Implications of Narrow Networks and the Tradeoff between Price and Choice

May 19, 2015

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Objectives

- To provide an overview of the effectiveness of network design strategies as well as highlight provider and consumer responses to date.
- To discuss recent state experience with narrow networks.
- To highlight potential policy responses to address the growth of narrow network plans.
- To identify where more evidence is needed, to inform policy and practice.
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Speakers

→ Michael Chernew, Harvard Medical School

→ Sabrina Corlette, Georgetown University

→ Lynn Quincy, Consumers Union
Thoughts on Tiered Networks

Michael Chernew
May 19, 2015
Tiered Networks

- Charge patients less (or waive copays/deductibles) if they receive care from preferred (typically low price) providers
  - Not service specific
  - Make sure quality is comparable
Motivation for Tiered Networks

- Use consumers to discipline providers
  - Encourage patients to avoid high price or inefficient providers
  - Encourage providers to lower prices
- Tiered networks increase plan negotiating power
- Shift cost of higher prices to patients
Advantages over other cost containment strategies

- More flexible than narrow/limited networks
- Broader than reference pricing
- Improve appropriability of managerial interventions relative to payment reform
Hospital Prices Vary

Sources:
Increasing prevalence of tiered and limited network plans

**Tiered network plans**
- All firms, 2014: 19%
  - 18% of large employers (over 200 employees)
  - 19% of small employers (3-199 employees)
- Most major commercial insurance firms now offering a tiered network product
- More prominent role in certain geographies

**Limited network plans**
- Prominent in the ACA exchanges

BCBSMA’s tiered hospital network copays

Evaluation of a Tiered Network

Figure 3: Predicted Probabilities That the TN Steered Patients from Nonpreferred to Middle and Preferred Hospitals

Notes: The main analysis includes all admissions after sample exclusions. The falsification test includes ED admissions identified by the admission source variable provided by BCBSMA. Figures are presented with 95 percent confidence intervals generated through bootstrap analyses.

Taft-Hartley Fund examined its physician network using efficiency and quality metrics and claims data.

~5% of physicians excluded from PPO

Patients notified of exclusion, informed that deductible and coinsurance would apply (a price increase of roughly $50 or more per visit)

81% of patients who had seen excluded physician in prior year did not return compared to baseline level of attrition of 54% (a 27 percentage point difference)

Physician Tiering in Massachusetts

- Combination of GIC and state regulation created favorable environment for tiering
- All-payer data from six participating health plans used to create physician performance profiles
- Specialist physicians most commonly tiered
- Early survey suggests:
  - 50% of members know about the tiering
  - 19% know which tier their doctor is in
  - 48% of those who knew the tier said it mattered
  - 40% trust the tiers to signal good value

Tiered networks affect patient choices of new doctors

- Significant loyalty to physicians seen previously - in contrast to prescription drugs
- New (and unknown) physicians are more likely to be viewed by patients as substitutable
- The effect of tiering may be at the lower end of the distribution rather than moving patients to the “best” performers
  - Physicians in the worst-performing tier experienced 12% loss in share of new patients

Hospital Tiering In Massachusetts

Massachusetts Group Insurance Commission:
- Offers health insurance to state employees and numerous municipalities
- 6 of 11 plans are classified as narrow networks

Large financial incentive for state employees to switch to narrow network plans in FY 2012:
- A 3-month “premium holiday” reduced employee share of narrow network plan premiums by 25%
- It did not affect municipal workers

Concerns

- **Quality/ access**
  - Will preferred providers be lower quality
  - Will beneficiary access diminish

- **Poor decision making**
  - Understanding of ramifications of plan choice
  - PCPs, specialists and hospitals in different networks?
  - Efficient providers may vary by service
  - Informing patients at time of provider choice

- **Beneficiaries less willing to switch plans**
Academy Health
Research Insights Webinar

Implications of Narrow Networks and the Tradeoff Between Price and Choice
May 19, 2015

