McKinsey Center for U.S. Health System Reform

Hospital networks: Updated national view of configurations on the exchanges

In December 2013, we released an Intelligence Brief on exchange hospital network trends based on analyses of the silver-tier plans offered in 20 geographically dispersed urban areas.[1] We have since enhanced our hospital network database to include all products in all tiers in all 501 rating areas in the U.S., which has given us a comprehensive view of the exchange network landscape. By leveraging the new database, we were able to generate additional insights into local market differences and patterns of network formation. We augmented these insights with findings from our April national open enrollment period (OEP) consumer survey, which explored (among other things) consumers' purchasing patterns during the 2014 OEP.[2]

Our database includes all 282 payors filing on the 2014 exchanges and all 4,773 acute care hospitals in the U.S.[3] The payors offered a total of 20,818 on-exchange products across the five metal tiers; these products included 2,366 unique individual exchange networks. These networks had to meet adequacy requirements that were in place before, and then expanded by, the ACA; these requirements include the minimum number and types of providers, and the maximum driving distance and wait time, to ensure that patients have adequate access to care.[4]

For a few of the more detailed analyses discussed in this Intelligence Brief, we focused on silver-tier networks specifically. The vast majority of exchange

---

1 "Hospital networks: Configurations on the exchanges and their impact on premiums," McKinsey Center for U.S. Health Reform, December 2013.

2 Our national consumer survey included 2,874 consumers eligible for qualified health plans. More details about the survey and the methodology it used can be found in our May 2014 Intelligence Brief, "Individual market: Insights into consumer behavior at the end of open enrollment."

3 Includes general, medical, and surgical hospitals, orthopedic hospitals, heart and cancer hospitals, ear, nose and throat hospitals, and children's general hospitals, as defined by the American Hospital Association. See appendix for further detail.

4 Before passage of the ACA, network adequacy requirements existed for HMOs in almost all states and for PPOs in about half of the states. The ACA set network adequacy requirements for all QHPs but left it to the states to define and regulate adequacy. Both national agencies and the states may continue to add regulations over time.

networks (93 percent) are offered on the silver tier, and this tier is the only one in which income-eligible consumers can receive both federal premium and cost-sharing subsidies. More than 60 percent of all consumers who enrolled in an exchange product chose one in the silver tier.

For comparison with the 2014 hospital networks offered on individual exchanges, we used network data from the 2013 individual market products of all incumbent payors. In our analyses, we categorize each network based on the extent of hospital participation, as follows: broad networks have more than 70 percent of all hospitals in the rating area participating, narrow networks have 31 to 70 percent of all hospitals in the rating area participating, and ultra-narrow networks have 30 percent or less of all hospitals in the rating area participating. We classified a network as tiered if the payor put different hospitals into different tiers with different co-payment requirements. In the remainder of this Intelligence Brief, we use the phrase *narrowed network* to refer to narrow, ultra-narrow, and tiered networks in the aggregate.[5]

Seven key observations emerged from our analyses:

- Consumers now have an expanded choice of network offerings at the point of health plan purchase on exchanges. Broad networks are available to close to 90 percent of the addressable population.[6] In addition, narrowed networks are available to 92 percent of that population; they make up about half (48 percent) of all exchange networks across the U.S. and 60 percent of the networks in the largest city in each state. The increased prevalence of narrowed networks gives consumers a wider range of value propositions and prices among health insurance plans. But, if a consumer purchases a narrowed network product, then at the point of access, the choice of providers is reduced.
- Compared to plans with narrowed networks, products with broad networks have a median increase in premiums of 13 to 17 percent (when the analysis is controlled for payor, product type, rating area, and metal tier); the maximum increase is 53 percent. Across the country, close to 70 percent of the lowest-price products are built around narrow, ultra-narrow, or tiered networks.[7]

---

5 Narrowing of provider networks can occur across hospitals or physicians. For the purposes of this Intelligence Brief, we have focused on hospital networks.

6 Addressable population is defined as people who are eligible to purchase qualified health plans on the exchanges (i.e., non-elderly adults with incomes above 100 percent FPL in non-Medicaid expansion states and above 138 percent FPL in Medicaid expansion states).

7 Out of all rating areas where ultra-narrow or narrow networks are present (329 of the 501 rating areas). For each rating area, when the same payor offered multiple products based on the same network, the lowest-price product was used to determine the price of the network. Payor count represents unique payors at a state level. See methodology in the appendix for further details.

- There is no meaningful performance difference between broad and narrowed exchange networks based on Centers for Medicare and Medicaid Services (CMS) hospital metrics such as the composite value-based purchase score as well as its three sub-components (outcome, patient experience, and clinical process scores).[8] However, broad networks have higher rates of academic medical center participation.
- Certain market conditions are associated with a greater prevalence of narrowed networks—specifically, higher excess bed capacity, greater provider or payor fragmentation, and more significant potential for growth from the uninsured than from people who previously had coverage. Each of these market conditions is associated with 1.4 to 1.9 times as many ultra-narrow networks, and the combination of factors is associated with an even higher prevalence of ultra-narrow networks (up to 4.7 times as many).
- In those rating areas in which at least two different payors offer ultra-narrow, silver-tier networks,[9] 67 percent of the ultra-narrow networks share the majority of their hospitals (on average, over 80 percent) with at least one other ultra-narrow network. Fourteen percent of all acute-care hospitals participate in ultra-narrow networks; of them, 23 percent are in more than one such network.[10]
- Seventy-five percent of all ultra-narrow, silver-tier products include only some of the hospitals within participating health systems. Forty-four percent of these products exclude at least one hospital from every single participating health system. Ultra-narrow networks excluding hospitals from every participating health system are priced an average of 13 percent lower than ultra-narrow networks containing entire health systems.
- In our April consumer survey, 42 percent of the respondents who indicated they had enrolled in an ACA plan and were aware of the network type reported purchasing a product with a narrowed network. However, 26 percent of those who indicated they had enrolled in an ACA plan were unaware of the network type they had selected.

---

8 Specifically, we used the following metrics: the outcomes score of 30-day mortality rate for acute myocardial infarction, the patient-reported score of hospital rating, and the clinical process scores for surgery patient antibiotics delivery.

9 211 of the 501 rating areas in the U.S.

10 Of all acute-care hospitals in the U.S., 96 percent participate in an exchange network—84 percent in broad, 38 percent in narrow, and 14 percent in ultra-narrow networks. (Numbers add up to more than 100 percent because some hospitals are in multiple networks).

