription drug prices are likely to rise if prescription drug plans (“PDPs”) are less able to assemble selective pharmacy networks.

Proliferating Definitions of ‘Network’

Most states have laws dictating what a health care network should include, but those laws are all over the place, and they either fall short of or exceed federal regulations that pertain to marketplace exchanges, Medicare Advantage, and Medicare Part D plans, which themselves are subject to different standards. So there’s a Wild West feeling to network standards.

The CMS changed its standard for marketplace qualified health plans (QHPs) in 2015.⁴ The agency will no longer simply use issuer accreditation status, identify states with review processes of a minimum stringency, or collect network access plans as part of its evaluation of plans’ network adequacy. Rather, CMS will assess provider networks using a “reasonable access” standard, and will identify networks that fail to provide access without unreasonable delay. In making that analysis, the CMS will focus most closely on areas that have historically raised network adequacy concerns. These areas may include the following:

- Hospital systems
- Mental health providers
- Oncology providers
- Primary care providers

One month before the CMS announced its 2015 standard last May, the National Association of Insurance Commissioners (NAIC) wrote to Mandy Cohen, the Interim Director of the CMS Center for Consumer Information and Insurance Oversight, asking her not to increase federal scrutiny of plans’ provider networks, which the letter said “will add an additional layer of review and duplicate much of the work of states. We believe prescriptive federal regulation of network adequacy standards will lead to conflicting standards between state and federal requirements and that network adequacy regulation will be most effective at the state level where the needs of consumers, the cost of care, and the standards of the area, can best be evaluated,” the NAIC wrote.⁵

The NAIC Model Act requires covered health care plans to maintain a network that is sufficient in numbers and types of providers to ensure that all services to covered persons will be accessible without unreasonable delay. So it is somewhat less demanding than the PPACA standard for QHPs in 2015. Neither the Model Act nor the PPACA’s final rules include specific requirements for minimum geographic distances or time frames for access to providers.

Because of the perceived shortcomings of both the Model Act and the QHP standard, some states have come up with more detailed definitions of network. Take California, for example. It has two state agencies that regulate health plans, depending on the nature of those plans. One is the Department of Managed Health Care (DMHC), the other the California Department of Insurance (CDI). The DMHC regulates QHPs, HMOs, and Blue Cross PPOs. The CDI regulates all other PPOs. The California marketplace is called Covered California. All its QHPs must provide access to primary care and hospitals available within 15 miles or 30 minutes of an enrollee’s home or workplace. In addition, DMHC plans must provide ancillary services—that is, “laboratory, pharmacy, and similar services and goods dispensed by order or prescription on the primary care provider”—within “a reasonable distance” of primary care facilities. CDI-licensed plans (which are a very small percentage of QHPs) must provide access to specialty care within 30 miles or 60 minutes, and access to mental health care within 15 miles or 30 minutes. In addition, CDI-licensed plans must ensure that “facilities used by providers to render basic health care services are located within reasonable proximity to the
workplaces or the principal residences of the primary covered persons, are reasonably accessible by public transportation, and are reasonably accessible to people with disabilities."

California, as is normally the case when it comes to regulation, is an outlier among states, not to mention the federal government. Its network requirements are much more stringent than anyone else’s. Again, the CMS rules for QHPs don’t come close. Neither do the CMS rules for Medicare Advantage plans, although they are more detailed than the federal QHP rules.

For Medicare Advantage plans, the CMS first specifies the minimum number of providers that firms must include in their network in order to offer plans in each county. The CMS also specifies the maximum time and distance that can separate providers from beneficiaries in the county. Specifically, 90% of beneficiaries in a county must have access to at least one provider of each type within the required time and distance. The time and distance requirements vary across provider types and by the counties’ population size and density. For example, in urban Philadelphia, a primary care provider must be within a 10-minute drive or five miles, while in Galena, Illinois, a small, rural town, a primary care provider must be within a 40-minute drive or 30 miles. The time and distance requirements for hospitals are longer. In Philadelphia, a hospital must be within a 20-minute drive or 10 miles, while in Galena, a hospital must be within a 75-minute drive or 60 miles.