Sabrina Corlette, J.D.
Presentation Overview

• Stakeholder Perspectives in 17 states
• State Action in Response to Network Changes
• Challenges
• Recommendations
Stakeholder Perspectives: Provider Networks

- 12 of 17 SBM states have changed provider networks for QHP offerings
- Carriers’ goal: competitive pricing
- Complaints from consumers & providers
Issuer Perspectives: Findings

• No universal strategy
  – Carriers took different approaches in different markets
• Most narrowed networks
• Some carriers maintained or adopted broad network strategy
Issuer Perspectives: Findings

• Narrow network strategy
  – A non-group market strategy in 2014
  – But narrow networks becoming group market strategy too

• Bottom line
  – Lower per-unit costs to offer a more competitive premium
  – Quality largely not a factor
Consumer & Provider Perspectives: Findings

• Consumers: price sensitive
• Consumer & provider concerns
  – Lack of information in plan selection process
    • Inaccurate information
  – Lack of access to mental health/substance use services
  – Lack of choice of plans in some areas
  – Lack of communication from carriers
Effective January 2014

- 16 states used a quantitative standard for all QHPs
- 11 states used a quantitative standard for some QHPs
  - Max travel time/distance: 23 states
  - Provider to enrollee ratios: 10 states
  - Max wait time: 11 states
  - Extended office hours: 7 states
- 23 states and DC: did not use a quantitative standard to assess QHPs
- 10 states required insurers to update provider directories more than annually
Notes: State network adequacy standards may apply broadly, to all network plans, or more narrowly, to specified network designs (e.g., HMOs) or plan types (e.g., marketplace plans). The 16 states identified in orange have one or more quantitative standards that apply to all marketplace plans, specifically, or to all network plans, in general. By contrast, the quantitative standards in effect in the 11 states identified in blue apply only to particular types of network plans (usually HMOs) and do not regulate all marketplace plans, generally.

Source: Authors' analysis.
State Action in 2014: 50-State Survey

Few significant changes since 2014

– New quantitative requirements: 3 states
  • Arkansas, Washington, California
– New requirements to update provider directories: 5 states
– Beefed up review: 6 states
Policy Development: Major Challenges

- Balancing Price and Access
  - Quantitative or qualitative standards?
- Transparency: easier said than done
- Addressing consumer/broker perceptions
  - Exchange plans seen as “sub-par” by some
- Not yet addressed (in most states): surprise “balance bills”
Policy Development: Recommendations

- Fix provider directories & keep up to date
  - Include info on language proficiency, disabled access
- Improve usability of plan network comparison tools
- Need a clearer network adequacy standard
  - Include incentives to take quality into account, not just price
  - Pre-market review against the standard
- Proactive monitoring of network adequacy
  - Conduct and publish consumer survey results
  - Use Secret Shopper studies/audits
  - Accountability when standard not met
Thank you! Questions?

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Narrow Provider Networks

Consumer Considerations

Lynn Quincy, Director
May 19, 2015
Academy Health
Who are we?

- **Consumers Union** is the policy and advocacy arm of *Consumer Reports*

- The **Health Care Value Hub** is a new center that monitors, synthesizes, translates and disseminates evidence about interventions intended to improve value for our health care dollar. Our primary mission is to support and connect consumer advocates across the U.S. to help them advocate for change.
Consumers Care Deeply About Health Care Costs

Health coverage is one of most expensive purchases consumers make.

Consumers feel strongly that “someone” – probably a government entity - should address high health care costs.

Consumers willing to embrace a wide-range of solutions.

Provider Network Design Is An Important Cost Control Tool

Providers direct most of our nation’s health care spending and network design is potentially a key tool for identifying high value providers.

Consumers’ out-of-pocket spending is just 13% of our nation’s health care bill.

