

NARROW NETWORKS: ANALYSIS OF THE PAST AND
IMPLICATIONS FOR THE FUTURE

by

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ABSTRACT

The Patient Protection and Affordable Care Act (PPACA) has created exchanges, or insurance marketplaces, where insurance can be purchased more efficiently to enhance availability of coverage. In 2013, nearly 70 percent of the plans available on the networks contain either narrow or ultra-narrow networks (Mckinsey&Company 2014). The prevalence of these narrow types of networks has implications to patients, providers, and insurers. The healthcare industry has the advantage of being able to compare narrow network models of the past and use the information gathered to predict outcomes and possible solutions to potential problems in the future. This research hopes to compare the reasons behind early implementation issues to current legislature and determine if the industry has learned from its mistakes.

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INTRODUCTION

Since the implementation of the Patient Protection and Affordable Care Act (PPACA) in 2010, alterations to the healthcare landscape continue to be investigated in an attempt to bring stability and comprehensive understanding to the industry. The use of narrow networks as a cost containment strategy in health insurance plans has once again gained popularity due to PPACA, but not without apprehension of the health maintenance organization (HMO) backlash of the 1990s and the role narrow networks played in it. Concerns regarding patient choices, quality of care, and access to care have left some industry experts questioning the success of PPACA exchange programs that utilize narrow networks. Five years later, healthcare professionals are finally in a position to analyze the effects of these narrowed provider networks and to predict consequences that they may have on patients, providers, and payers in the future.

In this academic research, we will define provider networks and the narrowing of them as a method to contain costs in health systems. In order to better understand what sorts of ramifications are associated with the use of narrow networks, we will examine their inception and history as a cost containment vehicle in HMOs from the 1990s. We will draw parallels between narrow networks associated with HMOs of the 1990s in order to give a glimpse into where we could be heading as the new generation of narrow networks takes hold in the exchange created by PPACA. Taking an in-depth look at the features and goals of PPACA, we will be able to compare and contrast narrow networks from HMOs in the 1990s with narrow networks participating on the healthcare exchange.

While research has been performed considering the implications of PPACA ever since its establishment as law, there is insufficient comparisons with existing healthcare reform and the

drivers associated with their outcomes. My contribution to existing research in this field will be focused on comparing trends identified by industry professionals regarding narrow network impacts on HMOs of the 1990s, and current trends identified using data gathered since 2010. This will be done using the on-going examination of the trade-offs of price and choice within narrow networks and focusing on the financial implications that these networks are having on patients, providers, and their reimbursement levels from payers.

LITERARY REVIEW

Narrow Networks

The term “narrow network” is ambiguous in nature. A “network” is considered to be the facilities, providers, and suppliers that a health insurer or plan has contracted with to provide health care services. At a high-level, a narrow network simply refers to an insurance plan that covers a limited amount of providers in a coverage plan. In a narrow network, the networks of providers that are contracted in most all managed care plans are simply reduced in size. For the purposes of this research, narrow networks will be defined as an insurance plan that includes less than 70 percent of the doctors and hospitals in a given metropolitan area (McKinsey&Company, 2014). Narrowed networks are used by competing plans to control health costs.

Insurance plans using narrowed network strategies offer lower premiums by limiting the group of providers that are available to plan enrollees. In order to stay competitive, health insurance plans must have a diverse variety of providers and hospitals within their networks, as well as doctors and hospitals. Insurers solicit discounts from providers wishing to be in the networks who in turn obtain a higher patient volume. The negotiations between the providers and the insurers creates a vehicle to contain costs and drive down the ever increasing costs of healthcare (Summer 3). Narrow networks can also be a part of a tiered network offering as well. In a tiered network, providers are placed into different tiers based upon total cost of care, pricing, or some quality and cost index. Enrollees then have different cost sharing rates for different tiered providers, such as copays and deductibles.

To become part of a network, a provider must have a contract with the health insurance company. Insurers use a variety of provider indices on a cost basis. The metrics most commonly used are quality of outcomes of case processes and the relative cost for a particular episode of care. An example of this can be found in Exhibit 1. Providers will commit to providing better care management through utilization review and commitment to adhere to specialty specific practice protocols. They must also usually submit specific quality metrics (Bartstrum & Donelson, 2013). Although narrow networks are increasingly becoming a topic of conversation in the past 10 years, they are not a new phenomenon and will most likely be a prolific source of debate as the future of healthcare comes into question.

Cost Containment and Early Managed Care

What is Managed Care?

As defined by the American College of Healthcare Executives (2014), managed care “describes healthcare systems assembled specifically to deliver services in ways to improve quality and control costs” (Herman 2015). The main goals associated with the creation of managed care organizations (MCO’s) are to improve quality and accessibility of healthcare, improve outcomes and overall quality of life for patients, and to provide cost effective care. Cost effectiveness is achieved through the use of networks, which limit access to certain providers who have agreed to accept lower reimbursement rates for higher volume. All managed care plans have contracts set in place with doctors, hospitals, clinics, and other health care providers such as labs, X-ray centers, and medical equipment vendors. These negotiated contracts were the genesis of the network and use it as a cost containment strategy.

