

# Research Insights

## ■ Health Plan Features: Implications of Narrow Networks and the Trade-Off between Price and Choice

### Summary

The use of narrow provider networks in health insurance plans is a cost containment strategy that has gained popularity of late. Network design features differ among plans, but insurers generally seek to offer lower premiums by limiting the group of providers available to plan enrollees. As interest in the use of narrow networks has increased, so have concerns about their effect on consumers' choices, costs, and access to care. With the growth of narrow network plans, it is important to understand the effectiveness of existing and emerging network design strategies and the potential for policies to ensure consumer access to high-quality care.

This brief summarizes key points from an expert panel AcademyHealth convened in December 2014 to examine existing research on network design and use, to discuss the impact of narrow networks and tiered networks on consumers, to review policies and practices for ensuring that networks are adequate, and to identify areas for additional research. Research on the impact of narrow networks is limited, but early studies suggest that several factors affect whether narrow network strategies will succeed. These factors include the way networks are constructed, the characteristics of the broader market in which narrow network plans operate, and whether consumers have the knowledge and tools to make informed choices about

coverage. Additional research is needed to help policymakers better understand how to define and develop enforceable standards to measure the adequacy of narrow networks. Research can also help identify the quality considerations to be incorporated into the network design process, the development of network adequacy standards, and the type of guidance that can help consumers understand plan differences when making choices among products.

### Overview

The use of narrow provider networks in health insurance plans is a cost containment strategy that has gained popularity of late. Narrow network plans have proliferated on the new marketplaces established by the Affordable Care Act (ACA). They have also become more common in Medicare Advantage and commercial plans. Increasingly, consumers have the option to choose plans that offer lower premiums but limit provider choice. Insurers may offer narrow network plans to attract price-sensitive consumers who are willing to trade network breadth for less costly premiums and other out-of-pocket payments. Yet, anecdotal evidence suggests that the resulting provider networks may be narrower than consumers foresaw and, as such, may leave them vulnerable to the financial burden of out-of-network care for services not adequately covered within network. Narrow network plans conceptually offer one choice for controlling

### Genesis of this brief:

This brief is based on a meeting for federal policymakers which took place in Washington, D.C., on December 10, 2014. AcademyHealth convened the meeting as part of its Research Insights Project. Funding for this conference was made possible by Grant No. 2R13HS018888-04A1 from U.S. Agency for Healthcare Research and Quality (AHRQ). The views expressed in written conference materials or publications and by speakers and moderators do not necessarily reflect the official policies of the Department of Health and Human Services; nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government. The Research Insights Project convenes invitational meetings, holds webinars, and produces reports and issue briefs to foster discussion of existing, relevant research evidence among policy audiences who need it to implement health reform and develop new policy. Additional information and publications may be found on the project's website, <http://www.academyhealth.org/researchinsights>.

out-of-pocket spending, but consumers may lack sufficient information to make informed decisions that take into account the potential overall cost consequences of their choices.

The Affordable Care Act requires that qualified health plans sold in Exchanges offer provider networks that meet a general “reasonableness” standard. Pre-dating the ACA, at least 20 states had established network requirements governing one or more types of private health plans. Furthermore, the National Association of Insurance Commissioners is now in the process of updating their network adequacy model. Any consideration of appropriate policy responses to the growing number of narrow network plans must reflect an understanding of the effectiveness of existing and emerging network design strategies and policies’ potential for ensuring consumer access to quality care.

In December 2014, AcademyHealth convened a meeting that brought leading academic researchers together with policy audiences to discuss the use of narrow networks and network design strategies more broadly. The meeting featured research drawn from experiences with Medicare Advantage, Medicaid managed care, ACA marketplaces, and other commercial markets. Researchers presented findings on the impact and effectiveness of network design strategies and on current efforts to measure and enforce standards related to network adequacy. Attendees were asked to identify high-priority areas of study related to narrow networks.

This brief presents a summary of the December meeting. Given that the session was “off-the-record,” this brief conveys the general content of the meeting without attributing specific comments to particular participants. The discussion was informed by existing research, though neither it nor this brief incorporates a systematic review of the literature on narrow networks. A bibliography of important current literature on the topic appears at the end of the brief.

### **Understanding narrow and tiered network strategies**

Insurance plans with narrow networks seek to offer lower premiums by limiting the group of providers available to plan enrollees. Consumers choose among a set of providers under contract with the plan. An assumption underpinning the narrow network strategy is that narrow and limited networks can reduce costs by encouraging patients to seek care from low-cost providers and perhaps markets can be made more efficient given that currently, prices among the same types of providers vary. An examination of hospital prices, for example, shows considerable variation.<sup>1</sup> There is an expectation that providers may give plans a discount in exchange for the promise of greater patient volume and that negotiation between plans and providers who wish to be in the network will help contain costs.

