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asking the right questions about narrow networks

An increasing number of employer plans and many plans being offered through the federal health insurance exchanges use restricted networks of hospitals, and these plans often have limited networks of physicians as well.

This use of *narrow* or *ultra-narrow networks*—defined, respectively, as containing fewer than 70 percent or fewer than 30 percent of the hospitals in an area—was observed in a 2013 report by McKinsey & Company.[a] A July analysis of the federal exchanges, also by McKinsey, indicates that, at that time, 52 percent of the public exchange networks (60 percent of networks in large cities) had narrow networks, and among the least expensive plans, almost 70 percent had restricted provider networks.[b]

Narrow Networks: No Surprise

The increased use of restricted networks is hardly a surprise. Employers continue to look for ways to limit their spending (that is, with respect to their employees' compensation packages) by reviewing benefit packages, increasing deductibles, and narrowing choices of providers.

For plans in the public exchanges, the essential benefit plan defines the benefits that must be provided. State insurance commissioners have pushed back on initial premium pricing proposals to limit the cost of the plans being offered. Given the limited options available to them, and the view that narrowing networks allows plans to exclude physicians or hospitals that charge higher prices or spend more on treating their patients, it is easy to see why insurers have turned to narrow networks as a first-line strategy for at least some of their offerings. Moreover, the apparent attractiveness to consumers of the low-cost plans—at least in the first year of choices—only reinforces the strategy of limiting networks.

It is also hardly surprising that some of the newly insured are complaining about the narrow networks in the plans they chose. A McKinsey survey of consumers conducted in April indicated that more than 25 percent of people who had purchased a plan in the exchange did not know the type of network plan that they had selected.[c] Because many of the newly insured had little or no experience with purchasing health insurance, they tended to overlook issues relating to networks and network narrowness, which they had not been accustomed to considering—even though, ironically, to the extent that many of them had long been uninsured, a constrained choice of providers was nothing new.

Consumers also have faced challenges in determining which institutions and clinicians are included in the various plans. Again, for individuals who were previously uninsured, and attached to particular providers, these providers most likely were institutions rather than individual clinicians. Information on which institutional providers are included in network plans should be considerably easier to provide than information on individual clinicians or their practices. Generally, it is reasonable to expect that

a. Coe, E., Chiara, C., Oatman, J., and Ogden, J., *Hospital Networks: Configurations on the Exchanges and Their Impact on Premiums*, McKinsey Center for U.S. Health System Reform, December 2013.

b. "A Close Look at the Public Exchange Network in 2014," video, McKinsey & Company, July 2014.

c. Bauman, N., Coe, E., Ogden, J., and Parikh, A., *Hospital Networks: Updated National View of Configurations on the Exchanges*, McKinsey & Company, June 2014.

people who are choosing plans should have no difficulty knowing which institutions and clinicians will be available to them.

Getting the plan networks together, submitting the plans for approval, and having the exchanges operating in a timely fashion were all challenges in the first cycle of open enrollment. Whether that process is significantly improved in the next cycle should be known by the first quarter of 2015, when the next enrollment is scheduled to end.

1990s Revisited?

Several healthcare policy analysts and other observers of the sector have speculated about whether the narrow networks in the exchanges will elicit the same kind of consumer pushback that was observed in the late 1990s. In my opinion, however, today's circumstances differ significantly from what occurred then on at least two grounds.

First, in the 1990s, politicians were saying that healthcare costs could be reduced or slowed without any effect on patients and consumers because there was so much waste and abuse in the system. There was—and still is—a lot of waste and abuse in health care, but there also was a lack of understanding that reducing costs necessarily will affect how, where, or from whom patients receive care. More important, employers began offering limited choices of providers or limited managed care plans to people who had not previously experienced such constraints, and they also were presented with few alternatives.

The circumstances in 2014 are very different. The hope is that most of the people who are receiving coverage were previously uninsured or had limited insurance. Their point of comparison is distinct from that experienced by individuals in the 1990s who were finding their employer-sponsored insurance changing in ways that they had not negotiated—and not to their liking.

In 2014, some individuals were previously insured—primarily those whose individually purchased insurance did not meet requirements under the Affordable Care Act (ACA) and whose states may not have allowed the continued sale of such policies. Nonetheless, the ACA's primary focus is outreach to the previously uninsured (although exactly how much that has happened is still hard to discern). Moreover, people acquiring insurance through the exchanges have had a range of choices in plan levels (i.e., bronze through platinum) and, in some instances, numerous plan choices. In my opinion, it was availability of choice and the knowledge that another open enrollment period would be forthcoming that kept federal employees from engaging in the same kind of pushback that was observed elsewhere during the 1990s.

Relevant Questions

The narrowness of the overall network is less important than the *appropriateness* of the clinician network available, including the adequacy of access and the quality of the clinicians and institutions in the network. A recent study published by the National Bureau of Economic Research indicates that healthy and unhealthy public workers in Massachusetts who chose a limited network had lower overall spending without adverse effects on access.[d] Although this is only a single data point—and one that needs to be replicated elsewhere—it is encouraging nonetheless.

As long as the relevant questions about access adequacy and care quality can be answered affirmatively, disallowing narrow networks is ill-advised. It would invite a return to the circumstances facing the nation in the early 2000s, when rapid growth in absolute and relative healthcare spending emerged after a decade of slow growth and did not begin to abate again until 2006-07. ■

d. Gruber, J., and McKnight, R., "Controlling Health Care Costs Through Limited Network Insurance Plans: Evidence from Massachusetts State Employees," Working Paper 20462, National Bureau of Economics Research, September 2014.

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