Health Maintenance Organization (HMO)

Analyzing the HMO's successes and failures will provide some insight as to how different cost containment strategies, specifically narrow networks, affect consumer behavior. HMOs were first-movers in narrow network implementation, along with other types of cost containment strategies that led to initial success with inevitable backlashes that occurred in the late 1990s. HMOs require that the patient select a primary care physician (PCP) who is responsible for managing and coordinating all of the patient's health care. The PCP also provides all of the basic healthcare services. If the patient does not have a referral or choose to go to a doctor outside of the network, they will have to pay for all or most of the care provided (Bihari 2013). Besides the cost savings, one of the benefits of the set networks in HMOs are that generally, services do not need to be pre-authorized by the insurance company before the treatment can begin. At their simplest form, they are insurance programs that provide health care to a defined population for a fixed price, as defined by the HMO and the contracts it has negotiated with participating practices.

What Were the Initial Goals for HMOs?

Like many reforms throughout history, HMOs had great intentions that were overshadowed by poor management and faulty monetary incentives. Historical and present day concerns with healthcare revolve around what is known as the "cost-access paradox". The United States spends more on health care than any other nation, however 14 percent of the population lacks adequate health insurance (Thomas 12). Early on in the HMO lifecycle, officials and healthcare professionals alike had agreed that the tool to solve our health finance system was the HMO.

The graph in Exhibit 2 depicts the percent of National GDP spending on healthcare during the 20th century. As the graph illustrates, during the 1970s the HMO movement was of high importance due to the desire to control the ever increasing costs associated with healthcare. The Health Maintenance Organization Act of 1973 significantly increased governmental spending on healthcare, leaving legislature to figure out ways to find funding. Policy makers believed this to be imperative because government programs bear a significant fraction of overall costs, which increase fiscal pressure on federal and state governments.

Cost containment quickly became the hot topic among healthcare professionals. It was clear that the traditional fee-for-service model was one of the root causes, leading HMOs to find a new reimbursement system. In a fee-for-service system, a member has the ability to select their own provider. However, the apparent broadness of this provider selection is immediately narrowed by the willingness of the provider to accept the reimbursement amount the fee-for-service insurer is willing to pay. Historically this has had a substantial impact on patient choice due to insurers not giving the provider the desired rate. This is even more of a problem if the patient is attempting to use one of the now commonly accepted broad reimbursement schedules, such as Medicare, that may be so low the physician will deny access to treatment (Mardesich 12).

HMOs rapidly became a major source of health care, growing from 6 million people in 1976 to 51 million people in 1994. Enrollment grew by 11 percent in 1994 alone, which had been greatest among health insurance funded by employers (Center for Disease Control). For employers with greater than 500 employees, healthcare costs declined for the first time in a decade. This decrease was almost directly correlated to the shift of traditional fee-for-service indemnity plans to their less costly managed care counterparts.

The initial vision of the HMO was to create a competitive environment of multiple and responsible consumer choice of health plan where groups of doctors, or networks of independent doctors, would find it in their interest to commit to work together to manage quality and cost of care for their voluntary enrolled populations (Enthoven 281). The overarching goals of HMOs and managed care in general can be summarized as:

1. Match the resources used with the needs of the populations they serve in order to correct specialty imbalances in specific areas.
2. Concentrate costly and complex services in regional centers to realize economies of scale and experience.
3. Evidence-based medicine and outcomes measurement and management, avoiding treatments that were inappropriate or that conferred low marginal health benefits.

Source: Prof. Alain Enthoven, Stanford Graduate School of Business

While narrow networks were a very important tool used by HMOs to reduce costs, there were also other ways they had to reduce costs to stay competitive in their markets:

- Utilization management
- Preventative care
- Capitation

Utilization Management

HMOs wished to reduce the frequency and scope of services utilized by their members, inevitably driving costs away from the more expensive utilization methods. The McGraw-Hill Concise Dictionary of Modern Medicine (2015) defines utilization as “The measure of the population's use of the health care services available to them. This includes the utilization of Hospital resources, Personal Care Home (PCH) resources, and physician resources. Health care

utilization and health status are used to examine how efficiently a health care system produces health in a population.”

The term “utilization review” or “utilization management” refers to the techniques that are intended to produce a more appropriate and cost efficient use of health care services (Mardesich 22). URAC, the non-profit healthcare accreditation organization, defines utilization management as “the evaluation of the medical necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities under the provisions of the applicable health benefits plan, sometimes called ‘utilization review’.” This strategy encouraged second opinions, often questioning physicians’ medical judgements which had been rare outside of the HMO setting.

At this point in time, utilization management was in its infancy and the medical community had expressed concerns about the design of the clinical standards or algorithms governing utilization review decisions health insurers had been using. As payers sought to control costs more aggressively, physician organizations sought to review the criteria used for denial of services under second-opinion and prior authorization programs. Utilization controls in HMOs contributed to extreme practice changes including shifting care from inpatient to outpatient settings and shortening lengths of stays.

Preventative Care

HMOs do not merely provide financing for medical care, but actually deliver the treatment as well. They provide medical treatment on a prepaid basis, allowing members to pay a fixed monthly rate, regardless of how much medical care is needed in a given month. Within their network, members must receive their medical treatment from physicians and facilities. By

reducing out-of-pocket costs and paperwork, HMOs encourage members to seek medical treatment early, before health problems become severe. In theory, patients using preventative services on a regular basis may cost the HMO more in short-term basis, but on the long-term, the HMO saves money by not having to pay for extensive services such as surgeries and hospitalizations in the long run. This cost-saving is passed back down to the patient through lower premiums.

