Straightforward Contracting
For a Stronger Health Care System

April 28, 2014

California's health care system is arguably undergoing its biggest period of transformation since the introduction of Medicare 50 years ago. Roughly 1.4 million Californians across the state are now covered under dozens of new health insurance products offered through the state's health benefit exchange, Covered California, and many more are now covered under new products in the broader individual market.

Coverage, however, means little without access to health care providers, and many patients covered under these new insurance products, as well as the physicians contracted with the issuers of these products, are finding it exceedingly difficult to verify which physicians and facilities are in or out of these products' networks. Since these products became active on January 1, 2014, rarely a week goes by without articles or other reports in the media about difficulties with the exchange products' provider networks.

The integrity of California's health care delivery system is being threatened by the fact that patients cannot rely on certain major health plans' lists of participating providers and that many physicians have been or remain confused about whether or to what extent they are contracted to serve patients covered under the slew of new insurance products. Many Californians are signing up for one of these new products mistakenly believing that a certain physician or physicians are in the network when they are not, and many physicians are unknowingly seeing patients in these products as an out-of-network physician, incurring higher out of pocket expenses for their patients, because they are confused about their contracting status.

Much of this uncertainty over who is in and out of the narrow provider networks is due to intentionally vague or confusing contracting practices by certain health plans, and these health plans can force physicians to accept contracts on account of the overwhelming market power they possess in the substantial majority of California.

The most egregious of these practices is the forced acceptance of "all products clauses," which are intentionally vague contract provisions that can bind a provider to participating in unspecified current and future products offered by the health plan. In California, a loophole exists in law that allows preferred provider organization (PPO) health plans, which represent a significant percentage of the California market, to make unilateral changes to a provider's contract and consider a provider's lack of response to the contract as acceptance of the changes, also known as a "silent amendment." If the change is being made to a health maintenance organization (HMO) agreement, current law states the change must first be negotiated and agreed to by the provider.

This PPO loophole has created an uneven playing field where health plans can wield their overwhelming market power over many physicians with little to no concern over fairness in contracting and without even allowing contract negotiations. With the rollout of Covered California, certain major health plans used the loophole to push many physicians unknowingly into the addition of an all products clause to their contracts. The result of such contracting practices has been mass confusion for both patients and physicians about participation status in the new products, which has led to patient access issues, loss of patients and has negatively impacted patient care in California.

To help determine the scope of these problems and the degree to which health plan contracting practices were responsible, the California Medical Association (CMA), along with the county medical societies and several medical specialty societies, conducted a survey of physicians to obtain information about their experiences with contracting for the new Covered California and related insurance products. In a period of less than two days, over 2,300 physician practices responded to the survey.

The survey results suggest that health plan contracting practices, such as all products clauses and silent amendments, are the primary contributor to the current state of network confusion by patients and providers in California. Please see the survey summary below.

Survey Summary

- The survey gathered data from 2,337 practices representing physicians from over 30 different specialties in 46 different counties within California over a period of 2 days.

- Eighty percent (80%) of physicians report that they were, at some point, confused about their participation status in a Covered California plan.

- Almost 20% of physicians are still unclear about how they became a participating provider in the plan network(s).

- More than half of the physician respondents report that their confusion about participation status was because they were automatically opted into the network without their affirmative sign on. Another 41% report they never received notice that the plan was adding them to its exchange network and, moreover, 20% report the plan mistakenly listed them as participating in the exchange network.

- One in five doctors remains confused about their participation status in a Covered California plan.

- Due to confusion in participation status, more than half of these physicians report they lost patients. The number one reported reason for the loss was due to the patients believing the physician participated in the plan they selected.

- More than half of physician respondents report they have experienced difficulties finding an in-network physician or hospital to which they can refer their Covered California patients.

- Fifty percent (50%) of physician respondents believe accepting the discounted rates for exchange patients will endanger their patients' access to, or continuity of, care. Almost a quarter of physicians (23%) report that if forced to accept patients at a discounted rate, they will either have to sell or close the practice. Eleven percent (11%) report they will have to join a larger group, and 8% will have to move the practice to another geographic area.

- Only 12% of physicians report they will not continue to participate in exchange products, while 50% report they do plan to continue to participate.

CMA Survey – April 25, 2014, Results

Survey Results – 2,337 practices representing physicians in 46 different counties and over 30 different specialties responded to the survey.