Tiered networks, a variation of narrow networks, offer consumers a broader array of choices and more flexibility. Consumers are subject to different levels of cost-sharing such that consumers who choose providers in “high-value” tiers pay less. Tiered networks encourage enrollees to use lower-cost providers but, unlike narrow networks, provide some coverage for other providers. Expectations for the tiered network approach are that consumers can influence the market if they choose lower-cost providers and that providers will be motivated to change their behavior in order to maintain or improve their tier ranking and market share. The tiered network strategy takes advantage of recent advances in the use of data to develop profiles of provider groups or individual providers. Networks can target different types of providers such as hospitals, primary care physicians, or specialists. The tiered network strategy shifts costs to patients who go to the more expensive providers rather than spreading the cost of more expensive care across the whole population.

In part, the lessons from the managed care experience of the 1990s inspired the advent of tiered networks. With managed care, patients indicated that having a choice of physicians was important to them. Panel participants pointed out that, in the group market, employers want low prices but also want value for employees. In the nongroup market, consumers are more apt to shop simply on the basis of price. One panelist noted that tiered networks may be more attractive than narrow networks to consumers who have enough disposable income to make real choices. Panelists also observed that some consumers may be attracted to tiered network plans because of the choice element, but others may be put off by the more complicated calculations required to choose and use tiered plans.

Results from an early study of stakeholder perspectives in 17 states with state-based health insurance exchanges indicate that 10 of those states saw narrower provider networks for the ACA Qualified Health Plan (QHP) offerings in the first year; among the other 7 states, insurers in 2 states reported plans to narrow networks in 2015. Insurers did not, however, have a universal strategy for network design. Some shifted from preferred provider organization– (PPO) style networks to health maintenance organizations (HMO) or closed networks, some simply excluded high-priced providers, and others offered tiered networks. In all cases, though, insurers’ primary goal in designing networks was to offer competitive pricing. Generally, quality was not a criterion for exclusion or inclusion in a network. Some carriers maintained or adopted broad networks. Fewer offered out-of-state network benefits, but those who did saw it as a marketing advantage.

One discussant observed that developing narrow networks may be simpler than developing tiered networks and suggested that the short time frame for product development may be one reason that few tiered networks were offered. In addition, one expert speculated that the narrower, lower-cost products may have had greater appeal for the population purchasing insurance through the exchanges. In 2014, less than one-fifth of small and large employers used tiered networks.

### Broader market considerations

Participants discussed network strategies in the context of the broader market. While some see the narrow network strategy as a means of increasing plans' negotiating power and encouraging providers to lower prices, others characterize the arrangement as one that allows insurers to benefit from existing competition. Several participants noted that the supply of providers affects price. For example, insurers may need hospitals that have monopolies in certain geographic areas, but those hospitals may not be interested in compromising on price. In areas where providers are in short supply, such as many rural communities, providers may not have incentives to negotiate with plans. Another point raised by researchers is that provider organizations with considerable market power that offer services not available from other providers in the market may be able to block the use of narrow networks by refusing to participate or may be able to otherwise influence tier placements.

Participants also noted that consumers' strong loyalty to their physicians, particularly their primary care physicians, might explain why providers with thriving practices might not be motivated to participate or negotiate. Several panelists pointed out that providers direct much of health care spending through referrals; recommendations from primary care doctors often affect patients' decisions about which specialists to see. In addition, providers may face incentives apart from those presented by narrow network plans. If they are members of Accountable Care Organizations, for example, they are already affiliated with certain other providers. Further, many provider systems are aligning themselves with specific carriers, thus reducing their incentive to negotiate favorable rates with competing carriers.

### Practical considerations

Discussants observed that the success of network strategies depends on whether networks are designed in an optimal manner and on whether consumers have the information and tools they need to make informed choices.

### Network design

Several participants made the case for greater transparency regarding the criteria plans use to develop networks. It is important to understand, for example, the interplay between cost and quality considerations. Participants explained that measuring the relative cost, efficiency, and quality of health care providers is difficult. Given the challenges associated with the construction of tiered networks, participants voiced particular concern about the difficulty of interpreting the tiers. Another consideration is that the data on which tiered networks are constructed may be from prior years and therefore may not reflect current practices or circumstances.