Capitation

As defined by the American College of Physicians (ACP), “capitation is a fixed amount of money per patient per unit of time paid in advance to the physician for the delivery of health care services”. Capitation payments control the use of health care resources by putting the physician at financial risk for services provided to patients. In order to ensure patients do not receive substandard care through under-utilization of services, MCOs measure rates of resource utilization in physician practices (Alguire 2015). The intended potential benefits to capitation were seen as follows:

- Providers receive a fixed payment regardless of whether services are actually rendered. Capitation revenues are predictable and timely, and thus are less risky than revenues from conventional payment methodologies that are tied to volume.
- Capitation payments are received before services are rendered, so, in effect, payers are extending credit to providers rather than vice versa, as under conventional reimbursement.
- Capitation supports national healthcare goals – primarily increased emphasis on cost control as well as wellness and prevention.
- Capitation may ease the reimbursement paperwork burden, and hence reduce expenditures on administrative costs.

- Capitation aligns the economic interests of physicians and hospitals because risk-sharing systems are typically established that allow all providers in a capitated system to benefit from reducing costs.
- Similarly, capitation encourages utilization of lower-cost treatments, such as outpatient surgery and home health care, as opposed to higher-cost inpatient alternatives. Thus, capitation creates incentives to use those services that are typically preferred by patients when such alternatives are clinically appropriate.

Capitation rates are developed using local costs and average utilization of services and therefore can vary from one region of the country to another. Generally, capitation payments are expressed as some dollar amount per member per month, where the word “member” typically means enrollee in some managed care plan, which is usually an HMO. In some plans, the MCO will use a risk pool as a percentage of the capitation payment. The money in this risk pool is withheld from the physician until the end of the fiscal year. If the health plan is fiscally successful, the money is paid back to the physician (Alguire 2015). “During the 1980s and 1990s, physician capitation...was widely touted as a way to restrain cost and encourage more efficient care” (Zuvekas and Cohen). Capitation was one of the earlier attempts at what became to be called “risk-sharing” or “cost-sharing” between patients, providers, and payers. MCOs like the HMO have been continually culling their networks ever since their inception.

Narrow Networks and HMOs

During the development of the HMO, narrow networks were touted as the next great cost containment strategies of the future. Narrow networks were designed to deliver top value, but at the expense of consumer choice. One of the most significant drivers of the proliferation of the HMO, and subsequently the narrow network, was employers who provided employer-based

health benefits. As shown in the chart in Exhibit 3, health insurance costs sky rocketed out of control with a near 15 percent increase in costs from 1987 to 1989. Simultaneously, there was a downturn in the economy from 1988 to 1992 (Exhibit 4), creating even more pressure for employers to cut costs. Almost out of necessity, employers looked to the HMO and other managed care models to contain costs in some way.

The gradual decline in overall benefits costs can be attributed to the adoption of narrow networks as a cost containment strategy over the course of the next 10 years. Exhibit 6 depicts the rapid changes in types of enrollment plans. In 1984, the split between traditional fee-for-service and managed care plans was 95 percent and 5 percent respectively (Corlette, Volk, Berenson, Feder, 2014). By 1993, the mix was almost an even split 50/50. Employers began to share the burden of overall health insurance costs by making the employee pay part of the premium. The new cost-savings techniques had created an environment where consumers were considered to be cost conscious and were willing to sacrifice certain benefits, like choice of provider, in order to save costs on monthly premiums. Exhibit 3 depicts the decline in employee health coverage from 1983 to 1993. This decline is attributed to a decrease in the number of employees offered employer-sponsored health benefits, either because employees have dropped or restricted coverage for their employees. Now that health care coverage was no longer a priority of employers, employees were beginning to feel the impact of having to take some responsibility of these costs themselves.

HMO plans then began to implement requirements for preapproval for some forms of treatment. Soon the free market began to privatize these HMOs, allowing them to narrow their provider networks as much as they needed to sustain profits and remain competitive. The limited

choice of providers that the patient faced combined with the addition of preapproval requirements left consumers wondering what they were actually paying for.

Consumers Turn to the PPO

PPO plans contract with a network of “preferred” providers from which the patient can choose. One of the main differences between an HMO and a PPO is that consumers do not need a primary care physician. They are also allowed to get out of network care in a PPO, however they are required to pay the provider initially and then file a claim to get reimbursed up to a certain negotiated amount (Bihari 2013). While the cost savings might not be as prevalent in PPOs compared to HMOs, some would argue the benefits of not being tied to a particular primary physician and the larger access to healthcare facilities and physicians compensates for that. This expansion in network and overall choice of providers was enticing to consumers who for so long had their care compromised and choice limited by the HMO model.

HMOs peaked in 1996 (Exhibit 5) with 31 percent of covered workers enrolled, but the trend shows a continuous decline (Gapenski 18). In 2013, only 14 percent of workers were covered by HMO plans. Most employers did not offer multiple choice of plan to their employees and, in the attempt to lower administrative costs, outsourced health benefits to one carrier. Carriers promised lower premiums to employers who chose single plans. In return, employers wanted more provider choices for their employees within these individual plans. This placed pressure on MCOs, forcing them to expand their networks and inevitably compelling them to include just about every provider within a specified area. This weakened the bargaining power MCOs were so accustomed to, keeping reimbursement rates high, therefore increasing premiums further.