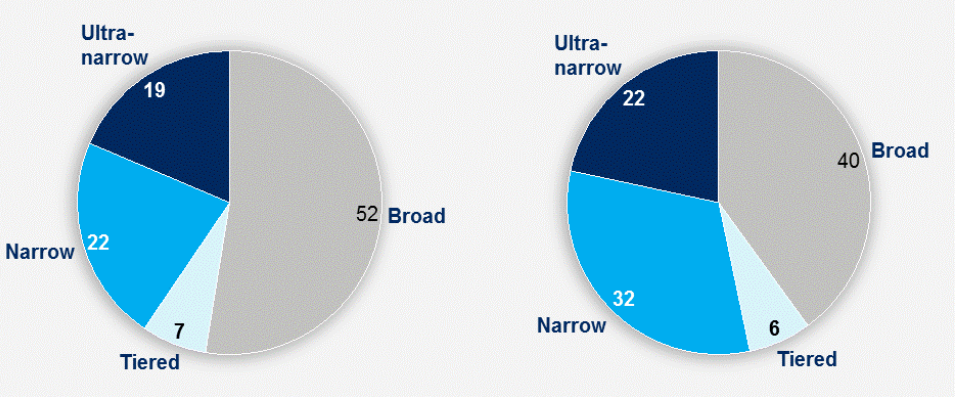
Consumers now have expanded choice at the point of health plan purchase. Broad networks are available to 90 percent of the addressable population; narrowed networks, to 92 percent

Across the U.S., at the point of purchase there is an expanded choice of network offerings. Broad networks are available on the exchanges in 419 of the 501 rating areas,[11] which together cover close to 90 percent of the addressable population.[12] Narrowed network options exist in 380 of the 501 rating areas (representing 92 percent of the addressable population). Narrowed networks make up 48 percent of all exchange networks across the U.S. and 60 percent of the networks in the largest city in each state *(Exhibit 1)*. Of all networks, 22 percent are narrow, 19 percent are ultra-narrow, and 7 percent are tiered. Although the choice of offerings at the point of purchase has expanded, consumers who select a narrowed network have a reduced choice of providers at the point of access.

EXHIBIT 1

Consumers are being offered a wide range of network types

Distribution of 2014 individual exchange networks by network breadth[1]



SOURCE: McKinsey Center for U.S. Health System Reform/McKinsey Advanced Healthcare Analytics analysis of publicly available rate filings and carrier information; AHA database

Data as of 02.24.2014

1 Broad networks: more than 70 percent of hospitals within a rating are participating; narrow networks: 31 to 70 percent of hospitals within a rating area are participating; ultra-narrow networks: 30 percent or less of hospitals within a rating area are participating; tiered networks: narrowing is introduced when the payor puts different hospitals into different tiers with different co-payment requirements.

---

11 Of the 82 rating areas that do not have a broad network on the 2014 exchange, 35 did not have any broad networks in the 2013 individual market either.

12 Addressable population is defined as people who are eligible to purchase qualified health plans on the exchanges (i.e., non-elderly adults with incomes above 100 percent FPL in non-Medicaid expansion states and above 138 percent FPL in Medicaid expansion states).

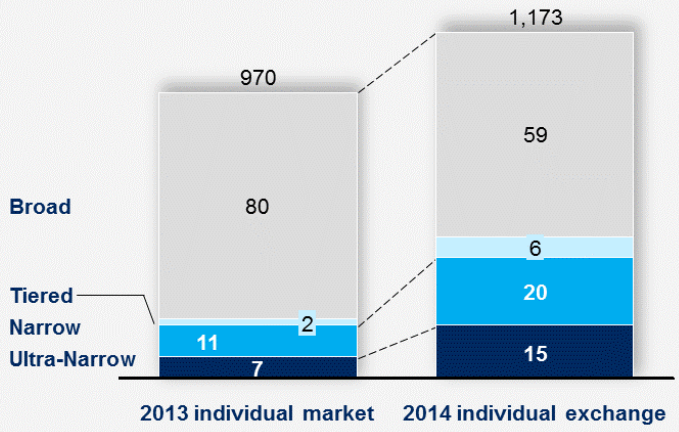
The prevalence of broad and narrowed networks varies by geography. In 104 rating areas (representing 8 percent of the addressable population), broad networks are the only network type offered. In many cases, these are rural areas with provider market structures not conducive to narrowing (e.g., they contain only one or two hospitals). In addition, local regulations in some markets may lead to different network configurations or levels of narrowing. In contrast, across the largest cities in each state (which together include 30 percent of the addressable population), the prevalence of narrowed networks is 60 percent.

The increased choice for consumers at the point of health plan purchase is illustrated through the comparison of incumbents' network offerings in the 2013 individual market against products in the 2014 individual exchanges in the same rating areas *(Exhibit 2)*.[13] Across the country, incumbent payors now offer 20 percent more products, driven by the increased number of narrowed network offerings. In addition to the expanded number of incumbent products, 90 percent of the new entrants are offering narrowed network plans as well. The resulting increase in the number of network configurations gives consumers a greater range of value propositions and prices among health plans.

EXHIBIT 2

Incumbents' network offerings have expanded; greater number are narrowed

Incumbents' 2013 individual market network offerings vs. 2014 exchange offerings[1]
% of ehealthinsurance.com networks and exchange networks across metal tiers



SOURCE: McKinsey Center for U.S. Health System Reform/McKinsey Advanced Healthcare Analytics analysis of publicly available rate filings and carrier information; AHA database

Data as of 02.24.2014

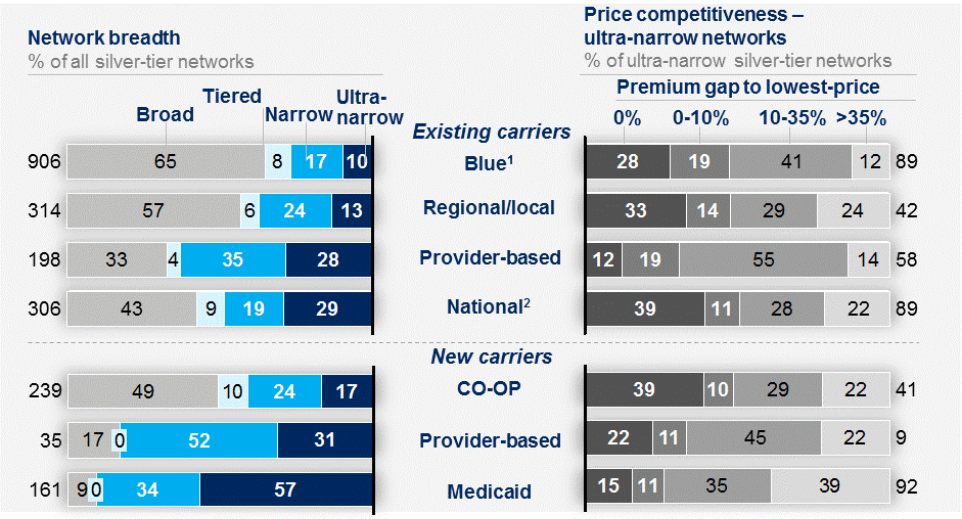
1 Incumbents are defined as any 2013 payor that filed on the exchanges in 2014, for which 2013 individual network data was available (2013 data was available for 138 of the 202 incumbents that filed on the 2014 exchanges).

