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Hospital networks: Perspective from four years of the individual market exchanges

McKinsey Center for U.S. Health System Reform

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Key takeaways

1. The **proportion of narrowed networks continues to rise** (53% in 2017, up from 48% in 2014). In the 2017 individual market, both incumbent carriers and new entrants carriers offered narrow networks predominantly

2. The **trend toward managed plan design** also **continues**. In the 2017 silver tier, more than 80% of narrowed network plans, and over half of the broad network plans, had managed designs

3. **Narrowed networks** continue to offer **price advantages to consumers**. In the 2017 silver tier, plans with broad networks were priced ~18% higher than narrowed network plans

4. Consumer choice is becoming more limited. In 2017, **29% of QHP-eligible individuals had only narrowed network plans available to them** in the silver tier (up from 10% in 2014)

5. Consumers who select narrowed networks in 2017 may have **less choice of specialty facilities** (e.g., children's hospitals) but, in the aggregate, have **access to hospitals with quality ratings** similar to those in broad networks

6. In both 2014 and 2015 (most recent available data), **narrowed network plans performed better financially**, on average, than broad network plans did

Definitions of "narrowed networks" and other specialized terms can be found in the glossary at the end of this document.

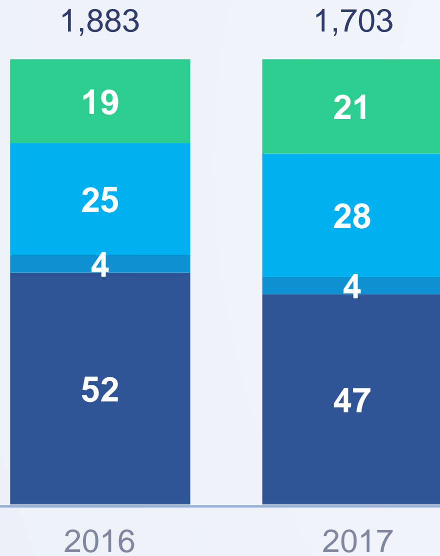
1 The proportion of narrowed networks continues to rise

Network breadth by carrier status

N = number of networks[1,2]

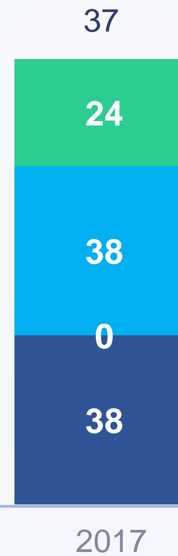
Ultra-narrow | Narrow | Tiered | Broad

Incumbents are using more narrowed networks



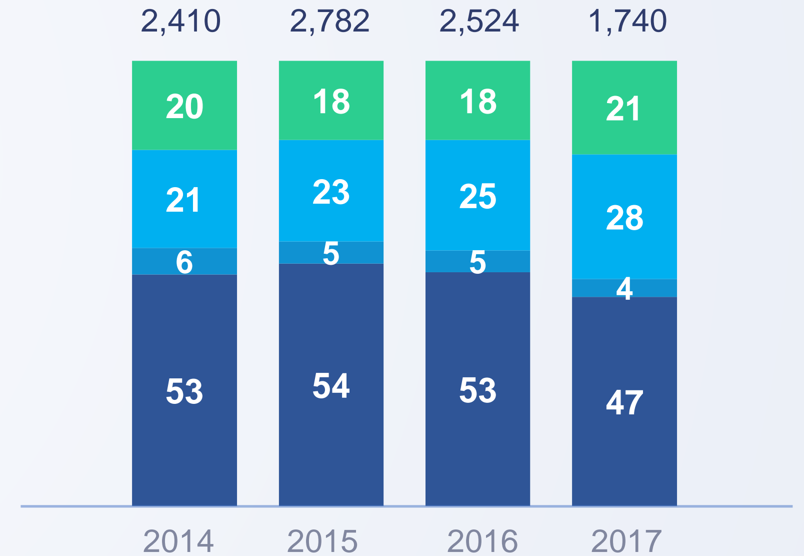
Carriers that remained in the market in both years

New entrants[2] primarily used narrowed networks



New entrants

More than half of networks are narrowed in 2017



National view

[1] Networks were counted at a state rating area level.

