Published in final edited form as:

JAMA Intern Med. 2015 March ; 175(3): 337–338. doi:10.1001/jamainternmed.2014.7763.

How Narrow a Network Is Too Narrow?

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The second open-enrollment period for coverage through the Health Insurance Market place extends from November 15, 2014, to February 15, 2015; millions of people in the United States are once again choosing from a menu of plans. Although federal law dictates some aspects of the plans, shopping for coverage—even on health insurance exchanges that are well organized—can feel like little more than educated guesswork.

The financial considerations, such as premiums, deductibles, and copayments, are relatively transparent. Plans must provide a minimum level of financial protection and are categorized as bronze, silver, gold, or platinum, depending on the share of medical expenses that they would cover for typical enrollees. The law also requires that plans must cover certain services, including physician visits, hospitalizations, and prescription drugs, and cover preventive services such as influenza shots and high blood pressure screening without copays. But in other dimensions, the plans may vary considerably.

One of the most difficult aspects to evaluate may be the adequacy of “provider networks” (ie, the specific people and institutions from whom enrollees can get care with full insurance coverage or the lowest copayments offered by their plan). Is there a reasonable choice among primary care clinicians, specialists, and hospitals? There is clearly a big difference to patients between having a “reasonable” number of physicians in the network and having their physician in the network. Compared with other aspects of the plans, the law offers relatively little on which consumers can rely. Networks must include at least 30% of “essential community providers.” Plans must attest that “all services will be accessible [to enrollees] without unreasonable delay.”¹ It is uncertain, however, what such words mean, and, indeed, there is no widely accepted definition of what constitutes a “narrow network.”

It seems clear from the first year of health insurance exchanges that provider networks were narrower than some consumers realized, especially consumers who may have had limited experience with the health care system and chosen plans based largely on their more easily

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Role of the Funder/Sponsor: The National Institute on Aging had no role in the analysis and interpretation of the data; preparation, review, or approval of the manuscript; and decision to submit the manuscript for publication.

Conflict of Interest Disclosures: Dr Baicker reports serving as a commissioner on the Medicare Payment Advisory Commission and as a director of Eli Lilly and reports receiving funding for other research from the National Institute on Aging.

observed financial characteristics.² Many people were upset, and there were calls for more regulation or new legislation. In November 2014, voters in South Dakota approved “any willing provider” legislation, requiring insurers to include coverage of all qualified healthcare providers willing to care for patients at the negotiated price.³ This legislation severely limits the ability of insurance plans to use narrow networks.

But what is less clear is how narrow (or broad) health care networks should be. On the one hand, there are good reasons for networks not to be too narrow; consumers need protection against fraudulent insurance products that appear to provide coverage but do not, and policy should prevent the strategic narrowing of networks to appeal only to relatively healthy patients—a practice known as “indirect selection” or “cream skimming.”⁴ On the other hand, networks can also be too broad. Narrow networks can help direct patients to high-value clinicians or hospitals, and the option of constructing a narrow network gives insurers bargaining power vis-à-vis physicians and hospitals, which ultimately helps keep prices low for consumers.⁵ “Any willing provider” laws benefit physicians and hospitals because insurance companies cannot negotiate lower prices—a fact reflected in the political support for such legislation in the health care industry and opposition by insurers. In the short run, the likely impact on consumers is expanded access to clinicians and hospitals (which drives much of the support). In the long run, however, an unintended consequence may be higher costs, and eventually higher health insurance premiums.