[13] Incumbents are defined as any 2013 payor that filed on an exchange in 2014.

All payor types (but not all payors within each type) are offering products with narrowed networks. However, the prevalence of these networks differs by payor type *(Exhibit 3)*. New entrants offer a higher percentage of narrowed networks than incumbents do (68 percent versus 45 percent). Among the new entrants, Medicaid payors[14] and provider-based plans offer the highest percentage of ultra-narrow networks (57 percent and 31 percent, respectively). Among the incumbents, national payors[15] use ultra-narrow networks most often (29 percent).

EXHIBIT 3

Frequency and pricing of networks differ by carrier type



SOURCE: McKinsey Center for U.S. Health System Reform/McKinsey Advanced Healthcare Analytics analysis of publicly available rate filings and carrier information; AHA database

Data as of 02.24.2014

1 Includes every Blue Cross Blue Shield branded product

2 Aetna, Coventry, Humana, Cigna, UnitedHealth

Note: Due to small N size, existing Medicaid payors (n=2), new Medicare payors (n=3), and new regional payors (n=2) are not included

Products with broad hospital networks have median premiums 13 to 17 percent higher than plans with narrowed networks; close to 70 percent of the lowest-price products include narrowed networks

In general, narrowed networks appear to be an important and effective cost-control lever for payors. We found 292 instances in which the same payor is offering two

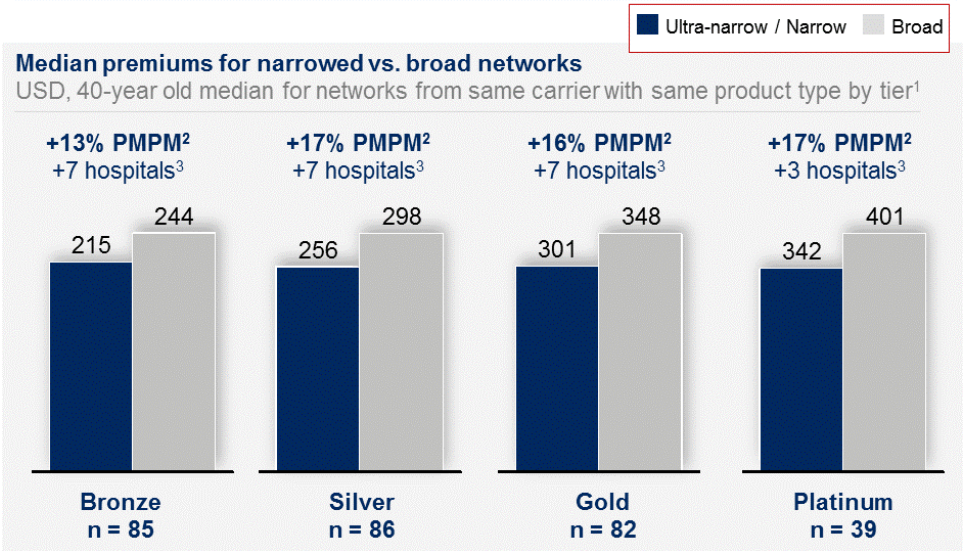
14 Defined as payors that are both formerly focused on the Medicaid segment *and* new to the individual segment

15 The term “national payors” refers to UnitedHealth, Cigna, Humana, and Aetna/Coventry. Anthem, HCSC, and Regence are excluded because they are classified as Blues plans. Molina and Centene are classified as Medicaid payors.

networks of different breadths (ultra-narrow or narrow network versus broad network) in the same rating area, on the same metal tier, and within products of the same type (i.e., HMO, PPO, EPO, POS). In these instances, the median difference in premiums between the narrowed and broad network products ranges from 13 to 17 percent ($29 to $59 per member per month[16]) across tiers. The maximum difference in premiums ranges up to 31 to 53 percent ($84 to $125 per member per month) *(Exhibit 4)*.

EXHIBIT 4

Broader networks are associated with a 13-17% median premium increase



SOURCE: McKinsey Center for U.S. Health System Reform/McKinsey Advanced Healthcare Analytics analysis of publicly available rate filings and carrier information; AHA database

Data as of 02.24.2014

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. When the same payor offered multiple products on the same network, the lowest-price product was used.

2 Median change in the premium difference from the narrowed network to the broad network.

3 Median change in the number of hospitals participating from the narrowed network to the broad network.

Although 69 percent of the lowest-price exchange products include narrow, ultra-narrow, or tiered networks,[17] network breadth does not always correlate with premium levels *(Exhibit 5)*. This finding may reflect other factors affecting payor costs that are not part of our analysis: for example, starting points for provider reimbursement levels; the choices made by low-operating-cost, more efficient

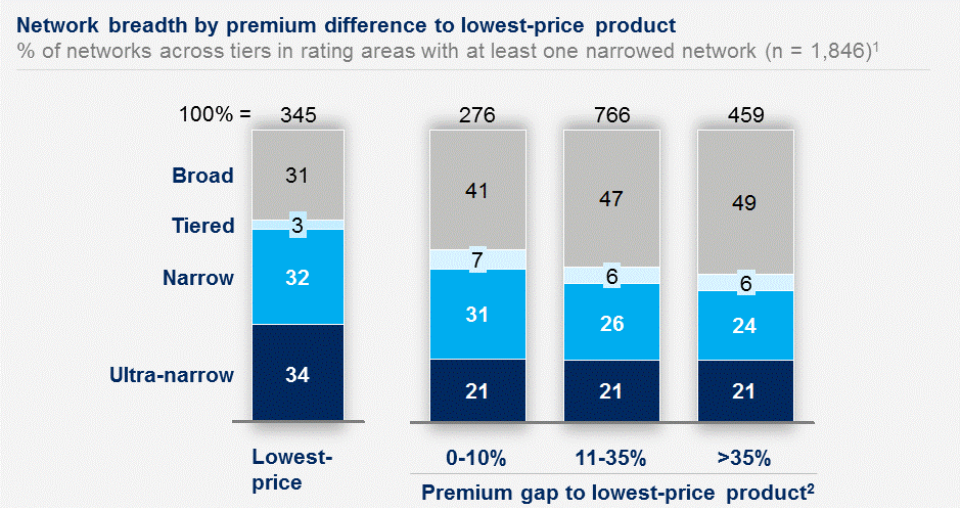
16 Analysis is based on PMPM premium for a 40-year-old nonsmoker who is not eligible for premium subsidies.