[2] We counted a carrier that offers health insurance in two states as two carriers. A carrier was considered a new entrant in a given state if previously it had offered individual insurance only in one or more other states.

SOURCE: McKinsey Exchange Offering Database

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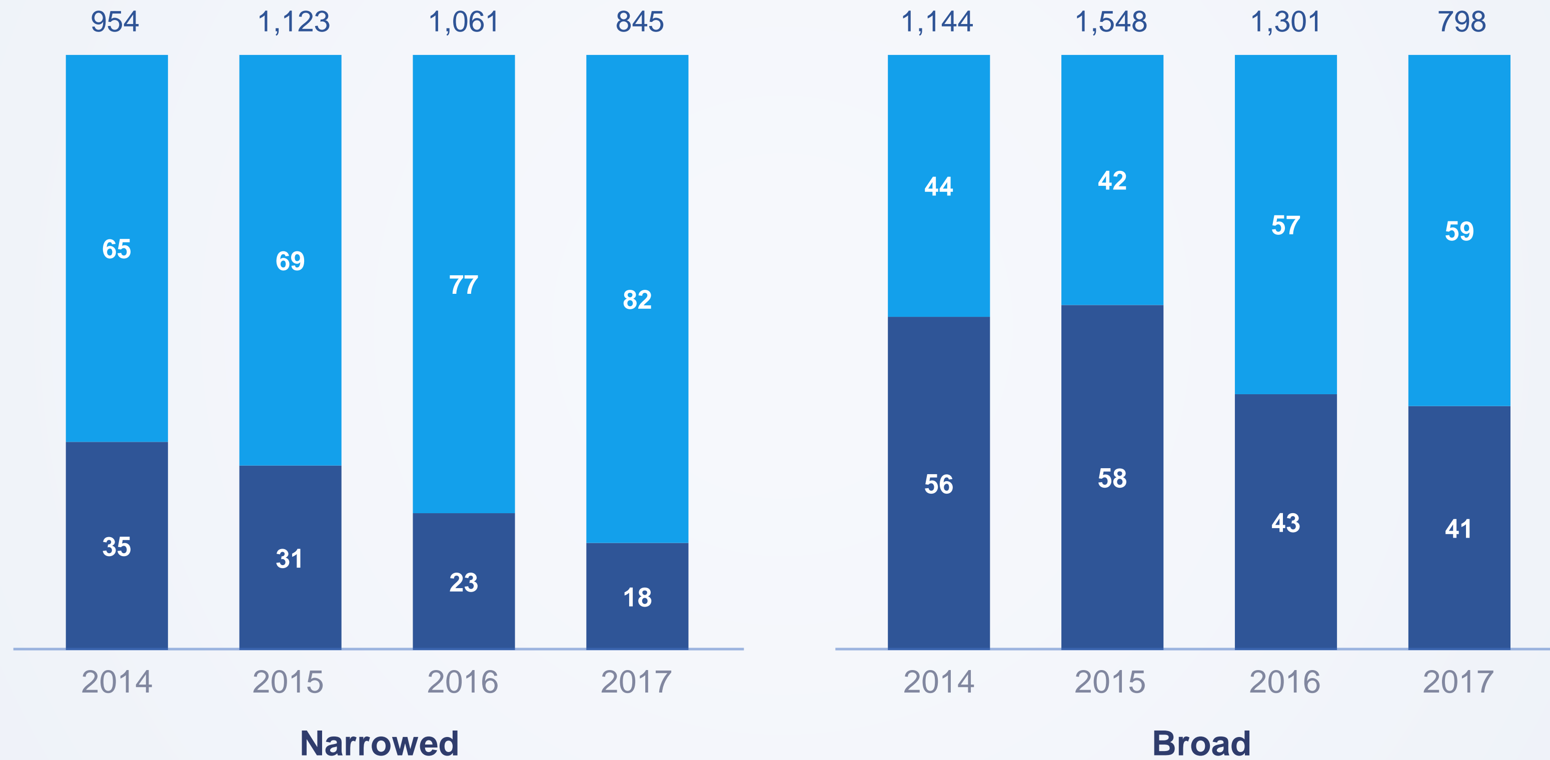
2 The shift toward managed design is occurring in both narrowed and broad network plans

Plan type by network breadth[1]
N = number of networks[2,3]



[1] Plans based on health maintenance organizations or exclusive provider organizations are considered managed. Those based on preferred provider organizations or point of service are considered unmanaged.
[2] Networks were counted at a state rating area level.
[3] When multiple silver plans were available on a single network, we used the plan type associated with the lowest-price silver plan in that network.

