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TREND WATCH

Narrow networks, a method to keep quality up and costs down, are growing in popularity

Limiting provider networks has been an effective method for managing costs without sacrificing quality for Accountable Care Organizations (ACOs), health plans and employers

The Trend to Watch

Characterized by relatively small panels of physicians and hospitals that reduce choices to consumers, narrow networks were a contributing factor to the HMO backlash of the 1990s. But with the rising cost of health care and the availability of better tools to measure quality as well as cost, narrow networks are making a comeback. Will they last?

Key Factors

The Affordable Care Act (ACA) is driving more health plans to use narrow networks as a cost lever.

The ACA prohibits health plans from using medical underwriting to hold down costs. In response, more insurers are narrowing the selection of in-network doctors and hospitals to those who meet certain benchmarks for cost and quality, as a means to control costs and manage care.[1]

"IF YOU'RE COMPETING ON PRICE AND YOU CAN'T VARY COPAYMENT STRUCTURE OR DEDUCTIBLES, THE ONLY THING YOU CAN DO IS TRY AND KEEP YOUR NETWORKS AS AFFORDABLE AS POSSIBLE."

— Gerald Kominski, director of UCLA Center for Health Policy and Research[2]

Narrow networks are helping employers manage risk and cost.

Narrow networks are also proliferating due to large employers contracting with large providers to cut the cost of insuring their employees. Boeing recently entered into an agreement where 27,000 of its Seattle-area employees will utilize one of two ACOs. Intel entered into a similar agreement for its 5,400 New Mexico-based employees. Other employers striking bundled-payment deals with narrow networks include Walmart, Lowe's and PepsiCo.[3]

Narrow networks are common in Accountable Care Organizations.

ACOs associated with narrow networks were introduced in California in 2008 and have become prevalent as insurers and providers compete to offer low-cost/high-quality plans.[4] Across the country, many of the Medicare's Shared Savings Plan ACOs (MSSPs) are analyzing their data to contract with high-performing physicians and avoid low performers.[5]

Data Points

Employers and consumers are beginning to embrace narrow networks

The National Business Group on Health found that **17% OF LARGE EMPLOYERS** have a narrow network health plan in place for their employees, while nearly half of large employers were considering narrow networks for within the next three years (HealthLeaders). Of all employers, nearly a quarter of those offering health benefits to their employees offered some form of narrow network health plan.[6]

The Kaiser Family Foundation found that **54% OF UNINSURED OR INDIVIDUALLY INSURED** respondents preferred cheaper narrow network plans over more expensive broad network plans.[7]

According to the National Bureau of Economic Research, narrow networks that focus on quality **HELP PEOPLE GET THE RIGHT CARE**. Members of such plans saved on the cost of insurance, used emergency care less and visited their primary physician more often.[8]

In California, narrow network plans are among **THE MOST POPULAR** on the state's health insurance exchange.[9]

"[NARROW NETWORK HEALTH PLANS ARE] GOING TO BE THE NORM RATHER THAN THE EXCEPTION. IT'S NOT APPARENT TO ME THAT YOU CAN KEEP BROAD, FEE-FOR-SERVICE NETWORKS AND GET TO THE PAYMENT REFORM EVERYONE WANTS."

— Joseph Berardo, President and CEO of health plan management company MagnaCare[10]

Narrow network ACOs are achieving shared savings

Monarch Pioneer ACO has achieved **THE SECOND-HIGHEST SHARED SAVINGS** for the program two years in a row. Monarch attributes its success in shared savings in part to its narrow network.

Monarch Pioneer ACO **SAVED 6.3%** of forecasted medical costs in Year 1 of the Pioneer model, and **5.4%** in Year 2.

Cost trends were driven mostly by utilization and unit cost reductions in hospitals and skilled nursing facilities.

Monarch contracts with 280 physicians in its Pioneer ACO. Together, they care for **APPROXIMATELY 29,000 MEDICARE BENEFICIARIES** in Orange County and Long Beach, California.[11]

"MONARCH CONTINUES TO BE SELECTIVE WITH REGARD TO WHICH PHYSICIANS ARE INVITED TO PARTICIPATE IN OUR ACO. PHYSICIANS WHO TAKE BROAD ACCOUNTABILITY FOR THEIR PATIENTS' HEALTH CARE, AND WHO ARE DEEPLY COMMITTED TO PREVENTIVE HEALTH, EVIDENCE-BASED GUIDELINES AND COORDINATED CARE ARE AN EXCELLENT FIT FOR OUR ORGANIZATION. WE LOOK FOR THESE SAME CHARACTERISTICS IN ALL OF OUR PARTNERS."

— Bart Asner, MD, Chief Executive Officer, Monarch HealthCare[12]

Business Impact

Narrow networks could become a political hot-button

Provider groups and patient advocacy groups have pushed the Obama administration to set rules for "network adequacy" that would regulate how insurers, employers and ACOs could limit provider networks.

Some providers have expressed fears that narrow networks could be based solely on cost; they report being left out of Medicare, Medicaid and commercial narrow networks because they didn't agree to significantly lower payments.

The Obama administration stated they would wait for the National Association of Insurance Commissioners (NAIC) to finish drafting a model state law before they propose a rule about network adequacy. The NAIC drafted an updated model state law in November and accepted comments through January.[13]

ACO networks organized by providers may be more of a threat to non-participating providers than payer-focused narrow networks. Those who aren't participating can't buy their way in by simply offering discounts.[14]

The popularity of narrow networks may spur the creation of more of them

For the time being, consumers are choosing narrow networks because they offer lower costs. Insurers and regulators say that very few are complaining about the narrow network structure (HFMA). But that could change. Narrow networks were also prevalent in the 1990s during the managed-care era; there was considerable pushback then, especially when networks changed from year to year and patients had to pay out-of-network prices to see their doctor.[15]

Consumers will make their voices heard

The narrow network value equation for health care consumers is a function of two variables: "How much will it cost?" and "Can I see my doctor?" If both answers are positive, choosing a narrow network is a no-brainer. But if consumers one year can visit their preferred physician or facility and the next they can't, narrow networks may see a drop in popularity.

"IF [NARROW NETWORK CONTRACTING] SPILLS OVER INTO EMPLOYER-BASED HEALTH INSURANCE I THINK WE'LL SEE MUCH MORE POLITICALLY POTENT BACKLASH."

— Jon Gabel, a senior fellow with the National Opinion Research Center at the University of Chicago[16]

Takeaways

To maintain the viability of narrow networks, consider the following suggestions:

Use data and analytics to optimize networks depending on population needs

Basing narrow networks solely on cost is using a blunt instrument. While data from the 1980s and '90s was mostly limited to cost, quality data is measured regularly and today's analytic technology can help score providers based on the golden mean of cost and quality.

Market networks as high quality rather than low cost

Consumer response to narrow network health plans has been generally positive. But "limiting choice" isn't a position that value-based providers want to be associated with. When marketing narrow networks, promote the quality thresholds used to determine the network. Cost-conscious consumers will do their own comparison shopping.

"THE WAY WE HAVE CONSTRUCTED THESE NETWORKS NOW — WITH THE QUALITY CRITERIA WE USE — IS DIFFERENT FROM THE WAY WE DID IT IN THE 1980s."

— Amy Oldenburg, head of national provider networks, Aetna[17]

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