A Closer Look at Provider Networks

A PART OF THE *FASTERCURES* VALUE AND COVERAGE ISSUE BRIEF SERIES

This issue brief, the fourth in a series prepared by Breakaway Policy Strategies for FasterCures, examines health plan provider networks—their history in the market, their current place in the market, their structure, and how they affect consumers. The brief also discusses changes that have taken place since implementation of the Patient Protection and Affordable Care Act, and the creation of state healthcare Health Insurance Marketplaces and how those changes have impacted health plans, provider networks, and patients' potential access to healthcare services and products.

Introduction to Provider Networks

More than eight million Americans have signed up for health insurance coverage through the Affordable Care Act's (ACA) Marketplaces. As with nearly every aspect of the ACA, the public and the press have been focused intently on the costs and benefits of the coverage available to consumers. Directly related to cost control and delivery of benefits is the formation of provider networks.

Provider networks are created when a health insurer contracts with a select network of providers—hospitals, physicians, retail clinics, pharmacies, and others—to provide medical care at negotiated rates to health plan members. Insurers and members benefit from the lower provider rates that insurers are able to negotiate by contracting with the network, and providers presumably get higher patient volume from being included in the network. Seeing a provider in the network ("in-network") generally will cost an insured individual less than seeing a provider outside the network ("out-of-network").

Network adequacy standards

"Network adequacy" standards set in the ACA require plans to retain their ability to deliver the benefits promised by providing reasonable access to a sufficient number of in-network primary care and specialty physicians as well as all healthcare services included under the terms of the contract.[i] Qualified health plan (QHP) issuers must also have a sufficient number and geographic distribution of essential community providers (ECPs), where available, to ensure reasonable and timely access to a broad range of such providers for low-income, medically underserved individuals in the QHP's service area. However, that "reasonable and timely access" standard currently applies only to ECPs, and does not apply to the large group of providers who are part of plan networks in the new Marketplaces. Some of those plan networks are relatively narrow in terms of the number and types of providers they offer plan members, due at least in part to insurance carriers' efforts to constrain costs. Some physician groups, hospitals, and consumer advocates take issue with these narrow networks, arguing that they limit consumer choice. Carriers and other healthcare stakeholders have taken the position that narrow networks are a reasonable—and necessary—way to keep premiums low while satisfying the requirements imposed by the ACA.[ii]

The ACA requires the Secretary of the Department of Health and Human Services (HHS) to establish, by regulation, criteria for the certification of Marketplace health plans as qualified health plans.[iii,iv] Among the criteria are network adequacy standards.[v] In addition to satisfying network adequacy requirements, insurance carriers must still provide a range of plans that offer affordable premiums and cost sharing to enrollees—the amounts they must pay themselves out of pocket (OOP).

Consumer choices

Insurance companies form provider networks of varying sizes and scopes, and tend to offer members a choice among plans with: 1) narrow or broad networks; 2) high or low OOP costs; and 3) greater or fewer covered services or health benefits, including, at a minimum, essential health benefits (EHBs)—which include items and services in 10 statutory benefit categories, such as hospitalization, prescription drugs, and maternity and newborn care.[vi] A recent analysis of plans offered through the Marketplaces revealed that many networks are narrow in scope.[vii] One poll noted that more than half of the individuals choosing plans in a Marketplace would opt for a narrow network with lower OOP costs over a broader network plan that costs more.[viii] Some consumer advocates have concerns that consumers may not have the full picture about what costs they will incur down the road when choosing a plan with a narrower network—either that they do not know where to obtain that cost information or the information available is not easily understandable.

In an effort to balance access to appropriate medical coverage with costs—while meeting the ACA standards required to participate in the Marketplaces—insurance carriers have developed a range of health plan options for consumers. Consumers, however, are left to do the research necessary to make informed decisions when choosing from those plans. Whether the most affordable plan options offer adequate provider networks—giving consumers sufficient access to the physicians and hospitals offering the care they need—continues to be debated.