SOURCE: McKinsey Exchange Offering Database

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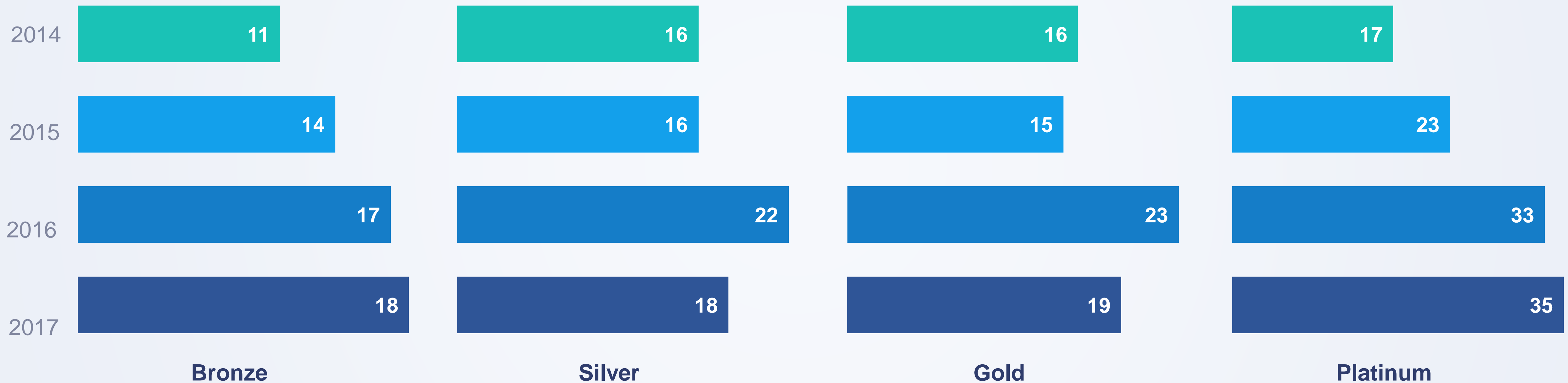
3 Narrowed network plans remain more price competitive[1]



[1] More consistent price differences across metals may indicate that payors are increasingly basing network price on experience.
[2] When a network has multiple plans, the lowest-price plan was used as the price of the network. If there were multiple networks available for selection as “narrowed,” the narrowest was selected. If there were multiple networks available for selection as “broad,” the broadest was selected.
[3] Difference between plans within the same rating area, carrier, and plan type.

SOURCE: McKinsey Exchange Offering Database

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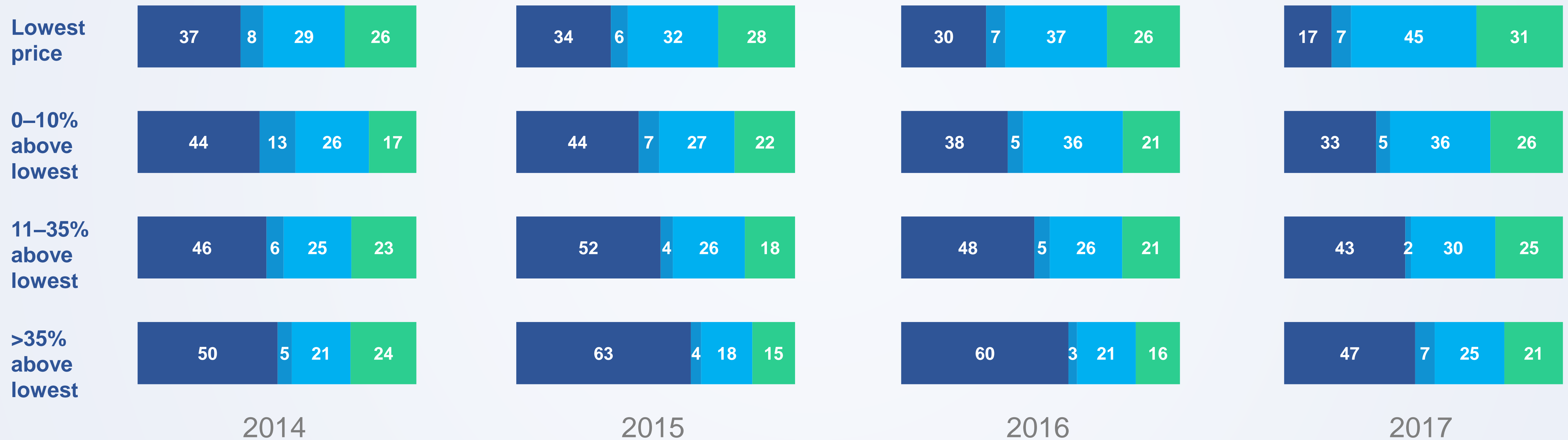
3 Increasingly, broad network plans are less likely to be price leaders