Even in the Golden State, with its relatively tough laws specifying network accessibility, problems arise. At least three lawsuits have been filed since the summer of 2014 alleging problems with physician and/or hospital accessibility in plans offered by Anthem Blue Cross, Blue Shield of California, and Cigna. “Blue Shield and Cigna lied to patients about the most important aspect of their health care plans: which doctors and hospitals they could visit under their new health coverage. As a result, many patients were left without coverage when they needed treatment,” says Laura Antonini, Staff Attorney for the California DMHC.

In November, the California DMHC released reports confirming that the directories issued by Anthem Blue Cross and Blue Shield of California contained numerous errors. Those directories list the physicians and hospitals that are in network for the health plans, which are marketplace plans under the Covered California umbrella. None of the three health plans being sued by California Consumer Watchdog responded to requests for their side of the story.

Preferred Provider Networks in Part D

Network adequacy has also been an issue in the Medicare Part D outpatient drug plans (also referred to as prescription drug plans, or PDPs). Many of them are run by big insurance companies such as Aetna, Humana, and UnitedHealthcare, often through their own PBM subsidiaries. The AARP is a major player, too, through UnitedHealthcare. In almost all of those plans, there is a “preferred provider” network of pharmacies, typically made up of certain retail pharmacies (often big-box chains) and a mail-order option. The big-box alternative is often Walmart, Walgreens, Safeway, or another large player in the drugstore business. Members of the plan are supposed to pay lower prices for prescriptions filled at those preferred pharmacies. But those networks sometimes exclude independent, mom-and-pop pharmacies, which can be a problem for seniors—particularly in rural areas. Those seniors might have to pay higher prescription prices for using an out-of-network pharmacy.

The PBMs have argued, through their industry association, the Pharmaceutical Care Management Association (PCMA), that they are better able to keep costs in check by giving members incentives to use direct mail or favored retail pharmacies, with whom the PBMs have contracts that contain price concessions.

The CMS published a study on April 30, 2013, taking issue with that argument. “We have determined that negotiated prices are sometimes higher in certain preferred networks—contrary to our expectations,” the study concluded.

Preferred networks are proliferating in both PDPs and Medicare Advantage-Prescription Drug plans. The number increased significantly in the past few years, from 163 in 2011 to 853 in 2014, according to the CMS. In 2014, more than 70% of stand-alone Part D plans offered preferred cost-sharing, according to the CMS.

In early 2014, the CMS proposed two significant changes to PDP operations in 2015 as part of its “Call Letter.” The first would have allowed “any willing provider” to join a PDP’s preferred network. The second required PDPs to provide cost sharing at least as attractive for all preferred drugs as for any one drug. Typically, that attractive cost sharing is available only at preferred pharmacies. Explaining why it was making the proposal, the agency said: “We are concerned that offers of preferred cost sharing may be influencing beneficiaries to enroll in plans in which they do not have meaningful and/or convenient access to preferred cost sharing. This may have the effect of misleading or otherwise making material misrepresentations to beneficiaries in violation of our marketing requirements.”

But Part D plans objected to the proposed changes. “Adding ‘any willing pharmacy’ requirements will also result in federal government cost increases of up to $9.3 billion over the next 10 years if plans can no longer use preferred pharmacy networks,” said Steve Nelson, Chief Executive Officer, UnitedHealthcare Medicare & Retirement. “Additionally, the proposed rule interferes with plan/pharmacy contracting relationships, contrary to statute and the competitive principles that have kept this program affordable for beneficiaries.”

When the CMS published its final 2015 Call Letter three months later, the AWP proposal was gone. The agency said it would instead award a contract to study beneficiary access to preferred cost sharing. Since then, dueling surveys have been released by the National Community Pharmacists Association and the PCMA showing diametrically opposite results, i.e., rural seniors have plenty of access to lower-cost preferred pharmacies, or they have very limited access.

Ferment with regard to networks will continue across the health plan landscape. But proving network adequacy is close to an unwinnable argument: Either networks are narrowed, or they are broadened, with lower costs to enrollees, or they are broadened, with higher costs to enrollees. To borrow a line from the classic film Network, it’s enough to make anyone yell in frustration: “I’m mad as hell and I’m not going to take this anymore.”

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