Other complications arise when several health plans use tiered networks in the same geographic market. Information from studies of benefit design changes sponsored by the Massachusetts Group Insurance Commission (GIC), an agency that administers health benefits for state and municipal employees, illustrates some of the complications. The group's "tiering initiative" created a master database of physician performance and gave it to participating plans with broad instructions to create tiered networks. Physicians were evaluated, first, on quality and, second, on cost efficiency. Physicians with an insufficient number of observations were placed in the middle or the average-performing tier. All of the GIC health plans offered three-tier physician networks. However, there were differences in physicians' tier rankings across plans that may have resulted from plans' use of different thresholds to divide physicians between top and lower tiers. Plans with more selective or smaller networks may have ranked the same physician lower (in percentile terms) than a broad network simply because they excluded lower-performing physicians from the network. Plans also may have considered additional data on performance, leading to differences in tier rankings across plans. That doctors could have different rankings at the same time could be confusing for patients.

Panelists stressed the importance of publicizing the measures and formulas used by plans, noting that a better understanding of the metrics can help policymakers as they seek to determine whether plan design features are effective. They also observed that, to be able to improve their rankings, providers need specific information about how tier rankings are calculated. Finally, attendees emphasized that greater transparency is essential if the goal is to steer consumers to providers that offer the best value rather than the lowest price.

### Consumer awareness

Discussants agreed that consumers care deeply about health insurance costs and that they are receptive to benefit designs that may reduce costs. Nonetheless, they questioned whether consumers have the knowledge and tools they need to make informed decisions about choosing narrow networks or choosing among tiers. Some participants noted that, while a certain amount of choice is desirable, too much choice can discourage consumer decision-making.

Current research indicates that consumers lack a basic understanding of health insurance in general. For example, half or fewer respondents to a consumer survey could correctly describe network characteristics of HMOs and PPOs. Furthermore, the survey showed that consumers are overconfident in their own knowledge of health insurance literacy.<sup>2</sup> In the GIC tiering initiative, researchers found relatively low awareness and use of the network design among plan enrollees.<sup>3</sup>

As noted, experience to date suggests that most consumers shop on the basis of price, particularly premiums and copayments, and do not necessarily understand other differences among health insurance plans. Several participants noted that giving consumers a choice of plans is often portrayed as a positive feature but is desirable only if consumers are able to make informed choices.

Panelists spoke specifically about the need for information on provider networks that is accurate and easy to understand. Findings from the study of stakeholder perspectives in 17 states indicate that plan-specific provider directories are often outdated and difficult to locate. In addition, if carriers sponsor more than one plan, consumers may have difficulty in determining which directory pertains to which plan. The study also reported that a lack of communication from insurers about plan network affiliation was confusing for providers who therefore were not able to give helpful guidance to patients.<sup>4</sup>

Tiered plans pose particular challenges. To make the best choices, consumers must be aware of the provider group—hospitals, primary care physicians, or specialists—for which the tiers are developed. They must also be aware that “high-value” providers may vary by service. Therefore, consumers need to understand the ramifications of plan choice if primary care physicians, specialists, and hospitals are in different tiers. In addition, the need for more transparency about tier placement is essential for consumers comparing plans, especially when the same providers have different tier rankings across plans.

Several people stressed that consumers should be well informed not only in order to choose plans but also so that they can use their

coverage effectively. A particularly serious concern raised by participants is that consumers are not aware that they may be financially responsible when out-of-network providers participate in episodes of care. For example, a consumer who undergoes a procedure in an in-network hospital may be surprised to receive a bill from a hospital-based physician such as an anesthesiologist or pathologist who is not in the consumer’s plan network. Thus, when selecting plans, consumers need good information about the level of financial protection provided by plans for out-of-network services.

Researchers noted that, in thinking about how to provide information to help consumers make choices, it is important to remember that consumers will only act on information that comes from a trusted source and that consumers generally do not view health plans as trusted sources for identifying better providers. In addition, many consumers are influenced more by their own experience, particularly if they are loyal to current physicians, than by other measures or incentives. Several people emphasized the need for consumer-tested, validated summary measures to provide consumers with information such as whether networks are narrow or broad; whether networks are high-quality or just low-cost, both, or neither; and what level of financial protection is available if out-of-network providers deliver care. Discussants said that, ideally, consumers should be able to make high-level plan comparisons and then have access to details related to participating providers and quality of care.

### Impact of narrow and tiered networks

Research on the impact of narrow networks is limited, but early studies have looked at how various network approaches affect consumer and provider behavior and at the effect of these designs on access to care and the cost of care.