Background on Provider Networks

Modern managed healthcare grew out of a desire to reform our traditional fee-for-service (FFS) healthcare system, which pays providers for each service performed and where these fees are not negotiated. (Note: FFS is discussed in more detail in *A Closer Look at Alternative Payment Models,* the second brief in the *FasterCures* Value and Coverage Issue Brief Series). With healthcare costs growing exponentially, managed care was introduced in the 1970s and 1980s as a way to control costs and improve care. The cost containment practices used at the time—including limited provider networks, primary care gatekeepers, and prior authorization, or approval from a health plan—along with reduced enrollee cost sharing, were ultimately unable to control healthcare costs.[ix] Less restrictive networks have since evolved with varying levels of cost sharing.

Today, most health insurance plans are managed care plans. While there are many types of managed care organizations, all managed care organizations supervise the financing of medical care delivered to enrollees. By purchasing healthcare services for large groups of members, managed care organizations can negotiate lower prices with doctors and hospitals. Thus, managed care organizations reduce costs by offering specific and limited networks of providers from which consumers can choose. While some physician groups, hospitals and consumer advocates feel this limited selection offered in a narrow network is a downside to managed care, consumers are often able to expand their choice of providers if they are willing to pay more OOP costs.

Glossary of Acronyms

ACA	Affordable Care Act
AV	Actuarial value
CMS	Centers for Medicare and Medicaid Services
ECP	Essential community provider
EHB	Essential health benefits
EPO	Exclusive provider organization
FFM	Federally facilitated Marketplace
FFS	Fee-for-service
HHS	Department of Health and Human Services
HMO	Health maintenance organization
OOP	Out of pocket
PCP	Primary care physician
PPO	Preferred provider organization
POS	Point of service
QHP	Qualified health plan
SBM	State-based Marketplace

Provider Network Structure

Network-based managed care has evolved considerably over the years from the original health maintenance organization (HMO) to a spectrum of models that exercise varying levels of control over an enrollee's choice of provider and use of services. Health maintenance organizations are the most tightly controlled type of managed care plan and enrollees must use "network providers"—doctors, hospitals, and other providers that participate in the plan. They also require members to select a primary care physician (PCP), who acts as a type of gatekeeper managing the patient's care, including making referrals to other providers and specialists. Certain HMOs, such as staff model HMOs, hire

physicians directly to work in HMO-owned facilities and fall at the most restrictive end of the spectrum.

Network Type	Description
HMO	The most tightly controlled of managed care plans, HMOs require enrollees to use network providers, except when obtaining emergency care. Enrollees must choose an in-network PCP to manage their care and make referrals to specialists—who also must be in network.
EPO	Similar to an HMO, EPOs require enrollees to use in-network providers to obtain plan benefits. If an enrollee visits an out-of-network provider, the enrollee will pay the entire cost of the provider's services. There is an exception for emergency care. Unlike HMOs, EPOs do not require enrollees to select a PCP or obtain referrals to see specialists, but enrollees must select in-network specialists and hospitals. EPOs generally have smaller networks than PPOs.
POS	POS plans offer reduced cost sharing to enrollees who use in-network providers. As in an HMO, enrollees designate an in-network physician as their PCP and must obtain a referral from their PCP to visit a specialist. Similar to PPO, patients may go outside of the network for healthcare services if they are willing to pay most of the cost. An exception is if the PCP has made a referral to the out-of-network provider, in which case the insurance plan will pay the costs.
PPO	PPOs are often owned by hospital systems and other providers. They often contract with insurers or self-insured firms and offer discounted FFS rates. Enrollees receive more comprehensive benefits by using in-network providers, but may see out-of-network providers if they are willing to pay higher OOP costs. With broader networks and more flexibility than most HMOs, PPOs typically are more expensive than HMOs and EPOs. Unlike HMOs, PPOs do not require enrollees to select PCPs or obtain referrals to see specialists.

Preferred provider organizations (PPOs) generally fall at the least restrictive end of the spectrum.[x] Like HMOs, PPOs have network doctors and hospitals, allow enrollees to seek care outside the provider network at greater OOP costs, do not require members to select a PCP, and permit specialist visits without prior authorization. Hybrids of these two models fall somewhere in the middle of the spectrum, including exclusive provider organizations (EPOs)[xi] and point-of-service (POS) plans[xii]. These plan types vary widely based on how they select and pay providers, their effectiveness in limiting the use of expensive services, and the kinds of incentives they offer providers and patients. Generally, the more plans limit choice and use of provider services, the greater the potential to control costs.

