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Narrow Networks in Colorado

Balancing Access and Affordability

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Introduction

Many health insurance plans purchased through the new online marketplaces — including Connect for Health Colorado — offer a limited selection of providers in their networks, a development that is raising important policy questions in Colorado and across the nation.

Insurers say that these narrower provider networks are a response to provisions in the Affordable Care Act (ACA) regulating their business practices.

Under the ACA, insurers in nearly all individual and group markets must sell plans to everyone, even people who already have health conditions. And they are required to extend many preventive services, such as Pap tests and colorectal screening, with no out-of-pocket costs.

Insurers in the individual and small group markets must offer a standard set of benefits. And they are allowed to charge higher premiums for only one health-related behavior — smoking.

As a result, narrower networks are one of the tools available to insurers trying to lower their costs in order to compete for price-conscious consumers who are comparison shopping through the marketplaces.

Narrow networks are not a new concept. Insurers have long used them as a strategy to increase their bargaining power with providers, for example. But the number of narrow networks has been growing in the wake of the ACA.

And it is clear that many Coloradans are more than willing to trade wider provider networks for lower premiums. For example, 40 percent of Colorado's marketplace enrollees in 2014 opted for the lowest-price bronze plans, a rate second only to Hawaii.[1] It is likely that many of these plans have narrower networks.

It is also likely that some of the bargain shoppers may not be fully aware of the trade-off they are making. For instance, one survey found that 26 percent of those purchasing a plan through a marketplace did not know whether they had bought a narrow or broad network plan.

It's this concern — whether consumers understand that they are buying plans with fewer in-network clinicians and hospitals,

potentially resulting in unexpected medical bills if they use out-of-network providers — that is driving the policy debate.

Questions also are being raised about whether policyholders will be able to obtain timely health care if they have fewer provider options.

The Colorado Health Institute anticipates that the issue of narrower networks will be addressed on a number of fronts by multiple stakeholders, including policymakers, in Colorado.

Look for action on network adequacy from:

- **State regulators:** The state's Division of Insurance (DOI) last year commissioned a study of networks in the individual and small group markets, aiming to set a baseline for developing standards to evaluate network adequacy. The DOI plans to begin conducting stakeholder meetings during the summer with consumers, providers, insurers and policymakers.

- **Consumer advocacy organizations:** Twenty Colorado consumer advocacy groups, led by the Colorado Consumer Health Initiative (CCHI), have urged state Insurance Commissioner Marguerite Salazar to support work by the National Association of Insurance Commissioners (NAIC) to revise the Network Adequacy Model Law. The group asked Salazar to "work within that process to ensure that consumers can obtain quality care in a timely, accessible and culturally appropriate manner." It urged support of quantitative standards for network adequacy, stronger language on plan transparency and continuity of care provisions.

- **The Colorado legislature:** A bill introduced by Democratic Sen. Irene Aguilar in the 2015 legislative session sought to protect consumers from some out-of-network charges, but lost on a party-line vote in a Senate committee. Consumers, insurers and advocacy groups spoke in favor of the bill, which Aguilar branded as "Know Before you Owe," while physician and hospital groups opposed it. This bill or similar ones may be brought back in 2016.

- **Insurers:** Insurers in Colorado will most likely continue to protect their flexibility to offer narrower networks in an ongoing effort to channel volume to specific providers, lower premiums and maintain quality.

The Colorado Health Institute, in this look at network adequacy post-ACA, has identified three key questions facing policymakers:

- Are patients able to get the care they need when they need it?

- Do health plans have enough flexibility to develop products that meet customer needs at prices they can afford?

- Does the regulatory environment sufficiently protect consumers?

This brief is the first in a series of reports delving into the implications of narrower networks on consumers, insurers, the insurance marketplace and taxpayers in Colorado.

What is a Provider Network?

Insurance companies contract with hospitals, doctors, other medical professionals and pharmacies — or, alternatively, with medical groups — to provide services to their policyholders. The insurers negotiate discounted prices with the providers. In exchange, the providers gain increased volume when the insurers direct plan members their way.

These negotiated arrangements result in a provider network. The health care professionals are referred to as network providers or in-network providers. Network adequacy generally refers to consumers having access to a reasonable number of in-network primary care and specialty providers, as well as other health care services.[2]

Plans with delineated provider networks have virtually replaced indemnity plans, which allowed policyholders to visit almost any hospital or doctor.

But network arrangements vary. A health maintenance organization (HMO) is considered a closed network because services obtained outside the HMO are generally not covered. A preferred provider organization (PPO) provides incentives for consumers to use designated providers by offering lower cost-sharing in-network but higher cost-sharing out of the network.

While the online marketplaces offer a variety of network-based plans, PPOs and HMOs led the way on the federal marketplace with about 80 percent of the plans.

What is a Narrow Network?

The issue of network adequacy is complicated by the fact that there is no single definition of what constitutes a narrow network. Early attempts at definitions focused on the percentage of clinicians and hospitals within a particular area that are included in a provider network.

Narrow networks generally limit the selection of providers in return for a discount on premiums. Narrow networks are found in plans with significantly lower premium costs and more limited provider choices than traditional PPOs or HMOs.

Variations of narrow networks may include high performance networks or tiered networks.

- **High performance networks** require providers to meet quality and performance benchmarks in addition to lower costs. By requiring the providers within the narrow network to meet performance standards, the expectation is that providers will compete on quality as well as costs, driving greater efficiency in the health care system.[3]

- **Tiered networks** encourage plan members to use economical providers by offering lower out-of-pocket costs. Providers are categorized in tiers based on efficiency, and plans offer consumers graduated cost-sharing between tiers, with lowest cost-sharing for the most efficient providers. Tiered networks can equate to a narrow network when the highest cost-sharing tier is too expensive.[4] These networks may or may not require providers to meet performance standards.