With these expanding networks, HMOs in particular had to accept the inefficient providers with over-utilization as well as the efficient providers, impairing their important dimension of selectivity. The combination of carriers seeking to meet the cost containment demands of government and employers, as well as doctors who wanted to maintain the status quo produced an adversarial relationship with a great deal of conflict over capitation rates, other method of payment, and utilization decisions (Enthoven 281). Narrowly focused plans such as staff model HMOs¹ and other closed panel organizations, which had low premiums but extremely narrow networks, practically disappeared due to market choice. Of course, with more choices comes a higher price, which members did not understand at the time. Members were considered cost unconscious and saw nothing to gain from accepting limited choice.

Quality and access to care had become so bad, the government developed what is known as the “Patient’s Bill of Rights” to combat the consequences of the HMO backlash. The Consumer Bill of Rights and Responsibilities was adopted by the US Advisory Commission on Consumer Protection and Quality in Health Care industry in 1998. The main goals of the bill were to help patients feel more confident in the US health care system by assuring that the health care system is fair and meets patient needs, giving patients a way to address problems they may have, and encouraging patients to take an active role in staying or getting healthy. It was also created to stress the key role patients play in staying healthy by laying out rights and responsibilities for all patients and health care providers. This was intended to stress the importance of a strong relationship between patients and their health care providers and diminish the animosity that had developed between patient and provider over the past 10 years.

¹ Staff Model HMO – HMO employs the physician; high degree of control over care delivered, thus premiums are often lower due to the HMOs ownership of the facility.

Employers, consumers, and providers discovered what they did not want from HMOs, leading them to search for alternatives. They found this in Preferred Provider Organizations (PPOs). The appeal of PPOs is often associated with the availability of more choice of providers, less restrictive features for consumers, fewer impositions on providers, and lower administrative costs to purchasers. PPOs are perceived as more flexible, able to be molded into different sets of arrangements like broader or narrower networks, extensive or meager benefits, and more or less cost sharing. The main factor associated with the PPOs surpassing of HMOs is their flexibility and customization, which strict price-sensitive HMOs did not offer.

Proponents of the PPO argue that it can be whatever the purchaser wishes it to be. Standard HMO products being sold may have more comprehensive benefits than an employer wishes to offer. In the PPO option, the components can be acquired separately from different vendors and assembled in a customizable fashion. This design also allows for considerable transparency to consumers, who can look at their plan and comprehend what is covered and what is not, which providers are in or out of network, and what the differential level of coverage will be based on site of service (Hurley, Stunk, White 62).

Doctors and hospitals are drawn to PPOs because they provide prompt payment for services as well as access to a larger client base. There are still restrictions on patients that are intended to control the frequency and cost of health care services, but not as many as with a typical HMO. Interviews conducted by the healthcare magazine *Health Affairs* indicate that providers have a less adversarial relationship with PPO networks than with HMOs. This is attributed to their more inclusiveness in network composition, less intrusiveness in medical management, fewer disputes over payment practices, and greater accommodation of provider

preferences for compensation methods and amounts (Hurley, Stunk, White 63). However, with more provider power brings less insurer leverage, creating smaller discounts than HMOs.

Managed Care Post-PPACA

The PPACA American Health Benefit Exchange was designed to expand the market for those non-group consumers who had little to no information on the types of insurances available, the prices of these insurances, or the consequences of their choice in insurance. An exchange is essentially an online marketplace where shoppers can research these options and buy the right insurance accordingly (Nussbaum 2015). The Affordable Care Act requires every state to offer an exchange to its residents. States have a few options:

- A state can choose to create and run its own exchange.
- If a state decides not to run its own exchange, residents of that state can shop on an exchange that will be run by the federal government.
- Or a state can partner with the federal government. In a partnership model, the state and federal government share responsibility for operating that state's exchange.

The necessity for healthcare exchanges was heightened by the PPACA and its implications:

- The Affordable Care Act no longer allows insurers to deny coverage or charge people more based on their health status or pre-existing conditions. So, many people who were unable to buy coverage in the past can now start shopping for a health plan.
- Starting in 2014, individuals are required to buy health insurance or face penalties. This is called the "individual mandate." Although the penalty for not buying coverage is initially low, it will grow over time. As the penalty goes up, so will participation on exchanges.
- The Affordable Care Act provides tax credits and subsidies for individuals who qualify, to help make insurance more affordable, when they shop on a public exchange.

The current exchange gives the consumer the option of choosing between 5 categories of marketplace insurance. The system used to describe it is commonly referred to as the “Medal System” due to its referencing of the medals used in the Olympics (McKinsey&Company, 2014). The online entity of the Health Benefit Exchange, Healthcare.gov, defines the tiers as follows:

- “Bronze: Your health plan pays 60 percent on average. You pay about 40 percent.
- Silver: Your health plan pays 70 percent on average. You pay about 30 percent.
- Gold: Your health plan pays 80 percent on average. You pay about 20 percent.
- Platinum: Your health plan pays 90 percent on average. You pay about 10 percent.
- Catastrophic: Catastrophic coverage plans pay less than 60 percent of the total average cost of care on average. They’re available only to people who are under 30 years old or have a hardship exemption.”

Source: Healthcare.gov

The vast majority of the networks on the exchange (93 percent) are offered on the silver tier and it is also the only level where income-eligible consumers can receive both federal premiums and cost sharing subsidies. Consequently, silver tiers have attracted 60 percent of all consumers enrolled in an exchange product (McKinsey&Company, 2014). Silver and Bronze tiers also contain the highest volume of narrow and ultra-narrow networks. The silver tier of network coverage is what is driving behavior of newly insured consumers in the past five years, and what will continue to be studied in the future due to its impact on the insurance market.