### Consumer behavior

Researchers have examined the extent to which tiered network incentives influence consumer behavior. The GIC’s tiering initiative study found that patients exhibited significant loyalty to the specialty physicians whom they had seen previously, even those with poor tier rankings and regardless of type of specialist. In addition, the tiers influenced consumers’ choice of new physicians; physicians with the worst tier rankings drew fewer new patients—equivalent to a loss in market share of 12 percent—than their top- and average-tier colleagues. Discussants also noted that other plan design features can affect consumer behavior. For example, if plans impose out-of-pocket spending caps to protect consumers, anyone who expects to exceed the cap in a given year will be less likely to be affected by differential cost-sharing.

The GIC sponsored another initiative, a one-year “premium holiday” program that offered significant financial incentives for state

employee enrollees who chose narrow network plans. Those who enrolled in narrow network plans did not have to pay premiums for three months, with the potential for total savings of approximately \$250 to \$750. Results from a study of that program indicated that many consumers were willing to accept the trade-off of a narrow network for reduced out-of-pocket premiums. The offer of a premium holiday resulted in an enrollment increase of 12 percentage points in narrow network plans, nearly doubling the number of employees in narrow network plans (Exhibit 1).<sup>5</sup> Several researchers noted, however, that consumers whose primary care physician was available in a narrow network plan were more likely to switch to a narrow network plan and that 86 percent of GIC enrollees who had the opportunity to switch plans could opt for a narrow network option that included their primary care provider. As a result, large numbers of consumers were able to remain with their primary care physician and pay less. Discussants cautioned that the findings from the study may not be relevant in other circumstances.

### Access

Another important research question is whether access to care will diminish for consumers who enroll in health insurance plans with narrow networks. At this point, information about access is very limited. The early study of stakeholder perspectives in 17 states with state-run health insurance exchanges documented access problems related to mental health and substance use services. Researchers noted that, while access to such services is not a new problem, it is a continuing concern. The study took place too early in the implementation process to provide information about what a change in networks means for access to most other types of care.<sup>6</sup>

Results from the GIC premium holiday study suggest that the premium holiday did not reduce access to high-quality care. Researchers saw no change in the quality ratings of the hospitals to which patients were admitted. Effects on the distance travelled to providers were mixed. Patterns were similar for those with and without chronic illness.<sup>7</sup> Experts cautioned that the results may not be generally applicable because the study was conducted in Massachusetts, a state with a high density of hospitals and other providers.

### Cost containment

Research on the impact of narrow networks on cost containment has also been limited. Researchers studying the GIC premium holiday program reported a 36 percent reduction in health spending for enrollees who were induced by the premium holiday to switch to a narrow network plan. Lower spending was related to reductions in the cost and quantity of care. Greater use of primary care and reduced use of specialty care occurred. Savings were concentrated among consumers who could keep their primary care provider.<sup>8</sup> The reasons for the changes in care patterns were not clear, though discussants suggested that fewer referrals from primary care physi-

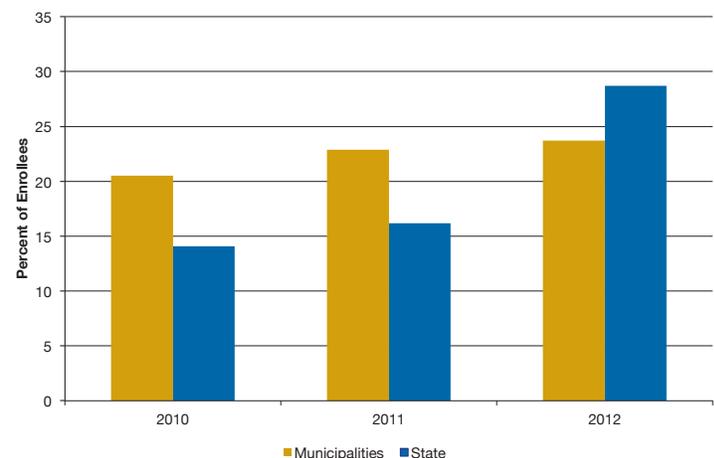
cians to specialists or patients' reluctance to visit out-of-network specialists could have been contributing factors. Noting that the great majority of enrollees in the program were able to choose narrow network options that included their primary care physician, researchers observed that the findings might not be relevant for other markets. Experts also questioned whether savings of the same magnitude would occur in future years.

### Network adequacy

The adequacy of plan networks is a key consideration when narrow network strategies are employed. In discussing the concept of network adequacy, participants stressed the importance of understanding the goals that drive the formation of networks. They noted that carriers want to include lower-cost providers in their networks and that they generally try to ensure that the number of providers is adequate. They were less certain about how often access considerations come into play, and they observed that the issue of quality has not received much attention. Participants also asked whether patient characteristics are a consideration when networks are formed, noting that it is difficult to build an adequate network for certain types of patients, such as for those with multiple chronic conditions or with disabilities or for those for whom English is a second language. They suggested that, unless risk adjustment accounts for differences in patient mix and health status is employed and working well, the constructions of narrow networks could be used to discriminate against patients with complex conditions and greater needs. They also noted that questions about the effectiveness of risk adjustment remain unanswered.