[1] Price category was defined as the premium gap to the lowest-price product. This 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.
[2] Networks were counted at a state rating area level.

SOURCE: McKinsey Exchange Offering Database

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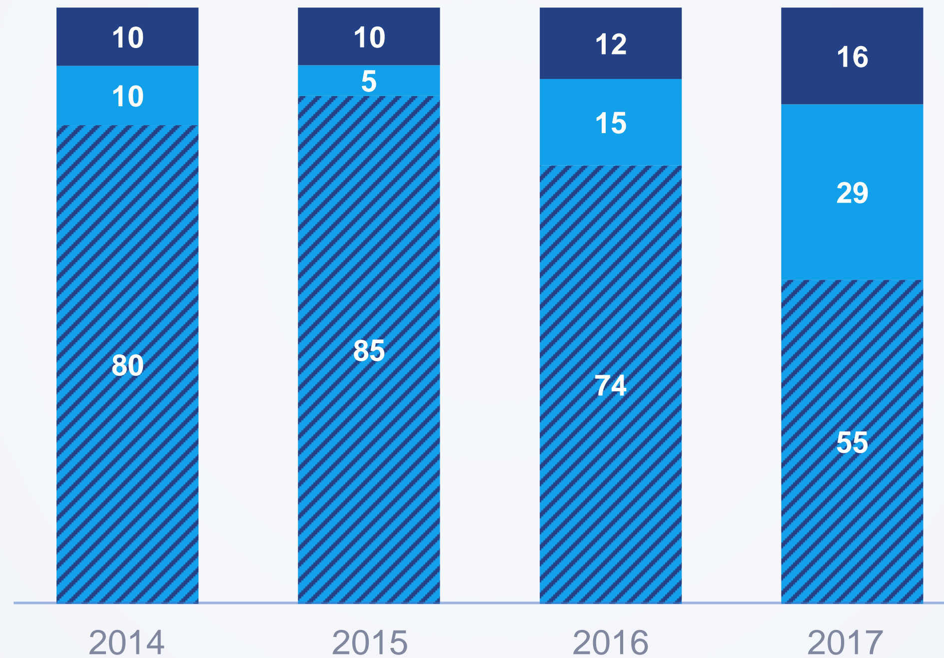
4 In the 2017 silver tier, 29% of QHP-eligible individuals had only narrowed network plans available to them

Consumer access to network breadth among silver plans

% of QHP-eligible consumers (N = 39 million)

Broad only | Narrowed only | Both



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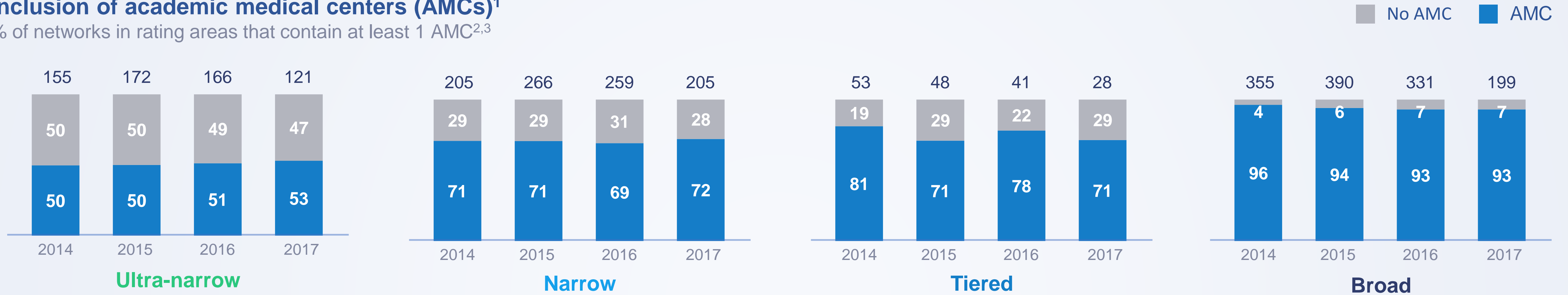
SOURCE: McKinsey Exchange Offering Database