1. **Are you a participating provider with any exchange (i.e., Covered California) plans?**

Yes	50%
No	29%
Not sure	21%

2. **In which exchange plans are you participating? (please select all that apply)**

Anthem Blue Cross	64%
Blue Shield of California	63%
Chinese Community Health Plan	2%
Contra Costa Health Services	2%
Health Net of California	51%
Kaiser-Permanente	8%
L.A. Care Health Plan	3%
Molina Health Plan	8%
Sharp Health Plan	5%
Valley Health Plan	2%
Western Health Advantage	4%

3. **How did you become a participating provider with this plan's exchange network? (please select all that apply)**

Plan automatically opted me in under the same terms as my base commercial contract	37%
Plan automatically opted me under different terms than my base commercial contract	15%

I chose to accept an offer to participate from the health plan 18%

I unknowingly became a participating provider due to a lack of clarity in the contract offer and/or amendment to my existing contract (e.g., ambiguous product name) 18%

I knowingly became a participating provider via a physician group affiliation (e.g., IPA) 14%

I unknowingly came to participate via a physician group contract (e.g., IPA) 10%

I contacted the plan expressing an interest to join its exchange network 4%

I am unsure how I came to participate in the exchange network 19%

4. Do you plan to continue participating in the exchange products?

Yes 50%

No 12%

Not sure 39%

5. Are you willing and able to terminate your contract for all commercial business with the health plan in order to terminate your participation in the exchange product?

Yes 20%

No 36%

Not sure 44%

6. What are your reasons for not joining an exchange network? (please check all that apply)

Not invited to join by plan 22%

Lack of capacity to accept new patients in my Practice 11%

Limited panel of physicians in which to refer my patients and/or limited participation by area hospitals 19%

Unacceptable terms offered by the plan 74%

Unreasonable administrative burden and costs to comply with requirements 47%

Comments (sample)

- Concern that by accepting lower compensation for these plans will eventually drive down others plan/product reimbursement rates, as we have experienced previously.
- Reimbursement rates are too low and the 90-day grace period puts oncology practices at unacceptable financial risk due to potentially very high drug costs.
- Reimbursement is less than my overhead costs.
- Unable to be financially solvent with fee schedule
- Restricted specialist network making it difficult to refer and coordinate care of patients.
- Plan rates are less than what I received when I first started my private practice in 1994.

- Most disturbing of all, was the lack of communication on behalf of these insurances to educate physicians about the plans that they would not be a part of in 2014 and how to identify patients with those plans before their appointments not after.
- Reimbursement levels for some plans are too low for our practice to remain viable.
- I've heard of two hour on-hold times for a PCP office to request a referral.
- Inadequate terms and no decrease in administrative burden/costs.
- We joined because we wanted to give patients access but it's been a nightmare. We are unable to verify detailed benefits and patients do not understand their plans.
- Don't like the coercive style these plans have promoted. I can only anticipate a poor future relationship because of recent Blue Shield and Blue Cross threatening phone calls. They said they would restrict access if we did not cooperate.
- We would not survive if we were forced to accept that contract.

7. If you contacted the plan to express interest in joining its exchange network, did they allow you to join?

I do not wish to participate in an exchange network	58%
Yes, but I am still considering my options	20%
Yes, but the terms of participation were unacceptable	17%
No, I was told the panel was full at this time	4%
No, I was told I have to refer to a certain hospital in which I don't have privileges in order to participate in their exchange network	2%

8. Were you, at any time, confused about your participation status in a Covered California plan?

Yes	80%
No	20%

9. Please indicate which of the following contributed to your confusion: (please check all that apply)

Plan didn't clearly identify its exchange product in contract materials	56%
I was automatically opted into the exchange network without my affirmative sign-on	50%
I was not aware that Anthem Blue Cross and Blue Shield of California were selling narrowed networks to Covered California patients. I assumed I was part of the exchange network if I was contracted for their PPO/EPO product.	51%
Covered California's cross-plan directory listed my participation status incorrectly	26%
I was given conflicting information by plan representatives about my participation status	27%
I was mistakenly listed as participating in the plan's exchange provider directory	23%
I did not receive notice that the plan was adding me to its exchange network	**41%**
Other	9%

10. Did you lose patients with the implementation of the exchange?

Yes 51%

No 49%

11. What is the reason for losing patients? (check all that apply)

I do not wish to participate in the exchange product 50%

Patients thought I participated in exchange product they chose, but they were unaware it was a narrowed network 71%

Patients thought I participated in exchange product they chose, because the Covered California cross- plan directory inaccurately listed me as participating 32%

Patients thought I participated in exchange product they chose because the health plan erroneously represented me as participating 33%

12. How many patients do you estimate you lost?

1-10 22%

11-25 31%

26-50 23%

51-100 13%

100+ 10%

13. Have you experienced difficulties finding an in-network physician or hospitals to which you can refer your exchange patients?

Yes 55%

No 45%

14. Have the challenges with network adequacy had a potentially negative impact on patient care in your practice (e.g. health complications due to lack of timely care, etc.)?