Current information about network adequacy measurement standards and enforcement comes from experience with managed care products associated with the Medicaid and Medicare programs, the QHPs sold through health insurance exchanges associated with the Affordable Care Act, and other commercial products.

**Exhibit 1. Enrollment in Narrow Network Plans**



Source: Gruber, Jonathan and Robin McKnight, "Controlling Health Care Costs Through Limited Network Insurance Plans: Evidence from Massachusetts State Employees." NBER working paper #20462, September 2014

### Measurement standards

A review of network specifications across a range of sponsors and regulators that purchase or oversee network-based coverage demonstrates that current requirements or guidance regarding network adequacy is apt to rely on general statements such as a “network has to be reasonable” or plans must “ensure that people have access without unreasonable delay.” Despite the development of specific requirements and measures in recent years, states, programs, or various types of plans have failed to apply them consistently.

Specific measurement standards for network sufficiency are often quantitative and based, for example, on numbers of providers or ratios of providers to enrollees. An important question raised by one attendee is whether standards take expected enrollment into account when network adequacy is initially assessed. Early in the implementation of the ACA, for example, some carriers designed QHPs with narrow networks to keep premiums low and attract market share, but they then had to accommodate greater-than-expected enrollment.

Geographic considerations, such as the time or distance patients must travel, are fairly common, sometimes with consideration given to available modes of transport and whether the service setting is urban or rural. Generally, greater travel distances and longer waits are seen as more acceptable for specialists than for primary care providers. Several people also noted a need for standards for emergency care. In addition, specific criteria may be needed to help ensure that services for certain populations are available, for example, obstetrics and gynecology and pediatrics for Medicaid enrollees. The Medicare program relies on well-developed time and distance standards, though discussants noted that the basis for the standards is not clear. Similarly, state Medicaid programs and state regulators have developed measures for time and distance to reach providers, but there is little consistent basis for the measures, which vary from state to state. Some states use geo-access software that can highlight gaps in service areas, but the accuracy or effectiveness of this method is not proven.

Many participants viewed provider network standards as part of a broader issue of accessibility. They cited examples of providers who participate in networks but are not taking new patients or who have long wait times for appointments. Participants also said that measuring accessibility factors could provide more accurate assessments of networks. Provider characteristics—for example, whether providers have the capacity to accommodate patients with particular language or cultural needs or patients with disabilities—can also be indicators of accessibility for some populations. The sense in the Medicaid program, for example, is that, in the absence of community health centers, which are part of a subsidized system, managed care plan networks would lack sufficient primary care providers to meet adequacy tests. Participants also cited the extent to which Es-

sential Community Providers, a component of the ACA’s reasonable network standard, are included in QHP networks as an indicator of adequacy and accessibility. Essential Community Providers encompass certain types of health care entities such as health centers, women’s health clinics funded under Title X of the Public Health Service Act, and other providers that predominantly serve low-income and medically underserved communities and populations.

Panelists agreed that measurement standards relating to the quality of network providers are desirable, but they acknowledged that more work is needed to develop and test quality standards and to encourage plans to make consistent use of such measures. The National Quality Forum has endorsed more than 700 provider performance measures, but there has been little research to show which measures are effective. A survey of large commercial plans shows substantial variation in which measures are used and indicates that about half of the measures in use are process measures.<sup>9</sup>

A forthcoming brief will report on a review of network adequacy standards applicable to marketplace plans in each of the 50 states and the District of Columbia at the outset of marketplace coverage in 2014. The brief will focus on quantitative standards adopted by states to test the sufficiency of provider networks and on requirements designed to ensure consumers’ access to updated provider directories.

### Enforcement activity

Discussants observed that simply establishing measurement standards will not ensure that enrollees have access to adequate networks of providers. They stressed the importance of consumer confidence in both the standards and the methods that will be used to judge whether networks conform to the standards. In addition, panelists said that all parties should have a clear understanding about whether the standards will be used as signals or guidance of best practices for plans to follow or whether these standards will be enforced. For example, will sanctions be imposed if plans fail to meet adequacy standards?

In discussing the need to develop and enforce network adequacy measurement standards, several people noted that some degree of deference to plan sponsors might be necessary in order for network strategies to achieve certain goals such as cost containment. They spoke about the delicate balance between ensuring that networks are adequate and providing plans with the flexibility to negotiate with providers.