17 Out of all rating areas where ultra-narrow or narrow networks are present (329 the 501 rating areas).

hospitals whether to participate in narrowed networks or not; and assumptions regarding care management effectiveness and risk selection and adjustments (i.e., morbidity of expected membership, impact of risk adjustors/re-insurance). Some of these assumptions, especially those related to morbidity, vary widely with the uncertainty of a new market.

EXHIBIT 5

Close to 70% of lowest-price products are narrowed



SOURCE: McKinsey Center for U.S. Health System Reform/McKinsey Advanced Healthcare Analytics analysis of publicly available rate filings and carrier information; AHA database

Data as of 02.24.2014

1 When the same payor offered multiple products based on the same network, the lowest-price product was used in the analysis.

2 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 in the same rating area. For networks with multiple tiers, the tier used for the network price is chosen in priority order: silver, bronze, gold, platinum, catastrophic.

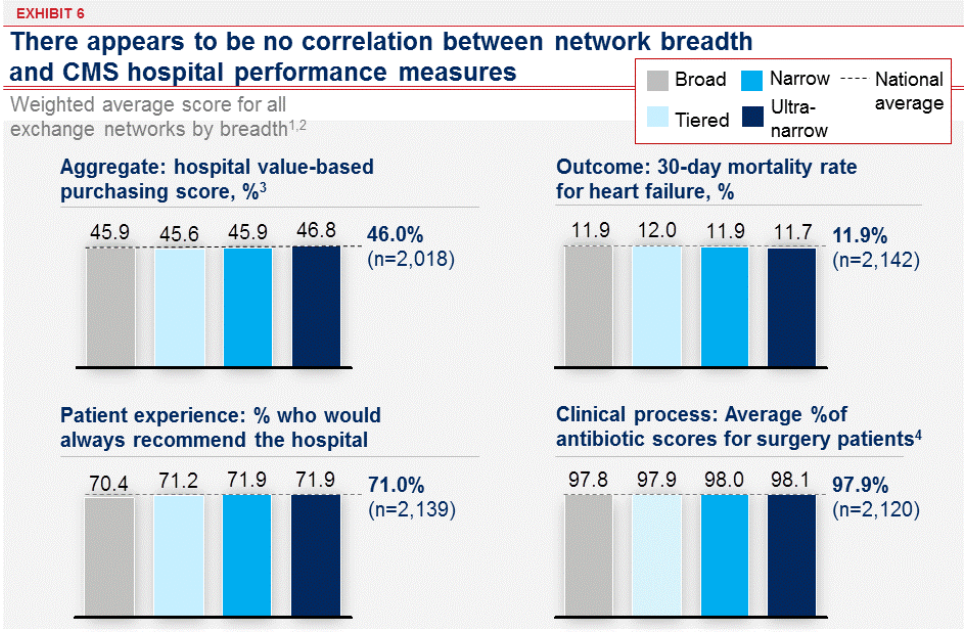
The ability to translate ultra-narrow networks into competitively priced products varies by payor type. Medicaid entrants have the lowest prevalence of competitively priced ultra-narrow networks (defined as being priced within 10 percent of the lowest-price product, regardless of network type, in a rating area); 26 percent of their ultra-narrow networks are competitively priced. In contrast, 51 percent of the ultra-narrow networks offered by national payors are competitively priced. Other payors use broad networks more often, yet achieve price leadership at times. For instance, 70 percent of the Blues' 2014 exchange networks are broad, and 42 percent of those networks are priced competitively.

Incumbents are more likely than new entrants to offer multiple silver-tier network options in a given rating area (25 percent and 13 percent, respectively). Among the incumbents, Blues payors offer multiple network options most often; 34 percent of them offer multiple silver-tier networks in at least one rating area.

There is no meaningful performance difference between broad and narrowed exchange networks based on key CMS hospital metrics. Broad networks are more likely to include an AMC

The performance of participating hospitals (as defined by the four metrics discussed below) appears to be similar across network breadths *(Exhibit 6)*. The four metrics we used are gathered routinely by CMS: the composite value-based purchase (VBP) score of outcome, patient experience, and clinical process measures;[18] the 30-day mortality rate from heart failure; the likelihood that a patient would recommend a hospital (as measured by the Hospital Consumer Assessment of Healthcare Providers and Systems); and the rate of antibiotic delivery to surgical patients. We acknowledge, however, that others may use different definitions of hospital performance, and differences among the hospitals might have emerged had other data been widely available.

EXHIBIT 6



SOURCE: McKinsey Center for U.S. Health System Reform/McKinsey Advanced Healthcare Analytics analysis of publicly available rate filings and carrier information; AHA database

Data as of 02.24.2014

1 Across all exchange networks. N refers to the number of networks and varies across metrics because CMS does not publish all metrics across all hospitals.

2 Scores reflect the weighted average of all network scores for given network breadths, weighted by the number of inpatient admissions for each in-network hospital in a given network.