In the past with HMOs of the 1990s, insurers kept their loss ratios low by “cherry picking” relatively healthy members and excluding individuals with pre-existing medical conditions. PPACA outlawed these discriminatory practices, forcing insurers to invent new ways to reduce costs and offer lower-priced premiums. These and other reforms left insurers to

compete on the basis of cost and the scope of the networks. To attract cost-conscious consumers, many plans have formed narrow networks of providers who agreed to accept low negotiated prices or who had a track record for delivering care at low cost. But those are hardly the only plans available. This was the beginning of the rebirth of the narrow network in the new era of healthcare.

ANALYSIS

Comparing and Contrasting HMO and PPACA Narrow Networks

Both early HMO and PPACA narrow network strategies attracted attention because of their perceived low-cost characteristics like lower premiums. Insurers turned back to the narrow network model in order to re-establish negotiation leverage over providers, which was a technique used in the HMO of the 1990s as well. In order to adequately predict the outcomes of narrow networks in the future, it is important to analyze where they went wrong in the past and determine if the PPACA has done anything to improve these networks or if perhaps the consumer of today will react differently than in the 1990s.

The most important distinction between narrow networks of HMOs in the 1990s and narrow networks in the PPACA era is the emphasis and accountability to quality of patient experiences and overall care. PPACA has seen narrow networks considerably drive development on the insurance market since its inception in 2010. Nearly 70 percent of all exchange products available are narrow or ultra-narrow networks and 60 percent of all consumers enrolled in exchange products are enrolled in a one of these networks (Mckinsey&Company, 2014).

The Medicare Shared Savings Program (Shared Savings Program) was established by section 3022 of the Affordable Care Act. The Shared Savings Program “aims to improve beneficiary outcomes and increase value of care by providing:

- Better care for individuals;
- Better health for populations; and
- Lowering growth in expenditures”

Source: Centers for Medicare & Medicaid Services (CMS)

The Shared Savings Program also looks to promote Accountable Care Organizations (ACOs) which CMS defines as “groups of doctors and other health care providers who voluntarily work together with Medicare to give high quality service to Medicare Fee-for-Service beneficiaries”. Providers that meet quality and cost-savings targets receive financial bonuses. Targets are easier to manage when patients cannot roam and seek treatments outside of their networks, with no controls on quality or costs. Narrow networks will help ensure that patients seek care from providers with an incentive to coordinate care and control costs. Because narrow networks have proven to be a widely used method of cost savings, ACOs will have the opportunity to test their viability using narrow networks as a vehicle in doing so.

In collaboration with ACOs, Value-Based Purchasing (VBP) was also created in an effort to link Medicare’s payment system to a value-based system to better measure, report, and reward excellence in health care delivery. This involves the actions of coalitions, employer purchasers, public sector purchasers, health plans, and individual consumers making decisions that take into consideration access, price, quality, and alignment of incentives (NBCH 2014). Participating hospitals are paid for inpatient acute care services based on quality, not just the quantity of the services they provide. Participating hospitals fund the program with a 1.75 percent reduction in diagnosis-related group (DRG) payments for that year. They are evaluated using their Total Performance Score (TPS) which is then compared with benchmarks to determine if they earn back a value-based incentive payment percentage that could be less than, equal to, or more than the reduction for that program year. PPACA also created the “qualified health plan” (QHPs) which is certified by the Health Insurance Marketplace that provides essential health benefits, follows established limits on cost-sharing, and meets other requirements. QHPs will have a

certification next to them when sold on the marketplace. These plans will help to ensure sufficient choice of providers and network adequacy. These quality indicators could be promising for the future as long as they are regulated properly.

Next it is necessary to look at the transparency issues of plans and uneducated consumers that often plagued early HMOs. It is impossible to have a free market if there is no access to information. Studies show this is also prevalent in narrow network plans on the exchanges. While there are plenty of options that do not contain narrow networks for consumers to choose from on the exchanges, the average consumer looking for a low-cost plan might not weigh their options properly if there is no transparency as to the characteristics of the plan. Consumers in early narrow networks were blinded by the substantially reduced premium costs which lead to a lack of understanding of what their plan even consisted of. The current exchange program still does not have many tools allowing consumers to see which doctors and hospitals are covered by the individual plans. In the federal marketplace, there is no easy way to compare the doctors and hospitals that are covered by plans without researching each one individually, which unfortunately is not convenient enough for some consumers. A survey from the health research group, the Commonwealth Fund, found that about 25 percent of people with the new exchange plans didn't even know whether they'd bought a narrow network plan (Blumenthal, 2014). This leads to surprised and often dissatisfied patients who learn after the fact that they had been treated by out-of-network providers, forcing them to foot the bill themselves which may not always be an option. However, in an effort to change this, there have been lawsuits and state-mandated regulations pertaining to transparency, specifically the directories² on the exchanges. In 2015, all plans on the exchanges are now required to update their directories once a month

² Directories on the Marketplace list the providers associated with each plan and the location of their practices.

(Appleby 2014). While this is a step in the right direction, there are not enforceable penalties and these rules are not enforced effectively.