Yes 77%

No 23%

Personal stories (sample)

- Some of my patients are also undergoing cancer treatment or surveillance. They are unable to continue with their current doctors even on an out of network basis because some exchange plans do not offer out of network benefits even they are labeled as "PPO" and not "EPO". The other doctor in our office asked to be part of the exchange network and was told that they have to be invited in. He is the only specialist in the county who accepts insurance for the specific conditions he treats and his patients knew that, thus were already calling in November to see if he would be in network. Because we were not told either way, we were not able to advise them.
- Massive delay in care is hurting patients. It almost seems the network is designed to be confusing, narrow…

- Pts I have seen for years suddenly cannot see me anymore without any notification to patients. Recent surgical patients can no longer come to me as I am no longer on their plans. Prospective surgical pts are now scurrying around trying to find a participating doctor. I have no idea where to send these patients!
- Unable to find spine surgeon.
- It takes forever to get a specialist referral for some of the plans. I've had patients who couldn't get timely follow-up for rule-out ectopic, fracture care, and kidney stones.
- Difficulty finding specialists to accept my patients. I am family practice in rural area and specialists are already limited.
- Patients have to travel great distance, i.e. > 100 miles to find accepting provider.
- We have several patients each day calling to schedule appointments with our doctors as the exchange has told them we are contracted. We tried to get contracted with Blue Cross but they won't take our practice. Our current patients who had to switch Blue Cross PPO plans at the beginning of the year had no idea we would not be a preferred provider, neither did we. Very misleading. Our patients are NOT happy. Blaming our practice for not being contracted when Blue Cross would not take us.
- A patient with a distal humerus fracture had trouble finding an orthopedic surgeon who was in-network, I finally saw her almost 2 weeks after the injury and had to operate on her pro bono because waiting longer would have caused many complications, in addition, to the pain that she was having from the fracture.
- A 31 week premature baby came to my office for newborn check after recently discharged from hospital on 4/21/14. The family said they have "regular Blue Cross PPO," not a plan from Covered CA. The staff noticed the card states pathway PPO. When we called Blue Cross after waiting on the phone for over 40 minutes, Blue Cross told us we are not in-network. Family did not know what to do. We asked them to fax a provider list for this infant so we could help this family. Blue Cross rep said it would take them 2-3 days to do so. This is not acceptable! The insurance companies are selling these products without clearly telling consumers what physicians are on the provider list! Many of my established patients switched plan not aware of the "narrow network" plans. They are now responsible for the balance that health plans did not pay.
- Plans have over enrolled new patients without adequate provider networks or hospitals to care for their enrollees-it is a bait and switch.
- Patients are commenting and walking away from us, assuming it is the provider's issue, that the health plans are stating we are contracted, when we are not. Patients are insisting that because they are off the exchange (and the health plans are telling them this) that they are not covered CA and can be seen by us.
- Delays in assessments due to lack of facilities in network and confusion by plans of where to have us send patients.
- A have a number of complicated patients who may well have gaps in there care or who have had to pay out of pocket for care while they try to figure out to who they may go.
- Poor online reviews from angry patients blaming my office for not educating them enough about CC plans.
- Often patients return to emergency because they cannot get follow up appointments in a timely fashion after emergency visits or after hospital discharge. My last shift I had somebody return with CHF exacerbation that had to wait 6 weeks for a follow up after acute hospitalization for CHF.
- A cancer patient of mine who I had operated on several years ago now has a large recurrent neck cancer and was told by Blue Cross that I was a provider for his exchange plan. However I was not. This has delayed his treatment as he seeks to find another head and neck surgeon who will remove his cancerous tumor.
- These are not "narrow networks" for specialists they are "non-networks."

- Especially difficult for those in need of mental health services.
- I had a patient with breast cancer who we thought had regular PPO insurance and when we went to schedule we were told "Covered California." We had to find another facility to do surgery in. In the meantime, we were informed by the broker of the patient's insurance that it was NOT Covered California. Her surgery for breast cancer was delayed an additional month because of this.
- A child in our practice with complex congenital heart disease was forced to find a new pediatrician and had limited options for cardiology and cardiac surgery, due to the Blue Shield narrow network.

15. If you are forced to accept exchange patients or be part of the exchange network at discounted rates, how is this likely to impact your practice? (Check all that apply.)

I believe accepting the discounted rates for exchange patients will endanger my patients' access to, or continuity of, care.	50%
I will likely have to sell or close my practice	23%
I will seek to integrate with or join a larger group, such as an IPA	11%
I will likely have to move my practice to another geographic area	8%
I will seek to hire non-physicians to handle a higher patient volume	13%
Unsure at this time	42%
Does not apply	13%
Other	12%

Specialty

Allergy	2%
Anesthesiology	3%
Cardiology	3%
Dermatology	4%
Emergency medicine/Trauma/Urgent Care	1%
Endocrinology	1%
Gastroenterology	3%
General surgery	3%
Infectious disease	1%
Internal medicine, Family Practice, General Practice	23%
Neurology	5%
Nephrology	1%
OB/GYN	5%
Oncology	2%
Ophthalmology	8%

Orthopedic surgery	4%
Orthopedics	2%
Other	3%
Otolaryngology	2%
Pain medicine	1%
Pathology	1%
Pediatrics	6%
Plastic & reconstructive surgery	1%
Psychiatry	3%
Pulmonary	2%
Radiology	6%
Rheumatology	1%
Surgery	1%
Urology	2%
Vascular surgery	1%

Number of physicians in practice

1	38%
2-5	29%
6-10	12%
11-25	10%
26-50	3%
51-100	2%
100+	5%