3 Composite score that looks at outcomes, patient experience, and clinical processes.

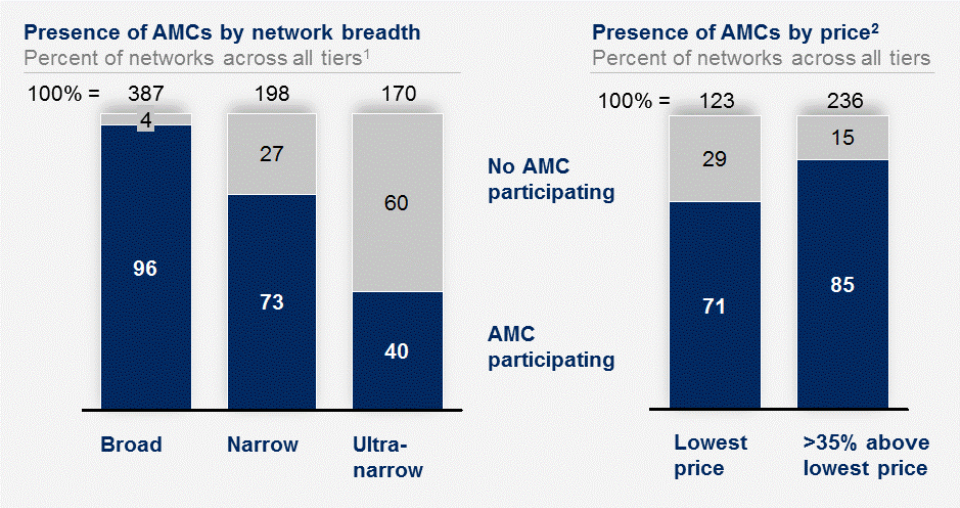
4 Average of the following three measurements: 1) percentage of surgery patients given an antibiotic at the right time (within one hour before surgery) to help prevent infection; 2) percentage of surgery patients whose preventive antibiotic was stopped at the right time (within 24 hours after surgery); and 3) percentage of surgery patients who were given the right kind of antibiotic to help prevent infection.

18 The VBP score is a composite; 12 core clinical process measures account for 70 percent of the score, and 8 patient experience metrics account for the other 30 percent. See the appendix for more details.

Academic medical centers (AMCs)[19] are participating most often in products with broad networks and higher premiums. For example, 96 percent of the broad networks across the U.S. have an in-network AMC, compared with 40 percent of the ultra-narrow networks. However, AMCs are participating in 71 percent of the lowest-price silver-tier offerings in each rating area, compared with 85 percent of the highest-price products in that tier *(Exhibit 7)*.[20] Products including an AMC have premiums that, on average, are 9 percent higher than products without AMCs ($317 versus $291, respectively).[21]

EXHIBIT 7

AMCs are participating in broader and higher-priced exchange networks



SOURCE: McKinsey Center for U.S. Health System Reform/McKinsey Advanced Healthcare Analytics analysis of publicly available rate filings and carrier information; AHA database

Data as of 02.24.2014

1 Only for rating areas that include at least one AMC (125 of 501 rating areas across the U.S.)

2 Analysis was based on PMPM costs for 40-year-old nonsmoker not eligible for premium subsidies. 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 in the same rating area.

Certain market conditions—higher excess bed capacity, provider and/or payor fragmentation, more growth potential from uninsured—are associated with a greater prevalence of narrowed networks

Across markets, narrowed networks are more prevalent in regions with higher excess bed capacity, greater provider and/or payor fragmentation, or greater

19 Defined as a hospital affiliated with an accredited U.S. medical school, according to the Association of American Medical Colleges. For medical schools with more than one affiliated hospital, the largest hospital was used.

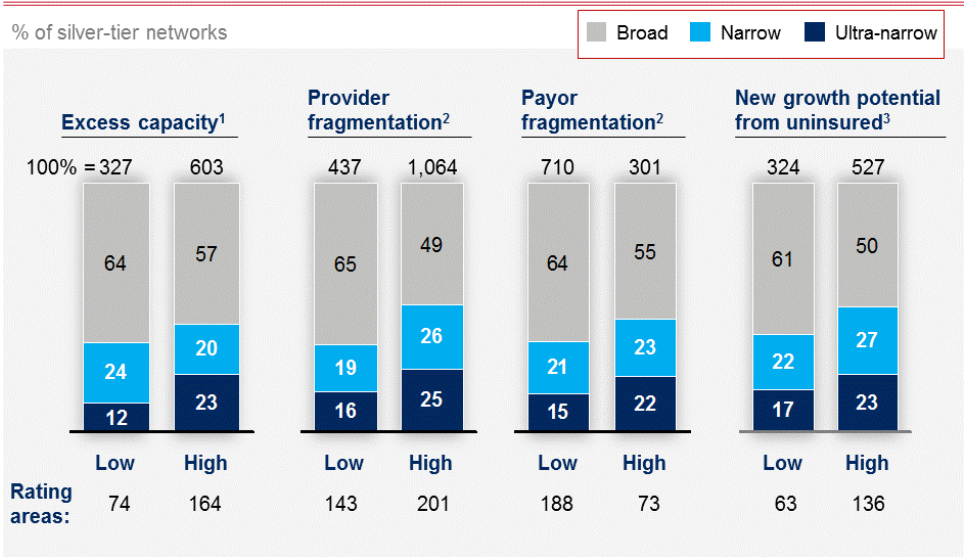
20 Defined as more than 35 percent greater than the lowest-price product.

21 Based on the silver-tier premium for a 40-year old nonsmoker.

potential for growth from the uninsured than from those previously insured *(Exhibit 8)*.[22] In markets with even one of these conditions, the prevalence of narrowed networks is 1.2 to 1.5 times higher, and the prevalence of ultra-narrow networks of 1.4 to 1.9 times higher, than in other markets. When more than one of these factors is present, the prevalence of narrowed networks increases further (up to 4.7 times higher).

EXHIBIT 8

Four factors appear to increase the likelihood of narrowed networks



SOURCE: McKinsey Center for U.S. Health System Reform/McKinsey Advanced Healthcare Analytics analysis of publicly available rate filings and carrier information; AHA database

1 Utilization was calculated as the rating area's total facility inpatient days divided by total facility staffed beds multiplied by 365 ; low utilization: <55 percent; high utilization: >70 percent.

2 Level of fragmentation was measured via Herfindahl-Hirschman Index, calculated as sum of squares of market share (for provider, defined as inpatient market share; for payor, defined as commercial market share); low fragmentation: >5,000 for provider, >2,500 for payor; high fragmentation: <2,500 for provider, <1,500 for payor.

3 Growth potential was calculated by QHP-eligible uninsured divided by total QHP-eligible population to compare new growth from those previously uninsured against a change in coverage among those previously insured; low growth: <60 percent; high growth: >75 percent.

