The New York Times | http://nyti.ms/1rqu9YL

U.S. | NYT NOW

To Prevent Surprise Bills, New Health Law Rules Could Widen Insurer Networks

By ROBERT PEAR JULY 19, 2014

WASHINGTON — The Obama administration and state insurance regulators are developing stricter standards to address the concerns of consumers who say that many health plans under the Affordable Care Act have unduly limited their choices of doctors and hospitals, leaving them with unexpected medical bills.

Federal officials said the new standards would be similar to those used by the government to determine whether Medicare Advantage plans had enough doctors and hospitals in their networks. These private plans, sold by companies like UnitedHealth and Humana, provide comprehensive care to 16 million of the 54 million Medicare beneficiaries.

States are free to adopt additional standards of their own, and Washington did so in late April.

"I heard from many consumers who were upset to find their health plan no longer included their trusted doctor or hospital," said Mike Kreidler, the insurance commissioner of Washington State. "Some people discovered this only after they had enrolled."

Mr. Kreidler said the new standards were needed to deal with "an emerging trend toward narrower networks of medical providers."

If a network is viewed as inadequate, patients may need to seek care from doctors outside the network, incurring thousands of dollars in costs not covered by insurance.

New York adopted a law this year to protect consumers against such "surprise medical bills." Before treatment, doctors must tell patients what insurance they accept. If an insurer does not have a doctor with the expertise to treat a patient's problem, the patient can go to providers outside the network at no additional cost.

The National Association of Insurance Commissioners, representing state officials, is updating its 18-year-old model law to add new consumer protections, after finding that some insurers tried to cut costs by excluding children's hospitals and academic medical centers. Cancer treatment centers say they, too, have been excluded from many health plan networks.

Consumers often chose health plans this year on the basis of price, without paying much attention to their provider networks. Even some careful, well-informed shoppers say they were misled.

Joshua P. Worth, a 43-year-old graphic designer in Los Angeles, said he and his wife had been expecting a baby. They chose a health plan offered by Anthem Blue Cross, a unit of WellPoint, after checking to be sure that its network included their obstetrician and pediatrician.

But after his wife gave birth in March, Mr. Worth said, Anthem notified him that her visits to the obstetrician were not covered because the doctor was "out of network." In April, they visited the pediatrician with their baby, presented their insurance card and were told that the doctor did not accept their plan.

"It felt like bait and switch," Mr. Worth said. "I was lured into paying for something, but then when I tried to use it, it didn't work."

Kristin E. Binns, a vice president of WellPoint, said Anthem Blue Cross was working to improve the accuracy of its provider directory. Since January, she said, the company has added more than 3,800 doctors to its California exchange network, an increase of 10 percent.

Shelley Rouillard, director of the California Department of Managed Health Care, said she was investigating the provider networks of Anthem and a separate company, Blue Shield of California, because of a "pattern of consumer complaints."

Stephen Shivinsky, a spokesman for Blue Shield of California, said: "There was definitely confusion in the marketplace. The front-office staff in many doctors' offices were also confused about what networks they were in."

Dr. Lindsay K. Botsford, a family doctor in Sugar Land, Tex., said it was often difficult to find specialists willing to take her patients. Even when specialists were listed as being in a health plan's network, she said, many of the doctors had quotas limiting the number of patients they would take from plans purchased on the exchange.

The federal government has years of experience applying network adequacy standards in Medicare. The standards specify the minimum number of primary care doctors and specialists to be included in the network of a Medicare Advantage plan, depending on the population of a county, the population density and other factors.

In addition, Medicare sets maximum travel time and distance criteria. For example, in Muscogee County, Ga., which includes Columbus, 90 percent of the Medicare beneficiaries must have access to primary care providers within 10 miles and 15 minutes of their homes, and to cardiologists within 20 miles and 30 minutes.

In a large metropolitan area, Medicare beneficiaries are supposed to have access to primary care doctors within five miles and 10 minutes.

Insurers oppose highly prescriptive federal rules, saying consumers should be free to choose cheap plans with narrow networks or more expensive plans with broader networks.

For many health plans sold on insurance exchanges, premiums were lower than expected this year. One reason, insurers say, is that they were allowed to devise health plans with fewer doctors and hospitals than have typically been included in employer-sponsored plans.

Moreover, insurers say, when they are selective, they can exclude lower-quality doctors and hospitals.

June 27 was the deadline for insurers to file applications with the Obama administration if they wanted to sell insurance next year in the federal marketplace serving 36 states.

Aaron Albright, a spokesman at the Centers for Medicare and Medicaid Services, which runs the federal exchange, said, "We are increasing our review of provider networks."

In their applications, insurers were required to list every doctor, hospital and pharmacy in their networks. Federal officials are analyzing the adequacy of those networks with the same computer software they have used to evaluate Medicare Advantage plans.

The software, developed by Quest Analytics of Appleton, Wis., is also used by many insurers.

"The Medicare standards have been vetted and accepted by health plans," said John P. Weis, the president and co-founder of Quest Analytics. "It's natural that the government would use similar standards for the federal insurance exchange."

The software measures the distance between each potential beneficiary or policyholder and each doctor and hospital in a geographic area, performing hundreds of thousands of calculations.

Under federal regulations, an insurer must have "a network that is sufficient in number and types of providers" to ensure that "all services will be accessible without unreasonable delay."

In a recent memorandum to insurers, the Obama administration said it would focus on "those areas which have historically raised network adequacy concerns, including hospital systems, mental health providers, oncology providers and primary care providers."

Under the new standards, insurers will generally be required to have contracts with at least 30 percent of "essential community providers" that treat "low-income, medically underserved individuals" in their area. These providers include community health centers, clinics for people with H.I.V./AIDS and family planning clinics.

Some states are setting higher standards. Monica J. Lindeen, the commissioner of securities and insurance in Montana, said she had told insurers on the federal exchange that they must strive to include 80 percent of essential community providers in the state.

"Montana is a huge state that is sparsely populated," Ms. Lindeen said. "The 30 percent federal standard is not in the best interests of Montanans and could result in the closest essential community provider being 400 miles away."

A version of this article appears in print on July 20, 2014, on page A12 of the New York edition with the headline: To Prevent Surprise Bills, New Health Law Rules Could Widen Insurer Networks.