Lack of transparency leads to consumers who are either unable or unwilling to pay for surprise bills associated with unknown out-of-network costs. There is inadequate understanding of the trade-off between lower upfront premiums and higher out-of-pocket expenses like copayments and deductibles. The insurance industry is using the low-premium attributes from narrow networks and exchange programs to attract customers. While it had initial success, this is not sustainable for the long run unless consumers become educated on the type of insurance they are buying. Many people using exchange products are finding themselves unable to pay for procedures due to the high deductibles they are required to pay.

Another reason for failure of the early HMOs and the continuous narrowing of their networks was provider backlash. Providers were being bullied into participating with the narrow plans and soliciting larger discounts than were sustainable. Under ACA there is a provision which initially permitted insurers to include just 20 percent of “essential community providers” in their plans (Geyman 3). Once again, a backlash soon broke out among hospitals and physicians who were arbitrarily excluded, forcing disruption of their established relationships with patients and breaking up continuity of care. In response, the Department of Health and Human Services raised its requirement to 30 percent, which has not appeased those still far outside of that range (Howard 591). The continual negotiation of contracts that are subject to change at any time create confusion on both the provider and patient level. Because most of these plans do not include high-cost providers, specialists such as endocrinologists, rheumatologists, and psychiatrists are not included in the plan and 15 percent of these plans did

not include a single in-network physician in at least one specialty on the 2015 exchange (Geyman 5).

Predictions for the Future

Narrow networks will be around for the foreseeable future. As long as PPACA eliminates other cost containment strategies from insurance companies, their low-cost appeal to consumers and proven track-record of decreasing costs will keep them relevant. As these networks become narrower due to competition, premiums will become smaller. While lower upfront costs like premiums are initially beneficial, they come at the price of consumer choice just as before. For narrow networks to succeed, exclusivity must be balanced with access and quality, which was not a priority with HMOs in the 1990s.

There must be a defined population for those who are held accountable for care to actually manage. While narrow networks due limit patient choice, this limitation of the patient to move from provider to provider allows for the providers responsible for their health to better monitor their health. PPACA also required the implementation of electronic-medical records (EMRs) to take advantage of the information technology that could support tracking of health. Population management will allow providers to then be reimbursed appropriately with new performance-based reimbursement models. Providers and the networks they are involved in must also align their interests. Providers allow local initiatives to be “physician-led” and therefore can more effectively change the care models based on increased coordination and transparency as in the Accountable Care Organizations. If health plans are taking advantage of the EMRs and the data they present, they will be able to provide better risk management capabilities that will allow for data-driven decisions (Pawlack 4).

The largest complaint associated with HMOs of the 1990s will also need to be addressed. Consumers are demanding more choice and transparency in the marketplace. Although consumers have flexibility to initially choose a network, their choices could be limited once they select a plan. There must be a way for the consumer to have knowledge of every aspect a prospective plan offers before they purchase the plan. Plans that have been successful, such as some of the pioneer exchange programs in California, have proved that narrow networks can be successful if the consumer understands the trade-offs that are associated with the low-cost characteristics in narrow networks.

Conclusion

Health systems are just that, a system of patients, providers, and payers who must coordinate properly to achieve the goals of improved quality of care as well as reduction in costs. Successful health systems and exchange plans will have effectively aligned incentives, allowed for physicians to lead their patient base and create as well as enforce a disciplined approach to tracking outcomes through performance across empirically-based guidelines. To create value, these systems must learn from their breadth of past experiences, both successes and failures.

HMOs of the 1990s were successful at cost reduction, however they failed to adapt to the consumer's changing desire for more choice and higher quality. Their initial success came in the form of employers who saw them as the key to reducing overhead expenses due to their low choice. They were blinded by the savings they were receiving by sharing it with their employers. Historically, when the consumer must become accountable to their own care because they have a stake in it, they will begin hold the providers and payers to higher standards. Newly insured

consumers as a result of PPACA, they will search for the appropriate balance of choice, access, and cost that matches their lifestyles. Exchanges offering narrow networks will need to react to these consumer demands sooner than HMOs of the 1990s in order to achieve success of their own.

Future Research

For the future, more research must be focused on the following aspects of narrow networks within the new healthcare exchanges:

- Appropriate measurement standards for narrow networks must be developed that hold the patient, provider, and payer accountable for the patient's quality of care.
- There must also be analysis on the best ways to increase consumer awareness to be able to promote competent consumer choices that are being made based on educated decisions about the market.