In ratings areas in which at least two payors offer ultra-narrow, silver-tier networks, 67 percent of those networks share the majority of their hospitals with at least one other payor's network

Among the 75 markets with multiple ultra-narrow networks within the silver tier, the extent of convergence—the participation of one or more hospitals (in most cases, the majority of the network's hospitals) in more than one ultra-narrow network—varies greatly. While almost all acute-care hospitals (96 percent) are participating in an exchange product, less than half are participating in a narrow or

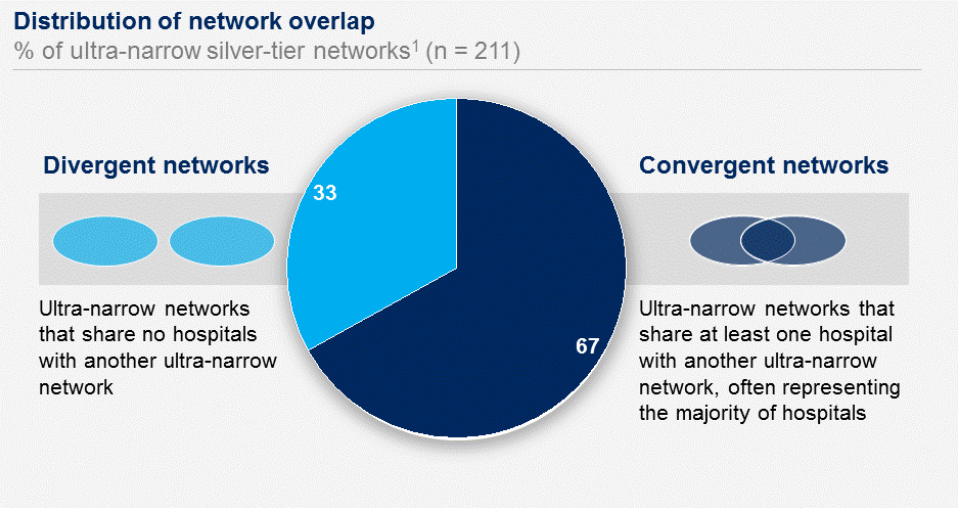
22 "Uninsured" and "previously insured" based on 2013 coverage status of all QHP-eligible individuals living in each rating area.

ultra-narrow network (32 and 14 percent, respectively). Of the hospitals participating in an ultra-narrow network, 23 percent are in more than one such network.

Nationwide, 67 percent of ultra-narrow, silver-tier networks are convergent (as defined above). Of these convergent ultra-narrow network products, 21 percent are the lowest-price product in their rating area. The remaining one-third of ultra-narrow networks are divergent—they did not share any hospitals with other ultra-narrow networks (*Exhibit 9*).

EXHIBIT 9

Most ultra-narrow networks share majority of their hospitals with another ultra-narrow network



SOURCE: McKinsey Center for U.S. Health System Reform/McKinsey Advanced Healthcare Analytics analysis of publicly available rate filings and carrier information; AHA database

Data as of 02.24.2014

1 Networks must be in rating areas with 2 or more ultra-narrow networks.

In areas with a high prevalence of divergent networks, a hospital's basis of competition for patients moves "forward" from the point of access to the point of health plan purchase. A hospital not participating in a given network essentially loses access to patients in that network (at least for elective procedures) for the entire enrollment period, potentially altering competitive dynamics in the market.

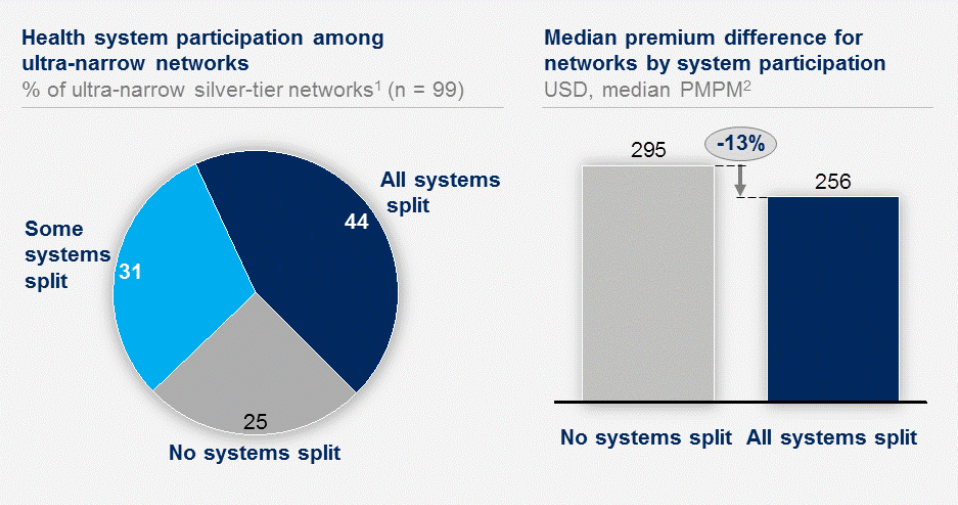
Three-fourths of ultra-narrow networks include only some of the hospitals within a health system. These networks are typically priced lower than ultra-narrow networks that contain entire health systems

Seventy-five percent of all ultra-narrow, silver-tier products include only some of the hospitals within participating health systems. Forty-four percent of these products exclude at least one hospital from every single participating health

system; only a subset of each system's hospitals is included *(Exhibit 10)*. Another 31 percent of the products exclude at least one hospital from at least one health system. The ultra-narrow networks excluding at least one hospital from every participating health system are priced 13 percent lower, on average, than those including all hospitals from every participating health system.

EXHIBIT 10

75% of ultra-narrow networks split some or all health systems



SOURCE: McKinsey Center for U.S. Health System Reform/McKinsey Advanced Healthcare Analytics analysis of publicly available rate filings and carrier information; AHA database

Data as of 02.24.2014

1 Networks were analyzed on a state level to account for health systems that span multiple rating areas.
2 Analysis was based on PMPM costs for a 40-year-old nonsmoker not eligible for premium subsidies.

Partial health system participation in a network may be the choice of either the provider or the payor. For strategic or financial reasons, a health system may opt to trade price for volume, thereby gaining disproportionate access to the exchange, or it may choose to maintain price and forgo the volume. Alternatively, a payor may select (where regulations permit) only the subset of the more efficient or more attractively priced hospitals within a system.

Local, regional, and national health systems are all represented in ultra-narrow networks with partial participation. The payors most often offering ultra-narrow networks with partial health system participation are the national players (54 percent of their networks) and new Medicaid entrants (47 percent).