5 While over half of ultra-narrow networks include an AMC, less than one-quarter include a children's hospital

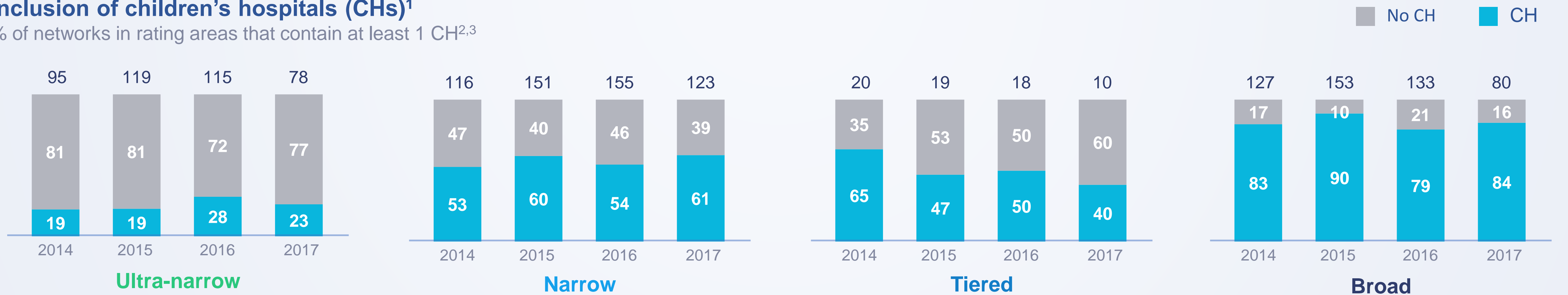
Inclusion of academic medical centers (AMCs)[1]

% of networks in rating areas that contain at least 1 AMC[2,3]



Inclusion of children's hospitals (CHs)[1]

% of networks in rating areas that contain at least 1 CH[2,3]



[1] Counting networks at a state rating area level.
[2] Carriers in any given year.
[3] Only tier 1 hospitals assessed.

SOURCE: McKinsey Exchange Offering Database

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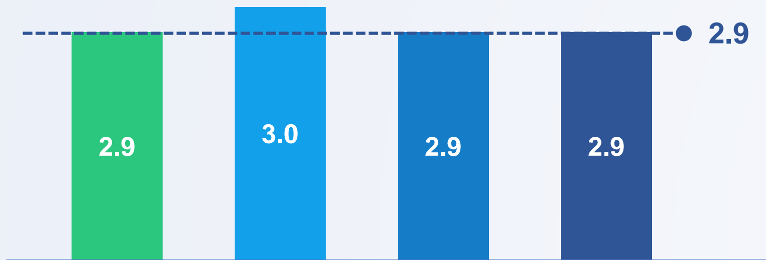
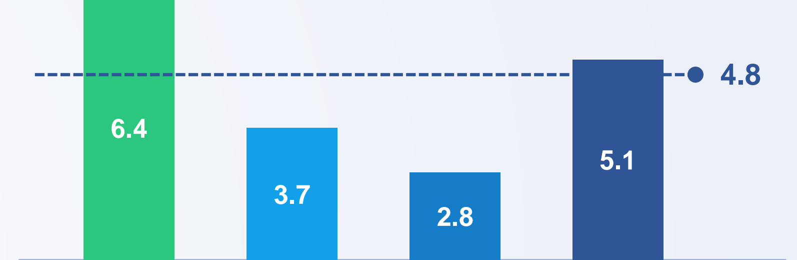
5 Ratings data suggest there is little difference in hospital quality between narrowed and broad networks