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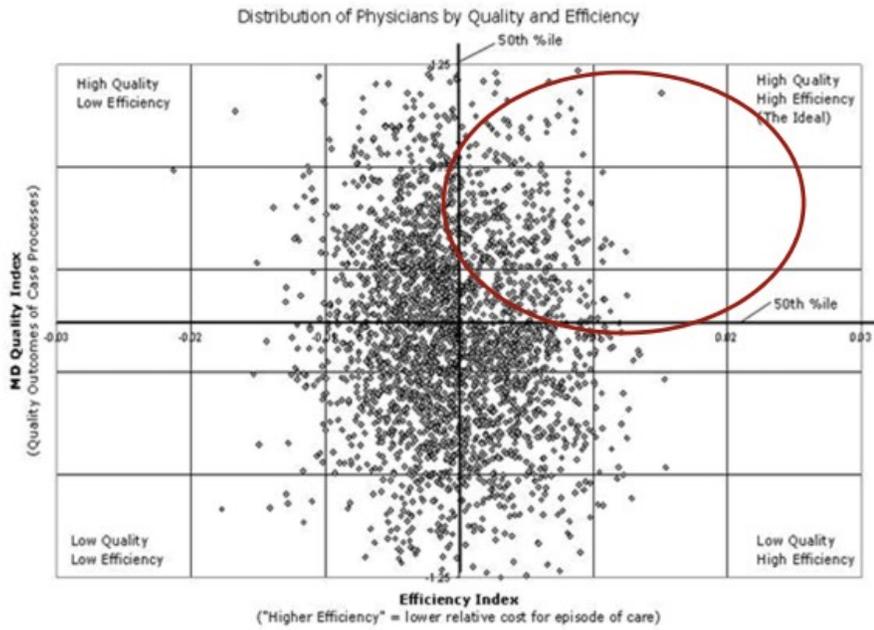
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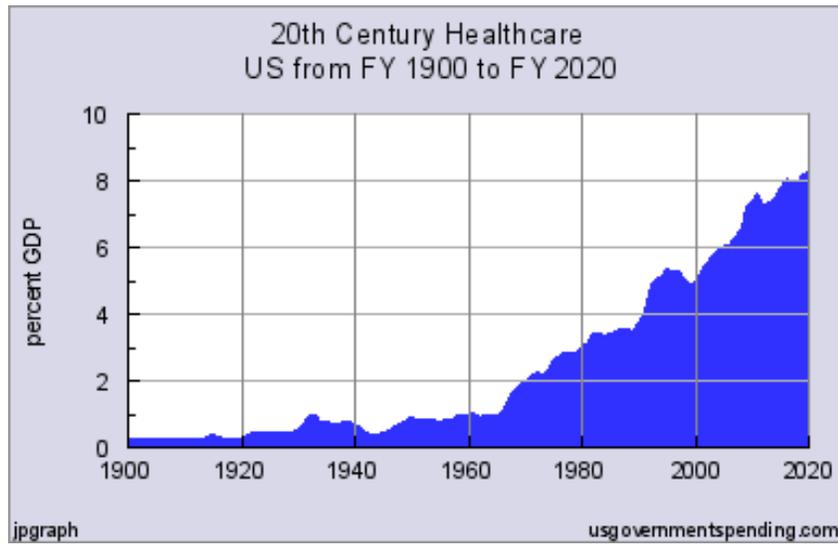
Exhibits

Exhibit 1



Narrow
Network
Invitees

Exhibit 2

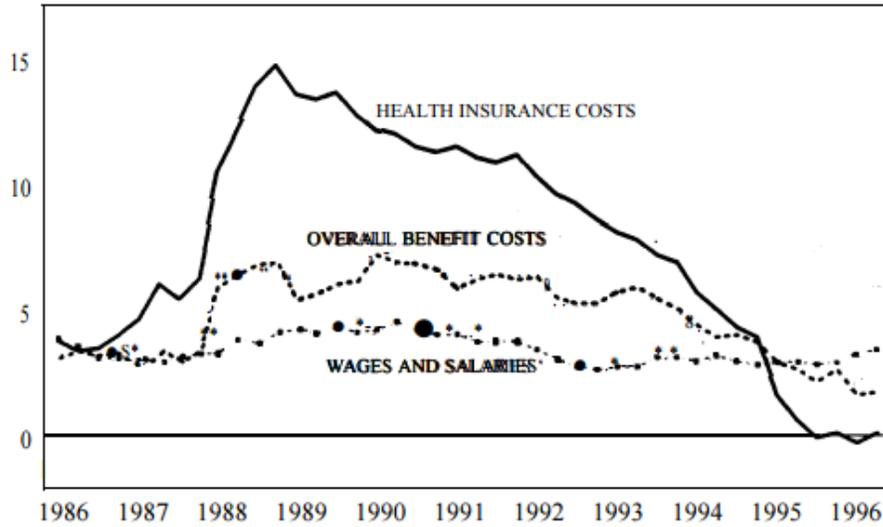


Source: USgovernmentspending.com

Exhibit 3

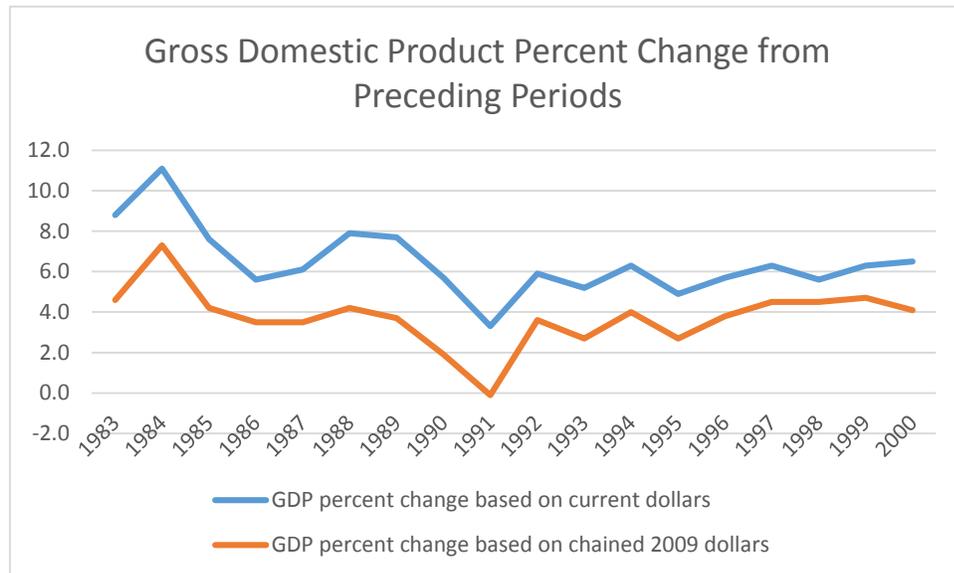
GROWTH IN EMPLOYERS' HEALTH COSTS SLOWS

Nominal Percent Change



Source Based on data from the Bureau of Labor Statistics, Employment Cost Index, Private Industry.. The nominal percent changes in employer costs for health insurance per hour worked are unpublished estimates from BLS