Cost Sharing and Provider Networks

All health plans involve some level of cost sharing—the amount an individual has to pay for a medical item or service covered by his or her plan (e.g., hospital stay, physician visit, or prescription drug). Examples of cost sharing include deductibles, copayments, and coinsurance. Patient cost sharing is closely aligned with the structure of a plan's provider network. Cost sharing incentivizes patients to stay in-network.

Deductible	A deductible is a set dollar amount an enrollee must pay OOP for covered services (at 100 percent of the cost) before cost sharing begins.
Copayment (Copay)	A copayment is a fixed dollar amount that an enrollee must pay for covered services. Copayments generally vary based on the type of service (e.g., the copayment for a physician visit is typically lower than the copayment for an emergency room visit).
Coinsurance	Coinsurance is a percentage of the cost of covered services that an enrollee must pay. For example, if a plan charges 20 percent coinsurance for a physician visit, the enrollee is responsible for paying 20 percent of the in-network cost for services, while the insurer covers the remaining 80 percent.

Another important cost sharing consideration for consumers is the maximum amount they will be required to pay OOP for covered services. For 2014, the ACA limits OOP costs to a maximum of $6,350 for an individual and $12,700 for a family. These amounts will be adjusted by HHS in subsequent years to account for changes in the cost of private health insurance.

Networks in the Marketplaces

Although narrow networks are not an entirely new feature of managed care, the ACA raises some new issues.

Actuarial Values

The ACA requires plans offered through the Marketplaces to provide benefits with an actuarial value (AV) sufficient to meet one of four coverage levels — bronze, silver, gold, and platinum. AV refers to the average share of an insurer's total spending on EHBs under a plan for a typical population. In plans with higher AVs (platinum and gold) the insurer covers more of an enrollee's OOP costs. In plans with lower AV, the insurer covers less of an enrollee's OOP costs.

While the ACA requires all plans in all metal levels cover EHBs, plans vary in how they provide such benefits (e.g., the number of visits covered, the specific prescription drugs included in the plan formulary). HHS issued a final rule in February 2013 that included an AV Calculator used to determine whether a plan meets one of these levels of coverage.[xiii] The AV Calculator does not take into account premiums, but the cost of providing the ACA-required EHBs at one of the four metal levels certainly impacts premium amounts.

Plan Level	Actuarial Value
Platinum	90%
Gold	80%
Silver	70%
Bronze	60%

Since AV is calculated based on a plan's coverage of in-network EHB, some stakeholders have expressed concern that the metal level designations do not provide consumers with sufficient information to select plans appropriate for their needs. For example, a consumer seeking to keep his or her OOP costs low may decide to pay a higher premium to enroll in a gold plan with lower cost sharing. If, however, that plan limits the consumer to a narrow network, he or she may have to seek care from out-of-network providers and incur greater than expected OOP costs. To accurately assess the costs and benefits of a plan, consumers need to consider metal level, premium amount, and provider network.

Network Size

The ACA requires that plans meet network adequacy standards, meaning a QHP is required to maintain a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance use disorder services, to assure that all services will be accessible without unreasonable delay. How network adequacy is reviewed depends on whether a Marketplace is a federally facilitated Marketplace (FFM), a state-based Marketplace (SBM), or a state-federal partnership. The Centers for Medicare & Medicaid Services (CMS) performs network adequacy reviews in FFMs and partnership Marketplaces. CMS recognizes determinations made by SBMs in states that conduct network reviews as part of their licensure process. Network adequacy standards set the floor for QHP provider networks, but existing standards are rather non-specific.