They also recognized that, in some cases, the level of available investment or resources might not be adequate to satisfy network requirements. For example, state Medicaid programs have developed some of the most stringent criteria regarding network adequacy, but having the regulations on the books has not guaranteed that enrollees have access to adequate networks. Many physicians are reluctant

to participate in Medicaid because of low reimbursement rates. In many parts of the country, specialty care for Medicaid beneficiaries is severely limited despite the criteria for network adequacy.

Panelists said that limited funding and insufficient staff hamper the ability of State Departments of Insurance (DOI) to engage in more aggressive monitoring. For the most part, DOIs assess network adequacy on the basis of consumer complaints. Discussants pointed out that the majority of consumers do not even know of the DOIs' existence or how the agencies operate.

The consensus among participants pointed not to fewer measures or less enforcement but rather to greater attention to developing and supporting reasonable and effective means of ensuring network adequacy. Panelists suggested that more proactive monitoring of network adequacy is needed. They observed that current measures of network adequacy are weak and depend heavily on health plans' self-reported data.

Several discussants referred to the increased amount of secret shopping that currently occurs among Medicaid programs, sometimes in combination with geocoding, and asked whether DOIs could use the technique to a greater extent to call network providers to determine whether they are available and accessible to plan enrollees. Discussants also raised the question of the timing of monitoring. They discussed the Medicaid program's disintegrating networks as a current issue of concern in the Medicaid program, along with the one-time assessment of networks that often occurs in the commercial market. Panel participants recommended network assessments not only at the time plans seek certification but also as part of an ongoing process to determine whether networks remain adequate.

Panelists also suggested that more requirements for and monitoring of directories of network providers would be helpful. Discussants said that provider directories are often out-of-date or inaccurate and can be difficult to locate because historically insurers have not invested in updating directories. They agreed that accuracy is the most important feature for directories but also suggested that the utility of the directories could be improved by including information on provider features such as language proficiency and accessibility for patients with disabilities. Participants stated that stronger requirements and oversight are essential to help ensure that consumers have access to accurate directories. One participant suggested possible value in relying on independent third parties to validate the directories. Another mentioned the potential for requiring carriers to update directories within a certain period when network changes occur.

Given the relative weakness of current requirements and enforcement activities regarding network adequacy, several participants concluded that there is a need for insurers to institute explicit policies regarding exceptions that allow enrollees whose needs cannot be met within networks to see out-of-network providers. They also noted that states can limit balance billing or, in some circumstances, require insurers to pay out-of-network providers. In addition, they spoke about the need for measurement standards to gauge how rapidly and appropriately carriers respond to ensure out-of-network access when necessary.

Finally, panelists noted that, while consumer feedback should not be the primary method used to monitor network adequacy, it can be critical to understanding whether networks are effective. For example, DOIs can reach out to consumers and can expand opportunities for consumers to communicate via online mailboxes. Participants endorsed the idea of conducting consumer surveys and publishing survey results. They noted that making the survey results available could permit comparisons among plans, thereby encouraging plans to improve networks and, when responses are favorable, promoting plans or programs.

### What are the highest-priority questions for researchers to study?

In the course of AcademyHealth's meeting, panel participants discussed the design, use, and impact of narrow network strategies, and they raised a number of questions to consider in planning for future research. For example:

- *How do network and broader plan design elements affect outcomes?*  
Participants suggested the following elements for further study: the type or types of providers included in networks, the criteria for network inclusion, the amount of copayments charged for nonpreferred tier providers, the methods used to adjust for risk, and the use of caps on consumer spending.
- *What is the impact of narrow networks on access to care?*  
Researchers were interested in understanding whether the narrow networks formed in different markets are sufficiently robust. Are there sufficient numbers and types of providers? Do networks include high-quality providers? Where are providers located in terms of geography and distance patients must travel? Also, when narrow networks do not include a needed provider, how quickly and easily can the need be met?

- *What measurement standards are most appropriate for narrow networks?*

Attendees were concerned not only with the development of standards but also with ensuring that standards are enforceable.

- *What are the best ways to increase consumer awareness and promote consumer choice?*

Participants called for studies that examine the current consumer experience. What do consumers understand? What are they confused about? Related research questions pertain to how particular concepts or information about networks may be conveyed. What tools are best for conveying the information? How and why will consumers act on the information? Do they understand not only how to choose their coverage but also how to use it? Given that consumers often rely on providers for information and guidance, research on the best way to inform and involve providers is needed.

