Narrow Networks Discussion Turns on Degree, Execution

State and federal regulators want to make sure that access to providers isn’t impinged, but maintenance of the lists is too often shoddy.

By Richard Mark Kirkner

The term “narrow network” has evolved as a pejorative of sorts to describe exchange plans that hold down premiums by limiting the number of hospitals and doctors their members can see. That got Simon Haeder, a doctoral student at the University of Wisconsin, thinking: Where is the empirical evidence that narrow networks were a bad thing?

So he and two of his colleagues set out to study both exchange and commercial plans in California. They found that exchange plans tended to have narrower networks, but that didn’t necessarily translate into lack of access to quality care. More surprisingly, they concluded in their study—published last May in Health Affairs—that exchange plans had networks of equal or higher quality than their commercial counterparts, even if they were smaller. “It seems that plans sold on exchanges generally have somewhat smaller networks than the ones you get on the commercial markets, but as we point out in our report, that’s not necessarily a bad thing under certain conditions,” Haeder says.

More positive light was cast on narrow networks by the consultant Avalere Health, which came out with a report last year that said exchange plans actually provide good access to cancer centers (Avalere advises health plans on their network strategies). “Coverage of leading cancer centers in exchange plan networks appears better than what has been anecdotally reported,” says Sung Hee Choe, a director at Avalere.

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There are still plenty of problems with narrow networks. Federal and state lawmakers and regulators are playing catch-up with rules aimed at fixing those lists and making sure networks aren’t so skimpy that members wind up with shoddy insurance coverage.

Much of the debate and discussion about narrow networks seems like it has been sampled from an earlier era. As Haeder mentioned in Health Affairs, many of the same issues—and reaction to them—bubbled up three decades ago with the advent of managed care. Then, the rise of HMOs and the idea of limiting provider networks ran into consumer and regulatory headwinds that caused the movement to lose steam and change course.

The topic is even more political today than it was then because of the association with the ACA, the Obama administration, and the Democratic Party, notes
Haeder. He worries another rare window of opportunity for controlling health care costs while maintaining quality will close. The push for today “might fall by the wayside as it did in the 1980s and 1990s because people are trying to make political capital out of this.”

Core notion
What exactly is a narrow network? The ACA is rather vague about it. The law states that networks must “ensure a sufficient choice of providers” and provide information about in-network and out-of-network providers. “Typically narrow-network plans include fewer providers than a typical HMO network,” according to the Kaiser Foundation. McKinsey injects some math into the hazy “fewer providers” characterization, defining narrow-network plans as having 30% to 70% of hospitals covered in a rating area and ultra-narrow networks as those with fewer than 30%.

Of course, the core notion of narrow networks—that full coverage extends to some providers and not others—is not new at all. Nor is it inherently unpopular. The increasingly popular Medicare Advantage program is built on narrow networks. What’s at issue is how narrow the network is. Last year, an Avalere analysis found that plans sold on the ACA exchanges had, on average, 34% fewer providers than commercial plans sold on the exchanges, and 42% fewer oncology and cardiology specialists. Of course that’s exactly what a narrow network means: fewer providers. But that’s a pretty sharp drop-off from what’s available to commercial plan members.

This is also obvious but worth mentioning for emphasis: If a network is too narrow, it will increase the chances of a member using out-of-network services and shouldering much larger out-of-pocket costs.

The appeal of narrow network plans sold on the ACA exchanges is pretty straightforward: The premiums are lower. For example, an April 2015 McKinsey study found that a narrow silver exchange plan in 2015 cost on average $272 a month compared with $317 a month for a so-called broad plan.

But McKinsey also found hints of buyer remorse in customer-satisfaction rates. Almost two thirds (64%) of those with a broad network plan were satisfied, compared with about half (52%) of those with a narrow-network plan. At the same time, few switched from narrow to broad networks.

The source of the disenchantment? At least through the first two open enrollment periods, narrow-network plans were notorious for not keeping their provider lists up to date or easy to use, as Daniel Polsky, a University of Pennsylvania health economist, said last year in a study.

The dissatisfaction may flame up into stronger feelings if a member has an established relationship with a provider who is no longer in an insurer’s network, for whatever reason.

Plans should prepare themselves for more regulation regarding narrow networks, says Sabrina Corlette of Georgetown University. State and federal officials will be holding “carriers’ feet to the fire.”

Another problem: Networks with too many doctors who are not accepting new patients. As Polsky points out, a seemingly decent network may not do many members of a health plan much good if the doctors have full panels and are not taking on new patients.