There is an instructive analogy to Medicare Part D, which has a well-developed method for assessing the adequacy of prescription drug coverage. Insurers offer plans to Medicare enrollees with different drug formularies or coverage tiers. The Centers for Medicare & Medicaid Services (CMS) defines therapeutic classes of medications and requires insurers to cover at least some drugs in a particular class. This requirement helps ensure that all Part D plans are adequate in the sense that consumers can get at least some medication—even if not their first choice drug—for any condition (and inhibits “indirect selection” against people needing expensive classes of drugs), while preserving an insurer’s ability to negotiate better prices from drug manufacturers. This is the reason that the Congressional Budget Office estimates that allowing the Medicare program itself to negotiate with manufacturers is unlikely to generate substantially lower prices: without the ability to exclude higher-priced drugs from formularies, there is little negotiating leverage.⁶

There is a balancing act, then, between ensuring access to care and allowing competition to keep prices low. But this balancing act is possible only if both consumers and regulators can assess network breadth. The paucity of information and the lack of regulatory detail stem from the difficulty in defining “narrow networks.” Discussion usually focuses on the representation of area-level clinicians and hospitals in the preferred tier of plans that have different coverage for in-network and out-of-network care. This involves defining what the local area is, how the inclusion of clinicians and hospitals is calculated, and what is considered adequate. How far should patients reasonably be expected to travel? Should network coverage be based on the share of different provider types (physicians, hospitals) represented or on the inclusion of particular providers? One widely cited report from 2014 (focused explicitly on hospitals rather than physicians) defined “narrow” networks as including between 31% and 70% of hospitals in the rating area, with “ultra narrow”

networks including 30% or less, compared with the 30% threshold used by CMS to define “adequate” participation of “essential community providers.”⁷ And these metrics are rapidly evolving; for example, CMS announced that beginning in 2015, it will no longer simply rely on indirect measures of network adequacy such as accreditation status by quality-ranking organizations but will apply an undefined “reasonable access” standard.⁸

Moreover, even if there were agreement on how to define a narrow network, it is not clear how any of these measures translates to patient access to care. Potential enrollees need straightforward and comparable metrics to make informed decisions, but it seems unlikely that overly simplified metrics such as the fraction of clinicians and hospitals in a city included in a network would adequately capture the real degree of patient access. The approach used in Medicare Part D is harder to implement for network adequacy because physicians and hospitals cannot be easily grouped into therapeutic classes as if they were pharmaceuticals. But there are other approaches to gauging patient access. Even if patients’ satisfaction with their physicians does not map well to other measures of the quality of care delivered,⁹ patient satisfaction with their overall ability to obtain care is a widely used marker of access. CMS and the Medicare Payment Advisory Commission (MedPAC) use large-scale surveys to assess waiting times and patients’ difficulty finding clinicians, hospitals, and health care services to meet specific health needs. Patient satisfaction with access to care is a central factor in determining the “star ratings” for Medicare Advantage plans that affect payments and have been shown to affect consumer choices about enrollment.¹⁰ Similar ratings systems for health insurance plans are already in place for exchanges in a few states; the Affordable Care Act requires them in all states by 2016.

These approaches are imperfect but may be able to provide a warning system when patients report that their needs have not been met. Of course, it is unlikely that patients who have already paid their insurance premium will be thinking about the tradeoff between network breadth and affordability when they seek care. But when patients choose plans, they should have readily accessible information about enrollees’ experiences in seeking care along with measures of the share of clinicians and hospitals participating and the quality of care delivered in addition to information on cost-sharing and premiums.

Health insurance exchanges are intended to leverage competition to improve access to affordable coverage and care, with insurers bargaining to get the best prices they can with the clinicians and hospitals seeking to be included in their networks. Insurers would reasonably take into account both prices and practice patterns of health care providers (such as quality of disease management or overuse of tests) in constructing their networks. But competition between health plans will fail to achieve its goals if insurers are hobbled in their negotiations with clinicians and hospitals and if consumers are not given sufficient information on both costs and benefits to make the choices that are best for them, taking into account premiums, networks, and other features of the plans competing for their business. For health insurance exchanges to reach their competitive potential, better ways are needed of measuring network adequacy and communicating this information to consumers.

Acknowledgments

Funding/Support: Dr Levy is supported by grant K01AG034232 from the National Institute on Aging.

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