- *What is the best way to incorporate the consideration of quality into network design strategies?*

This question was central to discussions of network design, measurement standards, and the development of materials to help consumers differentiate among plans.

- *Does the narrow network approach help contain costs?*

In addition to this basic question, participants want to know: If narrow networks are associated with cost containment, what are the reasons? Does provider behavior change? Do providers lower prices? Do consumers shift to lower-cost providers? Are networks designed to attract lower-cost consumers? As cost containment occurs, does quality improve, decline, or remain constant?

- *What is the relationship between broader market factors and the potential for narrow network approaches to succeed?*

Participants discussed the need for studies that examine the number, variety, and quality of providers in particular markets, along with studies that look at how networks perform and how they affect the broader market over time.

### Conclusion

The AcademyHealth panel focused on the design and operation of narrow and tiered network plans and what early experience suggests about how the networks can become more effective. Participants acknowledged the importance of striking a balance between flexibility for insurers in designing networks while ensuring consumer access to high-quality care. They discussed the need for greater oversight of and better standards to measure network adequacy. Experts agreed that the long-term implications of narrow networks remain to be seen. In identifying areas for research on narrow networks, they emphasized that research should account for market factors, both in the study design and in interpreting the

results. Given that the narrow network strategy relies on consumer behavior, a recurring theme was the need to educate and assist consumers in making informed choices. Panel participants emphasized the importance of considering quality as well as cost in the design, implementation, and evaluation of narrow network plans.

### About the Author

Laura Summer, M.P.H., is a senior research scholar at Georgetown University's Health Policy Institute in Washington, D.C.

### Selected Bibliography

#### Narrow Networks

Bauman N, Coe E, Ogden J, and Parikh A. Hospital networks: Updated national view of configurations on the exchanges. McKinsey & Company. 2014 June;1-20. <http://healthcare.mckinsey.com/hospital-networks-updated-national-view-configurations-exchanges>

CMS. 2015 letter to issuers in the federally-facilitated marketplace. 2014 Feb 4. (<http://www.cms.gov/CCPIO/Resources/Regulations-and-Guidance/Downloads/draft-issuer-letter-2-4-2014.pdf>)

Corlette S, Volk J, Berenson B, and Feder J. Narrow provider networks in new health plans: Balancing affordability with access to quality care. Georgetown University Health Policy Institute & Urban Institute. 2014 May. [http://www.rwjf.org/content/dam/farm/reports/issue\\_briefs/2014/rwjf413643](http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2014/rwjf413643)

Florence CS, Atherly A, and Thorpe KE. Will choice-based reform work for Medicare? Evidence from the federal employees health benefits program. *HSR* 2006;41(5):1741-1761. <http://onlinelibrary.wiley.com/doi/10.1111/j.1475-6773.2006.00580.x/full>

Gruber J, and McKnight R. Controlling health care costs through limited network insurance plans: Evidence from Massachusetts state employees. *NBER* 2014; w20462:1-47. <http://www.nber.org/papers/w20462>

Health Management Associates. Ensuring consumers' access to care: Network adequacy state insurance survey findings and recommendations for regulatory reforms in a changing insurance market. November 2014. [http://www.naic.org/documents/committees\\_conliaison\\_network\\_adequacy\\_report.pdf](http://www.naic.org/documents/committees_conliaison_network_adequacy_report.pdf)

Howard DH. Adverse effects of prohibiting narrow provider networks. *NEJM* 2014;371(7):591-593. <http://www.nejm.org/doi/full/10.1056/NEJMp1402705>

National Association of Insurance Commissioners (NAIC). Draft model regulation for states. NAIC November 2014. <http://goo.gl/ESskdL>

### Tiered Networks

Robinson JC. Hospital tiers in health insurance: balancing consumer choice with financial incentives. *Health Aff* 2003;22(3):W3-135. [http://content.healthaffairs.org/content/early/2003/03/19/hlthaff.w3.135.full.pdf?origin=publication\\_detail](http://content.healthaffairs.org/content/early/2003/03/19/hlthaff.w3.135.full.pdf?origin=publication_detail)

Rosenthal M, and Milstein A. Awakening consumer stewardship of health benefits: prevalence and differentiation of new health plan models. *HSR* 2004;39(4p2):1055-1070. <http://onlinelibrary.wiley.com/doi/10.1111/j.1475-6773.2004.00273.x/full>

Scanlon DP, Lindrooth RC, and Christianson JB. Steering patients to safer hospitals? The effect of a tiered hospital network on hospital admissions. *HSR* 2008;43(5p2):1849-1868. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2654164/>

