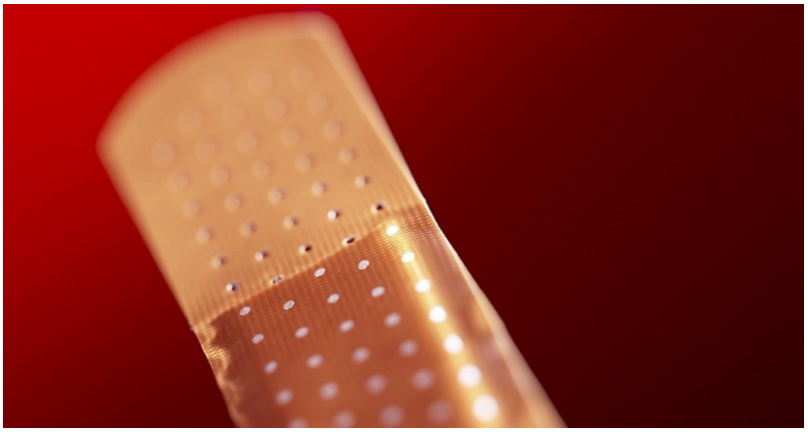
Written by **Michael Tennant** on July 1, 2014

Californians Have Insurance but Few Providers Under ObamaCare



Last year millions of Americans discovered the hollowness of President Barack Obama's pledge that under ObamaCare they could keep their health insurance if they liked it. Now, having obtained insurance on ObamaCare exchanges, many are also discovering that, contra Obama, they can't keep their doctors — or their own hard-earned money — either.

It has long been known that insurers were cobbling together narrow networks of providers whose services they would reimburse under exchange coverage; *The New American* and many other outlets reported this in late 2013. At that time, however, information on just how narrow the networks would be was still somewhat sketchy. In many states, hardly anyone — healthcare providers included — knew for sure just which doctors and hospitals would be covered by the various exchange plans.

Today, according to the *Los Angeles Times*, consumers are learning the hard way that the providers they desire simply aren't in their health plans' networks — and the insurance companies, not the law that created the problem, are taking the blame.

Simply put, people who bought coverage on California's exchange, known as Covered California, were often unable to determine which providers would be covered by their insurance before they purchased it — the exchange had promised an online provider directory for open enrollment, but it never produced an accurate one — and even now are plagued by contradictory provider information from insurers.

For example, Jean Buchanan, 56, of Fullerton, "lost her previous coverage when her insurer dropped out of the individual market last year," writes the *Times*. The paper continues:

> She was diagnosed with breast cancer in July, so she opted last fall for a Platinum plan, the highest level of benefits on the state exchange, from Blue Shield.
>
> Buchanan started treatment at UC Irvine Medical Center in the fall, and her oncologist there took her new Blue Shield insurance in January and February. Then the day before her lumpectomy, UC Irvine called to say her insurance wasn't accepted after all. She initially canceled the surgery, but her family and friends told her she shouldn't risk waiting.

Buchanan proceeded with the surgery and must now pay its $8,000 cost in monthly installments.

"I thought I had done everything right, and it's been awful," she told the *Times*. "How am I going to come up with that much money?"

Likewise, Tom DiCioccio, 64, of Oceanside, ended up stuck with a $20,000 tab for lymph cancer surgery after Blue Shield switched him from his old policy to an ObamaCare-compliant one with fewer providers, reports the *Times*. Contacted by the paper, the insurer agreed to cover DiCioccio's treatment in full, saying he "shouldn't be penalized for going out of network because he was already undergoing treatment before his policy changed."

Why are insurers so strictly limiting the providers in their networks? Insurance-industry expert Robert Laszewski explained on his blog:

> Under Obamacare, insurers can no longer underwrite, or exclude people, to keep the cost of their individual market health insurance plans down — a good thing [in Laszewski's opinion].

Under Obamacare, insurers can no longer offer a wide variety of health insurance products in the individual health market — a good thing [again, in Laszewski's opinion] when it gets rid of the worst of the health plans out there but not such a good thing when it gets rid of the many policies people could choose and have liked and are now mad about losing. Now, all health plans have to fit into four strict boxes: Bronze, Silver, Gold, and Platinum. And, these boxes can only differ by out-of-pocket costs — not benefits.

So, if a health plan can no longer vary its benefit choices, how can it distinguish itself on price?

One of the few remaining options for making a plan less expensive is to restrict the number of providers on the plan, excluding those with higher costs. "Just which doctors and hospitals a health plan picks to offer on the health insurance exchange can make a big difference in what that plan charges its customers," wrote Laszewski.

"Clearly," he concluded, "one of the consequences, intended or unintended, of Obamacare has been a dramatic escalation in the use of provider networks to vary health insurance exchange premiums." Indeed, as the *Times* notes, consulting firm McKinsey & Co. finds that about half of all exchange plans nationwide have narrow networks, with those plans costing up to 17 percent less on average than other plans. "New data show that 57% of doctors in Covered California are in a single health plan, compared with 28% in the individual market a year earlier, according to consulting firm Cattaneo & Stroud Inc.," writes the newspaper.

"People need to be diligent in deciding where to go" for healthcare, Blue Shield spokesman Steve Shivinsky told the *Times*. "We are trying to do our part to educate people, but it's a big task when *the market has been totally turned upside down*." (Emphasis added.)

None of this excuses genuine malfeasance on the part of insurers, but it does explain why both insurers and consumers are having a difficult time making the transition to ObamaCare. Insurers have been forced to toss their business models out the window and come up with ways to cover people who will almost surely draw vastly more in benefits than they will pay in premiums, and consumers are still learning their way around this new type of insurance that offers a multitude of government-mandated benefits at government-subsidized premiums but greatly restricts the number of healthcare providers they can see.

Of course, since many Americans falsely believed that ObamaCare was simply going to open the traditional insurance market to them at little or no cost, they are now shocked by this turn of events;

some are turning to government, which created the problem, to solve it. Many consumers have registered complaints about provider networks with the state; now, the California Department of Managed Health Care is investigating Anthem and Blue Shield for possible violations of state law with regard to provider lists and treatment access. Other Californians are taking insurers to court, accusing them of misrepresenting their provider networks. And, says the *Times*, "state lawmakers are considering two bills that would increase oversight of these network issues and require insurers to foot the bill for out-of-network care if regular providers aren't available" — yet another instance of piling on more laws to mask the problems created by earlier ones. It also won't work: Forcing insurers to reimburse all providers will lead to another round of "rate shock," argues Laszewski. That, in turn, will probably result in more laws cracking down on "greedy" insurers, and so on, *ad infinitum*, until the government completely takes over the healthcare system — the dream of most of those foisting ObamaCare on us in the first place.

Americans can't say they weren't warned about these eventualities well before ObamaCare was passed and went into effect. The good news is that the remedies suggested by those who sounded the alarm — repeal, defunding, nullification, and (as the Hobby Lobby case shows) litigation — can still be employed to great effect today.