Figure 1. The Trend Toward Narrow Networks

Why are Narrow Networks Increasing?

The ACA has done away with many strategies previously used by insurers to set premiums. For example, premiums in the small group and individual markets can no longer be based on a policyholder's health status or use of services. This permits only limited rate adjustments for factors such as age, tobacco use, geography and family size.

Insurers are designing some lower-cost networks with fewer provider options. At the same time, more employers are asking for narrower networks in an effort to manage premium costs.

Nearly one of five employers in firms with three or more workers (19 percent) nationally added either tiered or high performance networks to their largest health plans, an increase of five percentage points between 2007 and 2014, according to a survey conducted by the Kaiser Family Foundation and the Health Research & Educational Trust. These networks are increasing even faster in the western United States, including Colorado, jumping 11 percentage points from 13 percent to 24 percent during the same period.

Employers feel that tiered or high performance networks are a more effective cost containment tool than simple narrow networks, the study found.[5]

Among small employers, more than half would choose a narrow network plan in return for a 5 percent cost savings, while 82 percent would select a narrow network if the cost savings jumped to 20 percent, according to a 2013 study by NORC at the University of Chicago, an independent social research organization.[6] Narrow network plans in this study were defined as those contracting with 25 percent or fewer of the doctors and hospitals in the community.

Meanwhile, consumers often opt for narrow network plans if they can save money. Likely customers shopping for coverage through the marketplaces prefer narrow networks that cost less to broader networks that cost more, according to the Kaiser Family Foundation's 2014 Health Tracking Poll.[7] The survey found that these cost-conscious consumers are more likely to be low-income and uninsured compared with the total population, which prefers broader networks at a higher price.[8]

Two-thirds of the 46,000 people who participated in an online simulation model before the marketplaces went live were willing to accept narrower networks in exchange for lower premium costs. These findings represent an average across simulations. Slight variations existed between individual simulations, depending on the products and pricing offered as well as other factors.

These findings (and other findings from surveys and polls about consumer preferences) support early conclusions that price has a strong influence over consumer decision-making for health insurance, although further study will be needed going forward.

Narrow Networks: The Debate

Many marketplace consumers are satisfied with their narrower network plans. But a number of policyholders, consumers and advocates, as well as policymakers, have raised red flags.

Some policyholders have discovered only after purchasing a plan that their provider is not in the network. Others have found that providers who are participating in a network may not be accepting new patients. Still others have said they have only limited access to specialists at sought-after medical centers.[9]

One survey found that more than one of four (26 percent) of those purchasing a plan through a marketplace did not know whether they had bought a narrow or broad network plan, suggesting the need for greater transparency as well as more consumer education.[10]

Figure 2. Narrow Network Pros and Cons

	Insurer	Provider	Consumer
Narrow Network Benefits	• Negotiate lower prices (with providers)	• Increased volume of patients (if in-network)	• Lower premiums
Narrow Network Challenges	• Some dissatisfaction among consumers • Lack of transparency on in-network plans and providers	• Potentially participating in fewer networks	• Risk of compromised access • Limited awareness of in-network providers

Regulating Narrow Networks: The State Role

States serve as the primary regulators of insurance, including oversight of provider networks.

The ACA requires that a network be "sufficient in numbers and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay."

Still, the law gives states significant flexibility to define "sufficient" and "unreasonable."

Colorado law requires carriers to maintain networks with enough providers to ensure that all covered benefits are "accessible without unreasonable delay."[11]

The law also establishes basic requirements for determining sufficiency of providers, including geographic accessibility, waiting times and hours of operation. Because there are no quantitative standards, plans have flexibility in demonstrating network adequacy. In addition, these requirements are not closely monitored by the state.

As policymakers explore network adequacy in Colorado, key consideration must be given to the realities of the current environment and what impact changes may have. Moving forward, decision makers should seek to understand:

Do patients in Colorado have access to the care they need when they need it?

There has been limited research regarding how narrow networks are affecting access to care. Exploration of access to care issues must factor in the type of service (hospital, primary care, specialty services) as well as the challenges faced by rural communities in availability of providers.

Do health plans have enough flexibility to develop products that meet customer needs at prices they can afford?

Colorado's regulatory framework provides significant flexibility in designing networks, which has likely contributed to a more competitive insurance market. The leverage created by a narrow network is a tool used by insurers in negotiation with providers, which can help to reduce costs for the most price-sensitive consumers. Policymakers should consider how proposed changes in rules affect this tool and the cost of health coverage.

Does the regulatory environment sufficiently protect consumers?

Colorado's network adequacy rules must ensure that consumers can access the care they need when they need it and that there is no discrimination based on health status. In addition, policymakers should understand the degree to which improved transparency and consumer education can address consumer needs. As networks narrow, consumers must have resources that accurately reflect which providers are in their network, so they avoid inadvertently seeing out-of-network providers and the associated costs.

Conclusion

As insurers continue to compete for price-sensitive consumers, the Colorado Health Institute anticipates increased scrutiny of network adequacy and consumer protection laws in Colorado. Policymakers, regulators, insurers, providers, consumer advocates and others will be grappling with this issue.

Stakeholder engagement will broaden as the staff of the Division of Insurance and other policymakers attempt to take on the challenge of defining what constitutes a reasonable network.

How well consumers understand and access their network benefits should become more apparent as new marketplace enrollees obtain health services. This evidence will help to inform the debate.

Meanwhile, insurers and providers will be closely evaluating actions by policymakers in order to protect the business strategies necessary to remain competitive.

End Notes

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