Sinaiko AD. How do quality information and cost affect patient choice of provider in a tiered network setting? Results from a survey. *HSR* 2011;46(2):437-456. [http://www.ajmc.com/publications/issue/2010/2010-01-vol16-n02/ajmc\\_2010febsinaiko\\_123to130](http://www.ajmc.com/publications/issue/2010/2010-01-vol16-n02/ajmc_2010febsinaiko_123to130)

Sinaiko AD, Rosenthal MB. The impact of tiered physician networks on patient choices. *HSR* 2014;49(4):1348-1363. <http://onlinelibrary.wiley.com/doi/10.1111/1475-6773.12165/abstract>

### Measurement, Standards and Regulation

Blumberg LJ, Peters R, Wengle E, Arnesen R. Physician network transparency: How easy is it for consumers to know what they are buying? Urban Institute 2014 August:1-11. <http://www.rwjf.org/content/dam/farm/reports/reports/2014/rwjf415098>

CMS. CY2015 MA HSD provider and facility specialties and network adequacy criteria guidance. 2014;1-13. [http://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/Downloads/CY2015\\_MA\\_HSD\\_Network\\_Criteria\\_Guidance.pdf](http://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/Downloads/CY2015_MA_HSD_Network_Criteria_Guidance.pdf)

Corlette S, Lucia K, Ahn S. Implementation of the Affordable Care Act: Cross-cutting issues Six-state case study on network adequacy. Georgetown University Health Policy Institute & Urban Institute. 2014 Sept:1-10. <http://www.rwjf.org/content/dam/farm/reports/reports/2014/rwjf415649>

Miller TP, Brennan TA, and Milstein A. How can we make more progress in measuring physicians' performance to improve the value of care? *Health Aff* 2009;28(5):1429-1437. <http://content.healthaffairs.org/content/28/5/1429.short>

Talbot JA, Coburn A, Croll Z, and Ziller E. Rural considerations in establishing network adequacy standards for qualified health plans in state and regional health insurance exchanges. *J Rural Health* 2013;29(3):327-335. <http://onlinelibrary.wiley.com/doi/10.1111/jrh.12012/abstract;jsessionid=A1335C0B0C21C95F88BC216C62F14BD6.f01t02>

Rosenbaum S, Lopez N, Mehta D, Dorley M, Burke T, and Widge A. Realizing health reform's potential: How are state insurance marketplaces shaping health plan design? *The Commonwealth Fund*. 2013 Dec:1-12. <http://www.commonwealthfund.org/publications/issue-briefs/2013/dec/state-insurance-marketplaces-shaping-health-plan-design>

Vita MG. Regulatory restrictions on selective contracting: An empirical analysis of "any-willing-provider" regulations. *J Health Econ* 2001;20(6):955-966. <http://www.sciencedirect.com/science/article/pii/S0167629601001059>

### Endnotes

1. Office of Attorney General Martha Coakley (2011). Examination of health care cost trends and cost drivers. Report for Annual Public Hearing. Retrieved from <http://www.mass.gov/ago/docs/healthcare/2011-hcctd-full.pdf>
2. Data extract from American Institutes for Research's new health insurance literacy measurement tool. See <http://airpcpe.org/health-insurance-literacy-measure-hilm-publications>
3. Sinaiko A, & Rosenthal M. (2010). Consumer experience with a tiered physician network: Early evidence. *Am J Medical Care*, 16(2) Retrieved from [http://www.ajmc.com/publications/issue/2010/2010-01-vol16-n02/AJMC\\_2010febSinaiko\\_123to130/](http://www.ajmc.com/publications/issue/2010/2010-01-vol16-n02/AJMC_2010febSinaiko_123to130/)
4. Corlette, S., Lucia, K., & Ahn, S. (2014). Cross-cutting issues *Six-State Case Study on Network Adequacy*, Center on Health Insurance Reforms Georgetown University Health Policy Institute. Retrieved from <http://www.rwjf.org/content/dam/farm/reports/reports/2014/rwjf415649>
5. Gruber J, & McKnight R. (2014). Controlling health care costs through limited network insurance plans: Evidence from Massachusetts state employees." NBER working paper #20462.
6. Corlette S, Lucia K, & Ahn S. (2014). Cross-Cutting Issues *Six-State Case Study on Network Adequacy*, Center on Health Insurance Reforms Georgetown University Health Policy Institute. Retrieved from <http://www.rwjf.org/content/dam/farm/reports/reports/2014/rwjf415649>
7. Gruber & McKnight (2014).
8. Gruber & McKnight (2014).
9. Higgins, A. (2013). Provider performance measures in private and public programs: Achieving meaningful alignment with flexibility to innovate. *Health Affairs*, 32(8), 1453-1461.