Hospital networks: Evolution of the configurations on the 2015 exchanges

Now that the 2015 open enrollment period (OEP) has ended, we have updated our network database to include all networks offered on 2015 exchanges. This has permitted us to compare the networks offered on the 2014 and 2015 exchanges, from which we have derived insights into how the networks are evolving in terms of price, and insurer and provider participation. We also conducted a consumer survey during the 2015 OEP to better understand what consumers know about these networks and what experience they have had with them.

Note: Throughout this Intelligence Brief, we use the phrase *narrowed network* to refer to narrow, ultra-narrow, and tiered hospital networks in the aggregate.[1]

Five key observations emerged:[2]

- Consumer choice has expanded with a high number of new networks. Yet, many consumers remain unaware of network choices. Overall, the proportion of narrowed networks and their relative narrowness has not changed.
- Median premiums continue to be lower for narrowed-network plans than for broad-network plans.
- Some insurance plan designs (e.g., managed care features, limited out-of-network coverage) have a compounding effect on the median difference in premiums between narrowed- and broad-network plans.
- Plans co-branded by an insurer and provider have lower median premiums than plans offered solely by providers.
- Consumers who bought narrowed-network plans in 2014 reported less satisfaction with their payors than purchasers of broad-network plans did. Few of them switched to broad-network plans, though.

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[1] Network narrowing can affect hospitals or physicians; we focused on hospital networks in this Brief. We defined networks and network breadth at the rating area level. Hospital participation is based on the AHA 2013 dataset. Network breadth was defined as follows: broad, more than 70% of all hospitals in a rating area participate; narrow, 31% to 70% participate; ultra-narrow, 30% or less participate; tiered if the payor has hospitals in different tiers with varying co-insurance rates.

[2] Most analyses in this Brief are based on all 2015 exchange networks in all metal tiers. A few of the more detailed analyses are based on the silver tier only for reasons outlined in the Appendix.

Choice has increased, but many consumers remain unaware of network types

Over 1,000 new networks were introduced in 2015. As a result, the number of exchange networks now totals 2,930.[3] This year, 90% of consumers had access to both narrowed- and broad-network plans, up from 86% in 2014.

Many consumers, however, do not appear to understand the choices available to them or the impact of those choices (especially limits on access to care). In our consumer survey, 44% of those who bought an ACA plan for the first time this year reported that they did not know the network configuration associated with their plan.[4] Nineteen percent of those who bought exchange plans last year also said that they were unaware of their plan's network configuration.

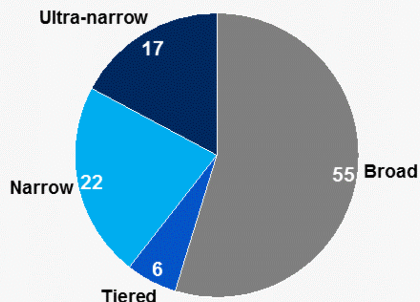
Across the country, close to half of the 2015 networks that consumers can choose from are narrowed; in the largest cities, almost two-thirds of the networks are narrowed (*Exhibit 1*). These percentages are consistent with last year. Large cities tend to have higher rates of provider and insurer competition and higher excess bed capacity—factors associated with higher rates of narrowing.

EXHIBIT 1

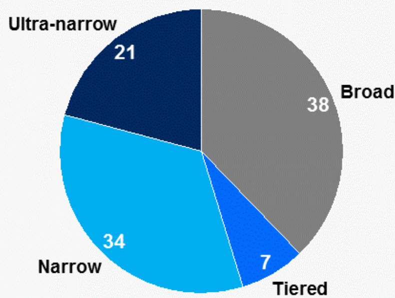
2015 consumers are being offered a wide range of network types

Distribution of 2015 individual exchange networks by network breadth

Across the U.S.
% of networks across all tiers (n = 2,864)[1]



In the largest city of each U.S. state
% of networks across all tiers (n = 372)



SOURCE: McKinsey Center for U.S. Health System Reform analysis of publicly available network information

Data as of 1.31.2015

1 Of the 2,930 networks in the U.S., 66 are in rating areas that contain no hospitals and thus cannot be assigned a network breadth (breadth is defined by the percentage of hospitals in a rating area that participate in a network). For this reason, the 66 networks are not included in Exhibits 1 and 2.