Even with network adequacy standards in place, a recent study of 120 silver-level Marketplace plans found that 70 percent of the plans offered narrow or ultra-narrow networks. Researchers defined a "narrow" network to be one in which 30-69 percent of the largest 20 hospitals in an area did not participate. An "ultra-narrow" network was defined as one in which at least 70 percent of the largest hospitals in an area did not participate.[xiv] An earlier 2013 study also found that many insurers in states such as California, Illinois, Indiana, Kentucky, and Tennessee, among others, did not include major medical centers in their networks.[xv]

Insurers and proponents of narrower networks argue that steering patients to less expensive doctors and hospitals that provide high-quality care enables them to offer more affordable options to enrollees while still allowing for appropriate access to care. Allowing insurers to include, or exclude, certain hospital systems or provider groups may promote competition among hospital systems and provider groups in a particular state by encouraging them to provide more cost-effective quality care to make themselves more attractive to insurers. This is a fundamental aspect of the Marketplaces. However, some policymakers worry that it is possible to use narrow networks to circumvent the ACA's prohibition of discriminating against people with pre-existing conditions. The fear is that narrow networks might discourage the enrollment of sicker patients by limiting the choice of specialists and/or disrupting established physician/patient relationships. Another concern is that patients may have to switch doctors or travel longer distances for care if a key hospital is left out of their plan.

In its 2015 Letter to Issuers and accompanying proposed rule, CMS indicated that it will exercise greater oversight of provider networks, reviewing them for "reasonable access," and continue to develop and update network adequacy standards as it gathers actual measurement data based on plans offered in the Marketplaces in 2014.[xvi] The proposed rule would require that carriers increase the number and variety of facilities and specialists offered by QHPs.[xvii]

Costs of Going Out of Network

While the ACA limits the amount of consumers' OOP payments for medical care (not including premiums), those limits apply only to care provided in a plan's network. Depending on the plan, there may or may not be a separate OOP maximum for services provided out of network.[xviii] This applies even to preventive services. While certain preventive care is covered at no cost to enrollees—such as vaccines, cancer screenings, and annual checkups—these services may come at a cost if someone uses an out-of-network provider. And since nearly one-third of all mid-level silver plans in the Marketplaces are HMOs—which do not cover any out-of-network care, except for emergency care—consumers are on the hook for the entire bill if they seek care from an out-of-network provider.[xix] Therefore, consumers who choose a plan with a narrow network may be taking a big financial risk.

Despite the potential financial risk of choosing a narrow network, a February 2014 Kaiser Family Foundation health tracking poll found that consumers are most likely to enroll in a plan with a lower premium over one with a broader network of providers.[xx] Fifty-four percent said they would rather have a less costly plan with a narrow network, while 35 percent said they would rather pay more for a broader network with a greater choice of providers.

An individual who obtains care out of network may also incur additional OOP costs in the form of copayments or coinsurance. In addition, while the ACA does offer protection to consumers who receive emergency care from a hospital that is not in their plan's provider network, patients who receive inpatient services following admission to an out-of-network hospital after the emergency care are not protected from the higher OOP costs associated with those services.[xxi] Patients who seek care from out-of-network providers may also find themselves "balance-billed" by those providers for any charges not covered by the insurance plan. Unlike network providers, whose contracts with insurers generally prohibit them from balance-billing health plan members, out-of-network providers are under no such obligation and may collect from members.

Conclusion

Consumers purchasing health plans through the new ACA Marketplaces have the opportunity to search for and compare plans. However, they also bear the responsibility to educate themselves regarding the terms and benefits of those plans, including the size and scope of each plan's provider network. This is not an easy task. First, there is little standardization across plans—meaning there can be tremendous variation in cost sharing even among plans at the same metal level. And within plans, there are significant cost sharing differences for services provided in and out of a plan's network, with some plans not offering any coverage for services provided out-of-network.

Even if consumers are aware of the importance of provider networks, it can sometimes be difficult to determine whether a specific provider is in a plan's network before enrolling. In the end, it is up to consumers to determine whether a cheaper plan with a narrow network is appropriate for them, or whether they require a plan with a broader network—and more expensive price tag. As open enrollment in the new Marketplaces wraps up, healthcare stakeholders and policymakers will be watching to see how well enrollees fared in choosing their plans and accessing the services they needed.

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[iv] ACA §1311(c)(1).

[v] 45 CFR § 156.230

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