

# How your in-network health coverage can vanish before you know it

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Sarah Feldman, 35, received the first ominous letters from Mount Sinai Medical last November. The New York hospital system warned it was having trouble negotiating a pricing agreement with UnitedHealthcare,

which includes Oxford Health Plans, Feldman's insurer.

"We are working in [good faith](#) with Oxford to reach a new fair agreement," the letter said, continuing reassuringly: "Your physicians will remain in-network and you should keep appointments with your providers."

Over the next few months, a flurry of communications about the dispute from both the [hospital](#) and the insurance company arrived. "It was, 'You have to worry, you don't have to worry,'" Feldman told me.

In late February, the other shoe finally dropped. As of March 1, Mount Sinai would no longer be in-network with Feldman's insurer.

"I suddenly have to change all my doctors—here's some stress for you," Feldman said. That included not only a beloved primary care physician but also a gynecologist, an orthopedist, and a physical therapist.

One of the most unfair aspects of medical insurance, in a system that often seems designed for frustration, is this: Patients can change insurance only during end-of-year enrollment periods or at the time of "qualifying life events," such as a divorce or job change. But insurers' contracts with doctors, hospitals and pharmaceutical companies (or their arbiters, so-called pharmacy benefit managers) can change abruptly at any time.

That is particularly galling for patients because, whether obtaining insurance through an employer or buying it on the marketplace, they generally choose a policy based on whether it covers their desired doctors and hospital or an expensive drug they need. Turns out that particular coverage could evaporate at any time during the policy term.

Consumers are put at risk, according to a recent report by the Robert

Wood Johnson Foundation, in the escalating warfare over pricing between big, consolidated hospital systems and ever-bigger insurers in a cutthroat market. Such contract disputes are increasing rapidly—the Becker's Hospital Review website cites 21 insurer-provider standoffs in the third quarter of 2023, a 91% increase over the same period the year before.

For example, last September, the physicians at Baptist Health in Kentucky abruptly cut ties with patients enrolled in Humana's Medicare Advantage plans, and physicians at Tennessee's Vanderbilt Health broke off contracting with a number of Humana Plans in April—in both cases sending patients scrambling to find new in-network doctors affiliated with other hospital systems. And experts predict more contract terminations in a merciless market. (That includes more Jan. 1 terminations each year—but in that case, at least, the patients cast adrift have the ability to shop for a new plan that covers their doctors and drugs.)

"The correct human response is that this is horrible," said Allison Hoffman, a University of Pennsylvania law professor, even if the practice, for now, is "probably legal." Hoffman said she found a clause buried on Page 32 of her own 60-page insurance policy suggesting that provider-insurance contracts may change at any time.

State and [federal regulators](#) have the authority to regulate insurers' networks and could end the practice, Hoffman said. But until now "there hasn't been federal regulation about continuity of coverage," particularly how to define it. She suspects that the apparent surge in contract disputes between insurers and providers stems from hospital price transparency regulations that took effect in 2021 and have allowed hospitals to compare reimbursement rates with one another.

Indeed, Mount Sinai said it was demanding better reimbursement from

UnitedHealthcare because it had discovered that it was being paid "substantially less" than "peer institutions."

Many insurers say they will continue paying for a period after a contract ends—often 60 to 90 days—or to complete an "episode of care," for a pregnancy, in particular. But with, say, cancer, would that mean one round of chemotherapy or the full course of treatment, which could last for many years? Is it continuity of coverage if a patient must change oncologists midstream or if a patient has to leave an effective therapist?

Erin Moses, who works for a small nonprofit, found a new therapist she liked after she and her husband moved to California's Central Coast in February last year. In September, she received a bill from the therapy group saying it had terminated its contract with Anthem because the insurer was slow in reimbursement, leaving her with a bill of \$814.

"It's not like we couldn't pay it, but my husband and I are trying to save for a house, and it's a big chunk of change," she said.

Patients are often caught unaware—and left holding the bag. When Laura Alley fell off a ladder in September 2020 and needed surgery to repair a broken pelvis, the hospital was in-network, as was the trauma surgeon.

In her submission to the "Bill of the Month" (the source of other examples in this article), a joint project of KFF Health News and NPR, Alley wrote: "What I could not possibly have known" was that the group that provided the anesthesia "was in dispute with our firm's insurance provider, and after July 30, 2020, they were no longer in-network."

She felt like "a pawn," she said. "As I am working to recover from a traumatic injury, I am stuck in the middle of a dispute between an enormous [insurance company](#) and a large physicians group."

She and her husband own a small architecture firm and ended up paying "nearly \$10,000" for out-of-network anesthesia services. (This type of out-of-network bill to the patient would now be prohibited by the No Surprises Act, which took effect in 2022.)

None of this will be news to Feldman, the Mount Sinai patient who was an innocent bystander in the hospital system's dispute with Oxford Health Plans. Feldman's parents called her recently, saying they'd received a letter from their insurer, Anthem, that on May 1 it might end its contract with NewYork-Presbyterian Hospital—where Feldman's stepmother is being treated for breast cancer.

It is bad for patients' health—and sanity—that the perceived promises of care in their insurance plans can suddenly disappear midyear. And regulators can do something about that: obligate providers and insurers to maintain their contracts with one another for the full term of patients' policies, so no patients are left in the lurch.

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