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[3] Our database includes 333 payors and all 4,698 acute-care hospitals in the U.S.

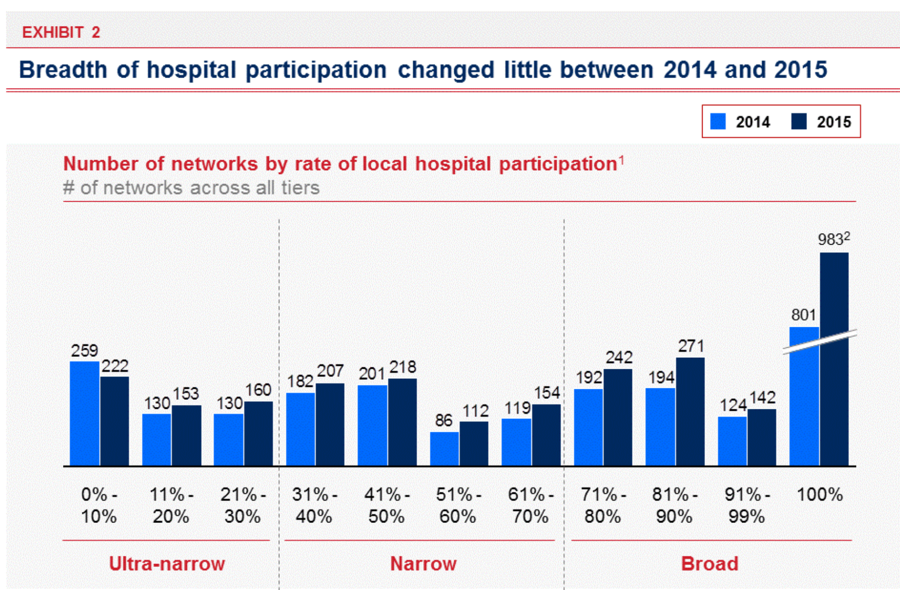
[4] Respondents were identified as having bought an Affordable Care Act (ACA) plan for the first time in 2015 if their answer to the question, "Which of the following best describes your primary insurance coverage in 2014? For most of the year I was covered by ...." with the response "I did not have health insurance, I was uninsured."

Hospital configurations did not change for 53% of the 2014 networks re-filed for 2015, and for the remaining 47%, configurations changed by a median of only two hospitals. Ninety percent of last year's broad networks remained broad, and 83% of narrowed networks remain narrowed.[5]

Between 2014 and 2015, the median percentage of hospitals in each rating area participating in broad and narrowed networks remained relatively constant. Broad networks maintained a median of 100% participation; however, the absolute number of networks with 100% participation increased, due in large part to the networks introduced by new national entrants. Narrow networks maintained a median of 50% of hospitals. Ultra-narrow networks grew slightly in size; a median of 13% of the hospitals in a rating area participated in these networks in 2015, compared with 10% last year *(Exhibit 2)*.

EXHIBIT 2

Breadth of hospital participation changed little between 2014 and 2015



SOURCE: McKinsey Center for U.S. Health System Reform analysis of publicly available network information

Data as of 1.31.2015

1 Participation rate is calculated as the percentage of hospitals in a rating area that are participating within the exchange network.