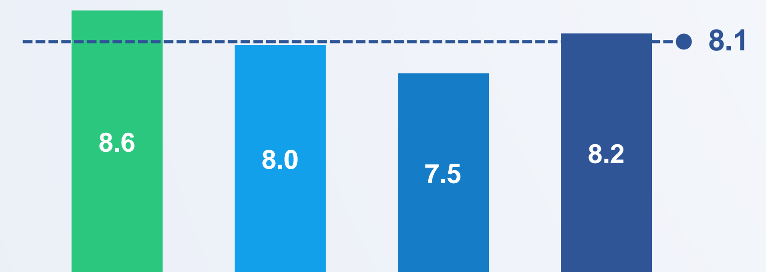
Hospital quality by network breadth[1]

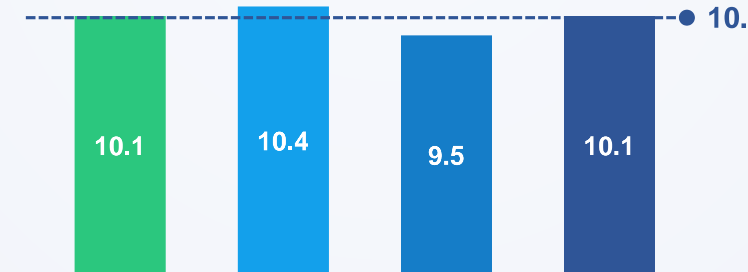
Weighted-average 2017 CMS hospital performance scores

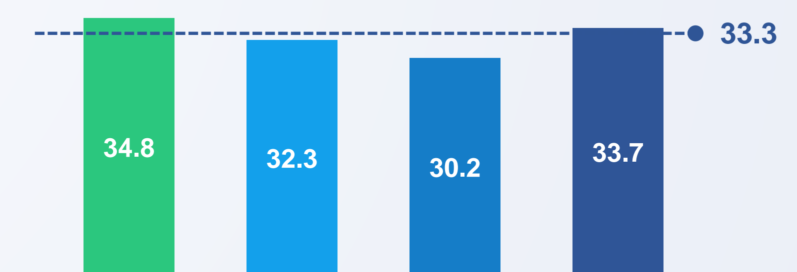
Ultra-narrow | Narrow | Tiered | Broad | National average[2]











[1] Total number (N) of networks varies across the metrics based on CMS data availability. The “Total” score is a weighted average based on the number of inpatient admissions for each in-network hospital in a given network breadth. In 2017, CMS reduced the weights for “Clinical process” an “Outcomes” and added the “Safety” score.

[2] Reflects all AHA hospitals participating in exchange networks for which CMS hospital performance data was available.

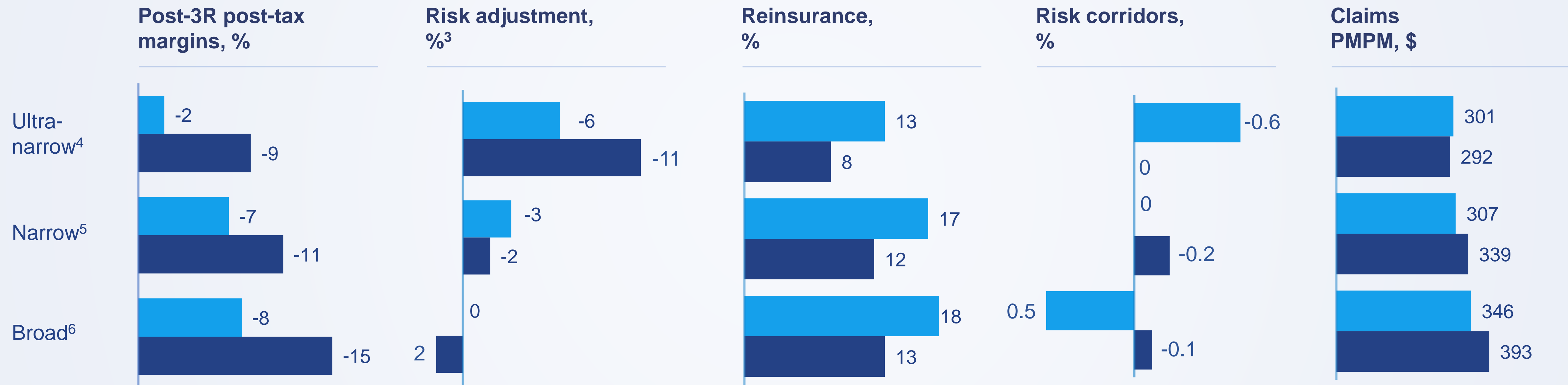
SOURCE: McKinsey Exchange Offering Database, CMS Hospital Compare Data 2017, 2016 American Hospital Association (AHA) Database

Definitions of "narrowed networks" and other specialized terms can be found in the glossary at the end of this document.