Exhibit 4



Source: World Health Global Health Expenditure Database

Exhibit 5

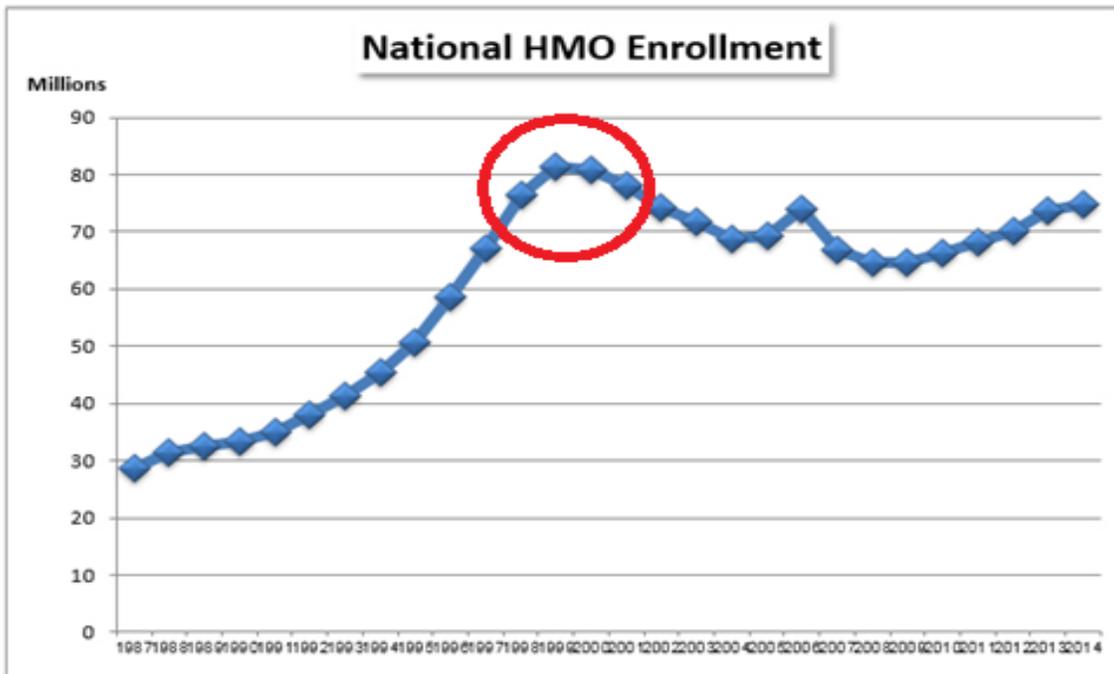
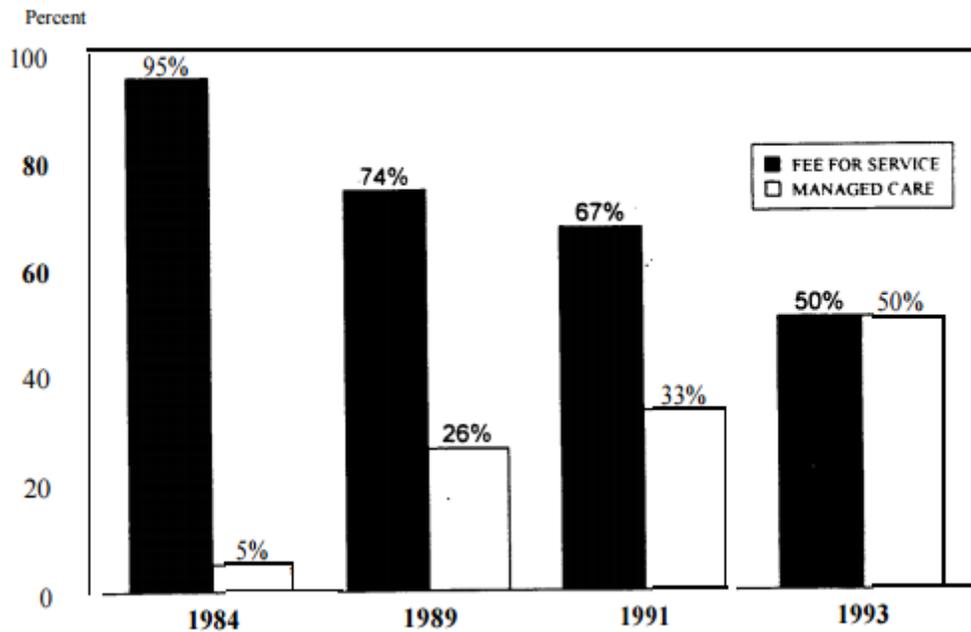


Exhibit 6

THE SWITCH TO MANAGED-CARE HEALTH PLANS

Distribution of Enrollment by Type of Health Plan,
Medium and Large Private Establishments . .



Source Based on data from the Bureau of Labor Statistics, Employee Benefits Survey.