2 New national entrants make up most of the increase in new networks with 100% hospital participation.

The overall number of hospitals participating in exchange networks rose in 2015, primarily due to the increase in the number of networks. This year, 64% of all hospitals are participating in at least one narrowed network, and 93% are taking

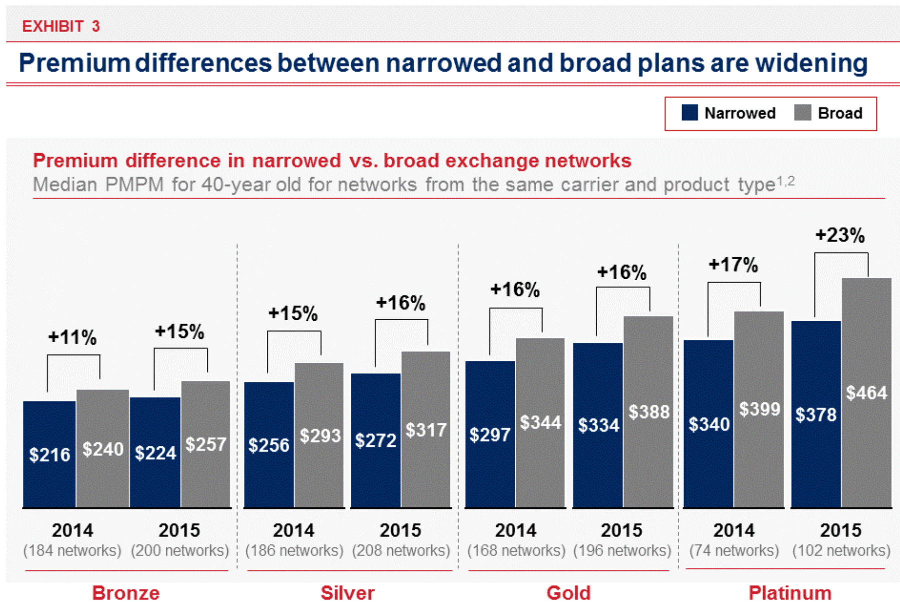
5 Given the short time frame between the close of the 2014 open enrollment period and the date by which 2015 plans had to be filed, payors had little experience on which to base network configuration changes, which may explain why few changes to network configurations were made.

part in at least one broad network. Last year, the comparable percentages were 59% and 87%.

Similar to 2014, there continues to be no meaningful performance difference between broad and narrowed exchange networks based on Centers for Medicare and Medicaid Services (CMS) hospital metrics.[6,7]

Narrowed networks continue to have lower median premiums

Among broad- and narrowed-network plans that are otherwise equivalent (i.e., offered by same carrier, in same rating area, on same metal tier, and with same product type), median premiums this year are 15% to 23% higher for broad-network than for narrowed-network plans (*Exhibit 3*). Last year, the range was 11% to 17%.



SOURCE: McKinsey Center for U.S. Health System Reform/McKinsey Advanced Healthcare Analytics analysis of publicly available rates and carrier information

Data as of 1.31.2015

1 If more than two networks offered by a payor had the same plan type (i.e., HMO, PPO, EPO, POS), only the broadest and narrowest networks are included. Analysis is based on PMPM premium for a 40-year-old nonsmoker not eligible for premium subsidies. For networks with multiple plans at different prices within the same tier and rating area, the lowest-price plan is used.

2 Within rating areas where a broad and narrowed network are offered by the same carrier and on the same metal tier and of the same product type. There are 353 instances of a single carrier offering a broad and narrowed network under these conditions in 2015, and 306 instances in 2014; thus, the total number of networks in this analysis is 706 for 2015 and 612 for 2014.