In our survey, 42 percent of those who indicated they had enrolled in an ACA plan and were aware of their network type reported purchasing a product with a narrowed network

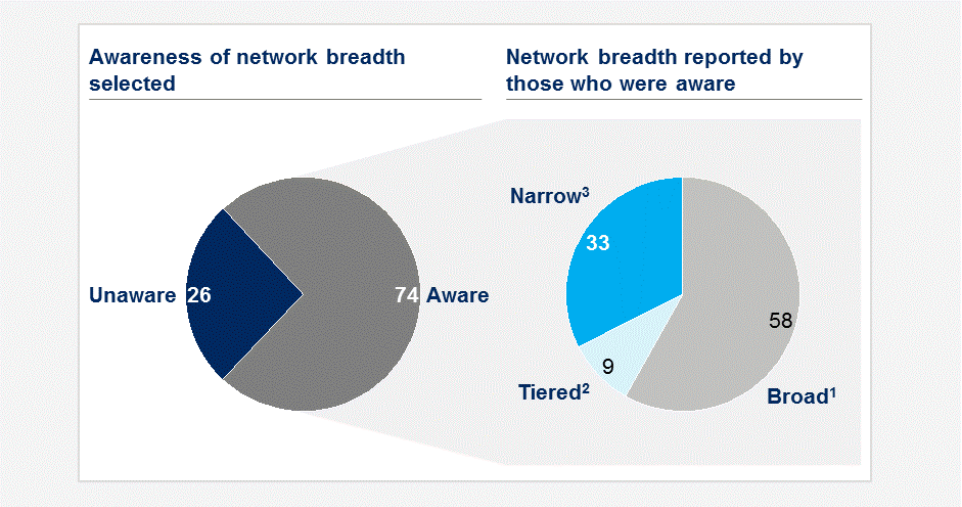
Among the topics covered in our April consumer survey was whether respondents had shopped for and then purchased healthcare coverage, as well as how network

breath may have influenced their decisions. Twenty-six percent of the respondents who indicated they had enrolled in an ACA plan were not aware of their selected product's network breadth *(Exhibit 11)*. This lack of awareness was highest among previously uninsured respondents[23]; they were more than twice as likely as previously insured respondents to be unaware of network breadth (41 percent versus 21 percent, respectively).

EXHIBIT 11

Close to half of respondents aware of their network breadth reported purchasing a narrowed network

% of April survey respondents who selected a new 2014 product



SOURCE: McKinsey Consumer Health Insights, Open Enrollment Tracker, McKinsey Advanced Healthcare Analysis, April, 2014

1 Survey response was "Broad network (includes almost all doctors and hospitals in my area)".

2 Survey response was "Tiered network (includes almost all doctors and hospitals in my area, but puts them into different levels where I pay a different amount for different levels)".

3 Survey response was "Narrow network (includes a limited selection of doctors and hospitals in my area; for those that are out-of-network, I would have to pay a significantly higher fee or the full bill)".

Among the respondents aware of the network breadth in their plans, close to half (42 percent) indicated they purchased a narrowed or tiered network.[24] This rate was also higher among the previously uninsured than among those previously insured (45 percent vs. 40 percent, respectively). In some cases, price may have been a factor affecting network choice, as the respondents who reported having selected a narrowed network product were more likely than other respondents to have indicated that they picked the lowest-price product in a given tier.

---

23 Our survey measured whether individuals were covered *prior* to the time of application (as defined by the answer they gave to the question: "Which of the following best describes your primary insurance coverage in 2013? For most of the year I was covered by …." Those we defined as being previously uninsured answered "I did not have health insurance, I was uninsured.")

24 As noted earlier, the survey did not ask respondents to differentiate between narrow and ultra-narrow networks.

Of all respondents who reported selecting a new ACA plan, 40 percent indicated they would have liked additional information about the providers included in different plans. Among the respondents reporting that they had shopped for health coverage but did not purchase a plan, only 7 percent thought the information regarding which providers were included in the plans was "extremely clear."

These survey results provide an early indication of how consumers are considering network configuration in their purchase decisions and are reconciling the tradeoff between premium levels and provider access. Yet, it will take much longer to gauge the full impact of consumers' reactions to narrowed network products and how they utilize out-of-network services. The resulting impact could affect the sustainability of narrow and ultra-narrow network products in terms of both economic performance and member retention, and will therefore have implications for product and network design in 2016 and beyond.

□ □ □

The findings presented in this Intelligence Brief provide an updated view of the network configurations being offered on the public exchanges across the country, as well as early indicators of the types of networks that consumers are purchasing. The exchange network data suggest that consumer choice of health plan design is expanding to include an increased number of offerings with varying breadths of hospital networks. We do not yet know how some of these network configurations will influence utilization and member retention. We will analyze data on enrollment and utilization as they become available to further inform the observations and implications described in this Intelligence Brief.

Noam Bauman, Erica Coe, Jessica Ogden, Ashish Parikh

The authors would like to thank Joseph Levenson, Brock Mark, Joseph Mitchell, Jim Oatman, and Brendan Murphy for their support.

Appendix

Additional background on the underlying research

The analyses supporting this Intelligence Brief are informed by a new McKinsey Health Systems and Services Practice asset that has been developed jointly by the Center for U.S. Health System Reform and McKinsey Advance Healthcare Analytics (MAHA). Instead of estimates and projections, this tool offers a real-time view of what was actually filed on the 2014 exchanges— 20,818 qualified health plans. The Reform Center/MAHA tool can compare individual and small-group rate filings, pre- to post-ACA trends, pricing across product types and actuarial value tiers by consumer characteristics, exchange network trends, predictions of market share based on filings and consumer-predicted dynamics, and more. Specific analyses are available upon request from the Reform Center/MAHA team; we look forward to helping our clients achieve success in the post-ACA market through the use of data-driven analysis on specific market trends.

Please contact reformcenter@mckinsey.com with any inquiries.

Methodology

The major analyses and other data sources used to develop this Intelligence Brief include:

Main analysis for targeted markets. For 2014 individual exchange market trends, we based our network analysis on exchange offering data accessed directly from the public exchanges as of February 24, 2014. All data was obtained directly from the public exchanges by shopping directly on all exchanges and by analyzing datasets released by the federal exchange. In addition, details about products' underlying exchange hospital networks were obtained directly from payor sites, utilizing their "provider search" capabilities. For pre-reform 2013 individual market data, we based our analysis on product data and underlying hospital network details accessed from both ehealthinsurance.com and payor sites.