Source: CMS, National Health Expenditures
Theoretically, consumers embrace narrow networks in order to keep costs down

In controlled experiments, given accurate information, a variety of options, and a valid structure for weighing the pros and cons, consumers report they prefer to narrow their provider choices in order to preserve or increase medical benefits.

Back to the real world….

Consumers lack a basic understanding of role of provider networks in plan design, leaving them ill-prepared to make informed health care decisions.

This poor understanding is likely compounded by narrow and tiered network structures.
Sobering data...

Only one-third of Americans (36%) can volunteer that HMO stands for health maintenance organization.

Only one-fifth (20%) recall that PPO stands for Preferred Provider Organization.

Source: https://www.ehealthinsurance.com/content/expertcenterNew/Demystifying-Health-Insurance-Survey-Results-01-10-08.pdf
More sobering data...

When presented with descriptions of possible provider network features, 50% or fewer could correctly describe HMO and PPO network characteristics.

<table>
<thead>
<tr>
<th>Knowledge of plan types</th>
<th>% correct</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is generally true of health maintenance organizations (HMOs)?</td>
<td>49.2</td>
</tr>
<tr>
<td>What is generally true of preferred provider organizations (PPOs)?</td>
<td>22.7</td>
</tr>
<tr>
<td>In general, what type of health plan tends to give fewer choices of doctors?</td>
<td>51.3</td>
</tr>
</tbody>
</table>

Important: this survey also found that consumers are overconfident in their own knowledge so self-reports of confidence using health plans must be weighed appropriately.

Source: data extract from AIR’s new health insurance literacy measurement tool. See: http://aircpce.org/health-insurance-literacy-measure-hilm-publications
Still more sobering data...

Consumer experience in health plans with tiered physician networks in Massachusetts found relatively low awareness and use of the network design among plan enrollees and low rates of trust in their health plan as a source of information for identifying “better” physicians.

Bottom Line: Very Likely Consumers Will Struggle To Navigate These Designs

Current measures of network adequacy are weak and rely heavily on self-reported data by health plans.

There are NO consumer-tested, validated summary measures to tell the shopper:

• Is network narrow or broad?
• Is network high quality or just low cost? Or neither?
• What is the level of financial protection if out of network providers are used (for PPO and POS products)?
Provider Directories

While important, directory information is insufficient and is likely to suffer from:

• Inaccuracies;
• Hard to find;
• Hard to ensure that the directory info goes with the plan under consideration, and
• Not validated by independent third parties.

Multiple studies finding inaccuracy rates of 50% and greater. These directories form the basis for network adequacy assessments.
Facts About Surprise Bills

- In a two year period, 30% of privately insured Americans received a surprise bill.
- Only 28% of this group was happy with how the issue was resolved.

Regulators aren’t hearing about these issues:

- 87% don’t know the state agency tasked with handling health insurance complaints.
- 72% don’t realize they have a right of appeal for coverage denials.

Needed Research

- Direct measurement of the consumer experience (modeled on Sinaiko 2010).
- Foundational work to develop new measures of provider network adequacy (multiple dimensions, see slide 10) to foster transparency and allow networks to be compared across plans.
- Consumer testing to determine how best to convey this information to consumers so they will act upon it.
- System-wide impact of new network designs: Are these plans holding costs down by limiting choice; are they deterring unhealthy people with costly conditions from joining in the first place; are they causing providers to practice in new ways?
- Foundational work to determine best remedies when narrow networks are don’t feature a needed provider, crafted so as to hold the consumer harmless.
Thank you!

Contact Lynn Quincy at lquincy@consumer.org with your follow-up questions.

Visit us at www.HealthCareValueHub.org
Submitting Questions

To submit a question:
1. Click in the Q&A box on the left side of your screen
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→ The Research Insights Project’s webpage
→ HCFO’s website
Survey

Please fill out a brief evaluation of this webinar. The survey will pop up at the end of the webinar, or can be accessed here:

https://www.surveymonkey.com/s/SHZW2YP

Thank You!