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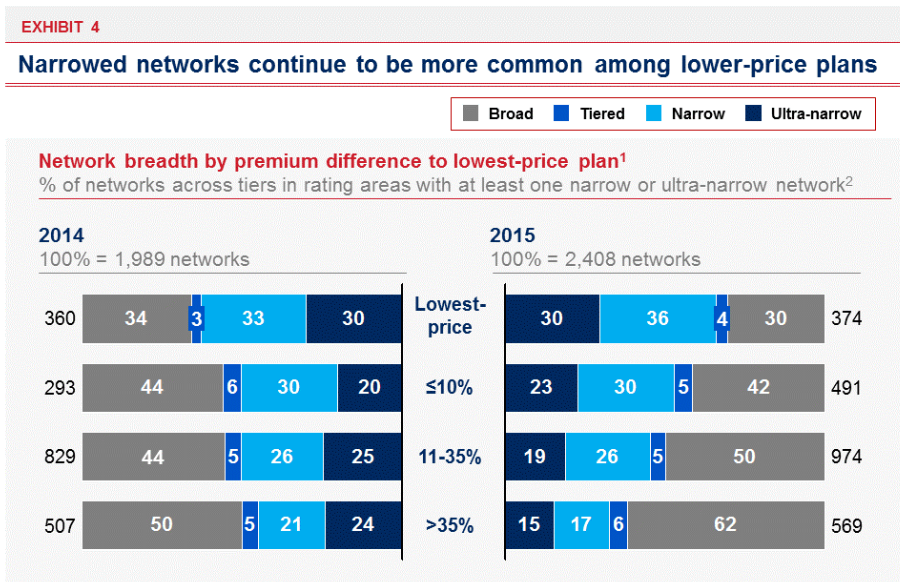
[6] Performance metrics evaluated include composite value-based purchase score as well as its three sub-components (outcome, patient experience, and clinical process scores).

[7] For last year's findings about hospital performance, see our June 2014 Intelligence Brief, "Hospital networks: Updated national view of configurations on the exchanges."

The percentage of less-expensive plans with narrowed networks has grown *(Exhibit 4)*. Seventy percent of the lowest-price plans this year, compared with 66% last year, are based on narrowed networks. Furthermore, among all re-filed 2014 plans, narrowed-network plans had a smaller median premium increase than broad-network plans (4% vs. 8%, respectively).



SOURCE: McKinsey Center for U.S. Health System Reform analysis of publicly available network information

Data as of 1.31.2015

1 Premium gap to the lowest-price product is the difference between a network's lowest-priced plan and the lowest-priced plan within the same metal tier and rating area. For networks with multiple tiers, the tier used for the network price was chosen in priority order: silver, bronze, gold, platinum, catastrophic. For networks with multiple plans at different prices within the same tier and rating area, the lowest-price plan was used.

2 In 2015 OEP, 71% of rating areas offered at least one narrow or ultra-narrow network; the total number of networks offered in these rating areas was 2,408. These ratings areas include 90% of all consumers eligible for a qualified health plan. Last year, 67% of rating areas offered at least one narrow or ultra-narrow network.

The absence of an academic medical center (AMC) from a network is also associated with lower premiums. In the rating areas that contain at least one AMC, 25% of the exchange networks do not include an AMC. Among narrowed-network plans, median premiums are 10% higher for plans with an AMC than for those without.[8] The median premium difference between broad-network plans with AMCs and narrowed-network plans without AMCs is to 18%.

[8] This analysis is based on the 118 rating areas that contain AMCs. This analysis, and those discussed in the next section, were confined to silver-tier plans for the reasons outlined in the Appendix.

Insurance plan designs can further lower narrowed-network premiums

Within the silver tier, 64% of narrowed-network plans are part of health maintenance organizations (HMOs) or exclusive provider organizations, compared with 43% of broad-network plans. Similarly, 56% of silver-tier narrowed-network plans have limited out-of-network (OON) coverage, compared with 37% of broad-network plans.

The presence of these insurance plan designs widens the median premium difference between narrowed- and broad-network plans. To estimate this effect, we looked at all insurers offering both managed, limited OON plans and unmanaged, full OON plans on the silver tier in the same rating area.[9] The median premium difference between the plan types was 23%.

Median premiums are lower for co-branded plans than for provider-led plans

During the 2015 OEP, 73 providers offered their own health plans on the exchanges (i.e., they served as insurer as well as provider).[10] Sixty-three other providers took part in co-branding arrangements with insurers.[11]

Most provider-led plans, and almost all co-branded plans, have narrowed networks (64% and 98%, respectively). However, co-branded plans are almost twice as likely as provider-led plans to have ultra-narrow networks (57% vs. 33%, respectively).