We ran an in-depth analysis of all 2,366 hospital networks included on all 20,818 exchange products offered across all tiers in 2014. 2,366 distinct exchange networks were offered by 282 payors (every payor that filed on the 2014 exchanges). Across the country, 4,605 acute care hospitals (including 374 health systems) are participating in these exchange networks, out of a nationwide total of 4,773 acute care hospitals (378 health systems). Our payor calculations are based on the number of payors that offered plans in each state. As a result, a national payor that offered plans in 12 states in 2013 was counted as 12 "unique payors" in that year. However, a payor that offered 2014 exchange plans in four rating areas within a state was counted as a single payor in that state. Network calculations are based on the number of networks offered in each rating area (the same network

offered in four different rating areas would be considered four different networks, each capable of different network breadths). For some of the more detailed analyses discussed in this Intelligence Brief, we focused on silver-tier networks, for three reasons. First, the majority of exchange networks (93 percent) are offered on the silver tier. Second, because all payors are required to offer a silver product to compete on the exchanges, products on the silver tier reflect all exchange payors in a given rating area. Third, the silver tier is the only tier for which income-eligible consumers can receive federal premium and cost-sharing subsidies, and more than 60 percent of all consumers who enrolled in an exchange product chose the silver tier. In addition, we limited our analysis to on-exchange offerings, as comprehensive off-exchange 2014 filings are not consistently available in a single source.

Classifications. The criteria we used to classify networks, hospitals, products, and payors are summarized below.

- *Network breadth.* Hospital networks were classified based on the degree of restrictions imposed, as defined by the percentage of hospitals participating in each network in the respective rating area.
  - Broad: More than 70 percent of hospitals participating
  - Narrow: 31 to 70 percent of hospitals participating
  - Ultra-narrow: 30 percent or less of hospitals participating
  - Tiered: different hospital tiers with different co-payment requirements for different hospitals
- *Hospital type.* Our analysis focused on acute care facilities defined general medical and surgical, surgical, cancer, heart, eye, ear, nose, and throat, orthopedic, and children's general, as classified by the American Hospital Association (AHA). We did not include psychiatric, rehabilitation, or veterans hospitals. Academic medical centers were defined as hospitals affiliated with an accredited U.S. medical school, according to the AHA.
- *Product type.* The product type of each exchange network offering was defined based on the product offering details listed on respective exchange websites.
  - EPO: an exclusive provider organization is a plan model similar to an HMO. It provides no coverage for any services delivered by out-of-network providers or facilities except in emergency or urgent care situations; however, it generally does not require members to use a primary care physician for in-network referrals.
  - HMO: a health maintenance organization is a plan model centered around a primary care physician who acts as gatekeeper to other services and referrals; it provides no coverage for out-of-network services except in emergency or urgent-care situations.

- POS: a point-of-service plan is hybrid of an HMO model and a PPO model; it is an open-access model that assigns members to a primary care physician and provides partial coverage for out-of-network services.
- PPO: a preferred provider organization is a plan model that allows members to see physicians and get services that are not part of a network, but out-of-network services require a higher copayment.

- *Payor type.* Insurance payors were classified based on the following definitions:
  - Blues: a Blue Cross Blue Shield payor; includes Anthem, HCSC, Regence; considered an incumbent.
  - Consumer-operated and oriented plan (CO-OP): a new entrant that is a recipient of federal CO-OP grant funding and is not a prior commercial payor.
  - Medicaid: a new entrant that formerly offered only Medicaid insurance in the past; includes Molina and Centene.
  - National: a commercial payor with a presence in more than four states that has filed on the exchanges (specifically, UnitedHealth, Cigna, Humana, and Aetna/Coventry); considered incumbents.
  - Provider-based: an entrant that operates as a provider/health system; classified as new or existing based on presence of individual business in 2013.
  - Regional/local: commercial payor with a presence in four or fewer states (most often just one state) that has filed on the exchanges; classified as new or existing based on presence of individual business in 2013.

Pricing analyses. When a payor offered multiple products on an exchange, plans with different premiums could be based on a single hospital network. In these cases, the premium used in our pricing analyses was the lowest one among the plans (e.g., if a payor offered three plans with the same network on the same tier, for $200, $220, and $240 per month, $200 was used for all pricing analyses).

Quality analyses. To test for a relationship between hospital performance and exchange network participation, we analyzed the elements of the Centers for Medicare and Medicaid Services (CMS) value-based purchase (VBP) score across the different categories of VBP metrics for 2014 (clinical process, patient experience, and outcomes). The VBP score was created under the ACA to incentivize individual hospitals to improve quality of care. It is a composite score of outcomes-based metrics, patient-reported metrics (from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)), and clinical process measurements. VBP performance scores are used to determine

the value-based incentive payment for each hospital. We used the FY2013 VBP based on hospital performance between July 2011 and March 2012.

- The *30-day mortality rate for heart failure* measures deaths from heart failure-related causes within 30 days of a hospital admission. Patients need not be admitted at the time of death. We used 30-day mortality rates reported between July 1, 2009 and June 30, 2012.
- A *patient-reported: yes they would recommend the hospital* is the sum of the scores reflecting that the patient would "usually" recommend and "always" recommend the hospital. We used the HCAHPS metrics reported between July 1, 2012 and June 30, 2013.
- The *clinical process: average of antibiotics scores* for *surgery patients* is an average of the scores reflecting: "Percent of Surgery Patients given an antibiotic at the right time (within one hour before surgery) to help prevent infection", "Percent of Surgery Patients whose preventive antibiotics were stopped at the right time (within 24 hours after surgery)", and "Percent of Surgery Patients who were given the right kind of antibiotic to help prevent infection". We used metrics reported between July 1, 2013 and June 30, 2013

Pre- and post-reform network analyses. We identified and pulled information about the individual pre-reform 2013 networks that were offered by incumbents that filed on the 2014 exchanges across the country (907 distinct 2013 individual networks in total, for 138 of the 202 incumbents that filed on the 2014 exchanges.) To identify pre-reform networks, we analyzed a list of 2013 products and networks from eHealthinsurance.com and identified all 2013 networks for incumbents. We applied the same network breadth methodology to the 2013 networks as was used for the 2014 networks. To measure the percentage contraction of each incumbent's network breadth from 2013 to 2014, we compared each incumbent's 2014 exchange network's hospital participation rate to the respective payor's 2013 individual market networks in the same rating area, for all 2014 exchange networks offered across metal tiers.

Please contact reformcenter@mckinsey.com with any inquiries about our methodology.

Obtaining previous Intelligence Briefs

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

- "Individual market: Insights into consumer behavior at the end of open enrollment" (May 2014)
- "2015 Medicare Advantage rates: Perspectives for payors" (April 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)

June 2014