Experts acknowledge that keeping provider lists up to date and accurate is harder than it might seem. “What many insurance companies will tell you is that their ability to provide an accurate provider directory is dependent in many ways on what they’re hearing from their providers,” says Sabrina Corlette, a senior research fellow at the Center on Health Insurance Reforms at Georgetown University. And Polsky notes that it is difficult to keep the information about who is accepting new patients up to date.

Healthcare.gov has taken steps to address provider transparency. For the enrollment period for 2016, it launched an integrated physician look-up file that’s supposed to provide more reliable information on participating plans’ networks. Polsky says federal health officials are supposed to be making payers submit machine-readable lists of doctors in their networks and holding them accountable for the accuracy of those lists.

Corlette says a strong message about network adequacy has been delivered: “My sense is that the transparency of the network and the accuracy of the provider directory historically have not been areas in which plans have made heavy investment, but they are increasingly under heavy pressure to do so now.”

States’ bailiwick
State regulators have considerable say over health plans and their networks, but they were caught a little off guard during the first two ACA open enrollment periods. Much of the state oversight has consisted of responding to complaints rather than reviewing networks upfront. States have typically required insurers to attach provider lists when they submit plans for regulatory review, but the reviews haven’t been extensive, notes Corlette.

CMS has proposed rules for network adequacy for plans.
plans that take effect in 2017, but the agency largely defers to the states for establishing so-called quantity and quality measures—rules about the number of providers and their proximity and access within a particular market. The decision to delegate rulemaking to the state level didn’t surprise health insurance experts. The CMS guidance cites the work the National Association of Insurance Commissioners (NAIC) has done to craft model legislation for network adequacy. That model, which NAIC agreed upon in November, would empower state insurance commissioners to determine network adequacy. The association also developed some language designed to ensure coverage and access to providers who serve low-income populations.

Twenty-eight states and the District of Columbia already have laws regulating network adequacy, according to the National Conference of State Legislatures database. In 2015, five states enacted such measures, although Floridians were struck down by a line item veto. States use four quantitative standards for regulating network adequacy, according to a May 2015 Commonwealth Fund report: maximum time and distance standards, provider-to-enrollee ratios, wait times, and requirements for extended hours of operation. Some also mandate how frequently plans must update their provider directories. They range from quarterly in insurance company-friendly Connecticut to weekly in California.

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Another vehicle states use to influence—some would say negate—provider networks are any-willing-provider laws, which require an insurer to include providers who are willing to meet their terms in their networks. Many of those laws have been on the books for decades. Bruce Henderson, at Navigant Consulting, says any-willing-provider laws “are probably the biggest challenges to narrow networks.

“Not that people want to exclude providers,” says Henderson. “It’s about how you include providers and their commitment to changing how they deliver care in a more integrated fashion. Otherwise, you don’t produce any new results; you continue to do the same thing.”

States may be getting more tolerant of narrow networks. Rhode Island is actually encouraging them, but with a tradeoff: greater scrutiny, which includes requirements that plans make efforts to educate consumers about the tradeoffs between premiums and out-of-pocket expenses.

Closer scrutiny is something plans should get used to. “The thing to take away is that network adequacy is really taken much more seriously than it has been in the past, and it’s something that plans should oversee and monitor on an ongoing basis,” says Christine Clements, a lawyer with the Washington firm of Crowell & Moring, which advises Medicare Advantage plans.

Mystery shoppers
But with experience, health plans may be getting better at creating networks that both pass regulatory muster and actually accomplish cost and quality goals, not just talk about them. The objective is to eliminate unnecessary variability, says Henderson, and new efforts to bring together claims and clinical data can help make that happen. As claims and outcomes data become richer, identifying high-performing, low-cost providers gets easier, says Haeder, the University of Wisconsin researcher. In those instances where insurers restrict the choices for consumers to a selected group of higher-quality providers, narrow networks are actually beneficial, he says, and insurance carriers can be viewed not as managed care bad guys but as sophisticated intermediaries.

More regulation is inevitable, so health plans need to get ready for it, says Georgetown’s Corlette. “States and certainly now the feds are going to hold the carriers’ feet to the fire to make sure that they do what they’re supposed to do.”

Health plans can help themselves with some self-policing, suggests Michael S. Adelberg, senior director at FaegreBD Consulting and a former high-ranking official at CMS. “If the regulator has numerical standards, health plans need to be routinely checking to make sure they meet those standards,” he says.

If regulators don’t have the right standards to go by, Adelberg says health plans should consider benchmarking themselves against a competitor or their own past successful practices. And, he adds, mystery shoppers are a way that they can test the accuracy of their provider network directories.

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