Median premiums are 12% higher for provider-led plans than for co-branded plans. Among the rating areas containing both co-branded plans and provider-led plans, co-branded plans are three times more likely to be the lowest-price product *(Exhibit 5)*. Co-branded plans are also more likely to have lower prices than do the non–provider-led plans in their markets.

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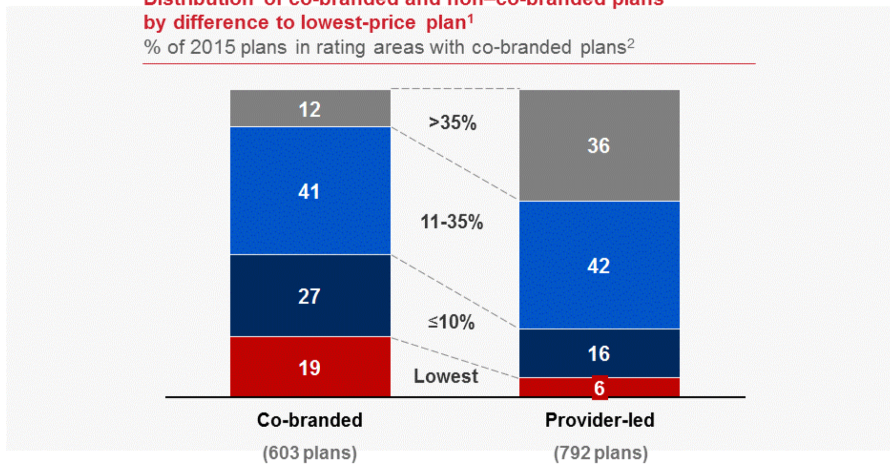
[9] Managed care product design and limited OON coverage are usually offered together; for example, 84% of HMO plans include no non-emergency OON coverage. For this reason, we analyzed the two variables together.

[10] In total, 4,023 exchange plans were offered by the 73 providers operating their own plans in 2015.

[11] In these arrangements, a payor offers one or more plans using the provider’s brand in the plan name(s); the network in each plan is built around the provider. The provider is typically a health system but could be an independent hospital, physician group, or accountable care organization. In 2015, 603 exchange plans were offered through a co-branded arrangement.

EXHIBIT 5

Co-branded plans are price leaders more often than provider-led plans are



SOURCE: McKinsey Center for U.S. Health System Reform analysis of publicly available network information

Data as of 1.31.2015

1 Premium gap to the lowest-price plan is the difference between each plan and the lowest-priced plan within the same metal tier in the same rating area. Because this analysis is at the plan level rather than the network level, all plan prices at the rating-area level are used (rather than just the lowest-price plan on a given network, as is the case in other exhibits).

2 14% of rating areas in the U.S. have a co-branded plan.

Satisfaction is lower among narrowed-network enrollees, but few report switching to broad networks

Premium pricing remains an important issue for consumers, but how many of them are willing to accept the trade-off between pricing and provider access is still unclear. To investigate this issue, our 2015 OEP consumer survey asked enrollees who had bought exchange plans last year about their experience with those plans, including their perceptions of network breadth, sufficiency of access, and overall satisfaction. We compared these perceptions with the consumers' reported 2015 enrollment actions (i.e., whether they renewed or switched plans) to see how their 2014 network experience influenced their 2015 purchase decision.

We found that among the consumers who enrolled in a 2014 narrowed-network plan, 66% felt they had sufficient access to hospitals and doctors, and 52% reported being satisfied with their payor. In comparison, 90% of broad-network purchasers reported that they had access sufficiency, and 64% were satisfied with their payor. Among those who bought narrowed-network plans last year, the most common sources of dissatisfaction were not receiving the coverage and benefits they expected and not getting answers to queries or issues regarding their health insurance coverage (e.g., in- and out-of-network details). Nevertheless, only 17% of those with narrow-network plans switched to a broad-network plan. Conversely, 13% of those with broad-network plans switched to a narrowed-network plan.

The findings presented in this Intelligence Brief provide a view into the evolution of exchange networks across the country. The network configuration data suggest that narrowed networks remain common, particularly among lower-priced plans. We do not yet know how some of these network configurations are influencing utilization and member retention. We are analyzing data on utilization and enrollment as they become available to further inform the observations and implications described in this Intelligence Brief.

– Noam Bauman, Jason Bello, Erica Coe, and Jessica Lamb

The authors would like to acknowledge Kija Kari, Brock Mark, Brendan Murphy, and Jim Oatman for their support.

Obtaining previous Intelligence Briefs

Previous Intelligence Briefs on exchange dynamics can be obtained online at healthcare.mckinsey.com/reform

- "2015 OEP: Insight into consumer behavior" (March 2015)
- "Exchanges Year 2: New findings and ongoing trends" (December 2014)
- "On the Eve of OEP Open Enrollment" (November 2014)
- "2015 OEP: Emerging trends on the individual exchanges" (September 2014)
- "Hospital networks: Updated national view of configurations on the exchanges" (June 2014)
- "Individual market enrollment: Updated view" (March 2014)
- "Exchange product benefit design: Consumer responsibility and value consciousness" (February 2014)
- "Individual market enrollment: Early assessments and observations" (January 2014)
- "Hospital networks: Configurations on the exchanges and their impact on premiums" (December 2013)
- "Exchanges go live: Early trends in exchange dynamics" (October 2013)
- "Emerging exchange dynamics: Temporary turbulence or sustainable market disruption?" (September 2013)

Appendix

Methodology

McKinsey Exchange Offering Database. The analyses supporting this Intelligence Brief are informed by the McKinsey Center for U.S. Health System Reform Exchange Offering Database. The information about 2015 plans included in this database was accessed directly from the public exchanges as of January 31, 2015. Please note three things about this database and our related analyses:

- The database's information about 2014 plans has been refreshed since our June 2014 Intelligence Brief on exchange networks. Thus, a few of the 2014 data points referenced in this Brief differ from those published last June. The most notable changes are these:
  - *Level of detail.* Our initial 2014 data were obtained at the rating-area level only. Since then, we have obtained more detailed, county-level data, which added a small number of new 2014 networks within a subset of counties.
  - *Hospital definitions.* Hospitals in the June 2014 brief were obtained from the 2011 American Hospital Association (AHA) database. We have since updated our data set with the 2013 AHA database.
- For some of the more detailed analyses discussed in this Intelligence Brief, we focused on silver-tier networks for two primary reasons. First, the majority of exchange networks (95%) are offered on the silver tier. Second, because payors are required to offer a silver plan to compete on the exchanges, plans on the silver tier reflect all exchange payors in a given rating area.
- More information about the methodology used in this Brief can be found on our website under 2015HospitalNetworks_Methodology**.** You are also welcome to contact reformcenter@mckinsey.com with any questions.

2015 OEP Consumer Survey. We regularly survey a national sample of QHP-eligible uninsured and individually insured consumers (excluding those eligible for Medicaid or Medicare). This research is independently funded by McKinsey & Company without contribution from any third party. The objective is to understand the intended actions, shopping, and purchasing behavior of consumers who are eligible to purchase individual coverage on the ACA exchanges or elsewhere.

Our most recent survey was conducted from February 21 to February 24, 2015, with a sample size of 3,007. This Brief includes findings from respondents' self-reported purchase actions in 2014 and 2015, such as awareness of plan's network breadth, sufficiency of network's access, and satisfaction with 2014 payor.

More information about McKinsey's OEP survey can be found on our website under 2015-oep-insight-consumer-behavior.

April 2015

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