6 Carriers with narrowed networks performed better financially, on average

Post-3R, post-tax individual market financial metrics among exchange carriers

Weighted-average by QHP membership[1,2]



1 Carrier performance was determined at the NAIC/HIOS (plan ID) state and entity level. Analysis includes only entities HIOS ID's associated with on-exchange plans in given year, with >1K 2014 QHP members.
2 Network breadth for each entity was rolled up to the state level (from county) using the QHP-eligible population and network associated with the lowest-price silver plan. Each state-level entity is then associated with their respective breadth category (broad, narrow, ultra-narrow). The financial metrics for all entities in each breadth category are weighted by their 2014 QHP lives, obtained from CMS MLR reports.
3 Risk adjustment does not total to 0 as data reflects only those entities with on-exchange presence in 2014. Negative values indicate payment into the program.
4 The ultra-narrow category includes 48 entities (18 with positive margins), 12% of the premiums among exchange entities (post-3R, post-tax margin as percentage of premium ranged from -81% to 17%).
5 The narrow category includes 127 entities (37 with positive margins), 55% of the premiums among exchange entities (post-3R, post-tax margin as percentage of premium ranged from -157% to 31%).
6 The broad category includes 132 entities (28 with positive margins), 32% of the premiums among exchange entities (post-3R, post-tax margin as percentage of premium ranged from -99% to 27%).

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SOURCE: McKinsey Exchange Offering Database, CMS Hospital Compare Data 2017, 2016 American Hospital Association (AHA) Database

Glossary

Network types

- Broad network: More than 70% of hospitals in a rating area participate in this network.
- Narrow network: More than 30% and no more than 70% of hospitals participate.
- Ultra-narrow network: No more than 30% of hospitals participate.
- Tiered network: Any network with multiple levels of in-network cost-sharing for hospital services.
- Narrowed networks: Narrow, ultra-narrow, and tiered networks, unless otherwise noted.

Note: Only hospital networks are considered in these analyses. (Physician networks are not covered.) If a network is tiered, only tier 1 hospitals were included in an analysis.

Plan types (which typically vary in their gatekeeping arrangements and out-of-network cost sharing)

- HMO (health maintenance organization): A plan that typically offers a primary care physician who acts as a gatekeeper to other services and referrals; it usually provides no coverage for out-of-network services, except in emergency or urgent care situations.
- EPO (exclusive provider organization): A plan similar to an HMO that usually 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.
- PPO (preferred provider organization): A plan that typically allows members to see physicians and get services that are not part of a network, but out-of-network services often require a higher copayment.
- POS (point-of-service plan): A hybrid of an HMO and a PPO; it offers an open-access model that may assign members to a primary care physician and usually provides partial coverage for out-of-network services.

Abbreviations used

- AMC: Academic medical center
- CMS: Centers for Medicare and Medicaid Services
- DMHC: Department of Managed Healthcare (California)
- HIOS: Health Insurance Oversight System
- MLR: Medical loss ratio
- NAIC: National Association of Insurance Commissioners
- QHP: Qualified health plan
- PMPM: Per member per month
- SHCE: Supplemental Health Care Exhibit
- 3R: Risk adjustment, reinsurance, and risk corridors

Methodology and sources

The findings described in this document are based on publicly available data.

Pricing: Individual exchange premiums were obtained from state-based exchange websites and CMS/healthcare.gov public use files. For analyses involving comparisons of network premiums, unless otherwise noted, if a network is associated with multiple plans we consider only the lowest-price plan in each metal tier when comparing that network with other networks. Premiums are based on a 40-year-old single non-smoker.

Hospitals: All hospital data was obtained, as is, from carrier website provider search tools available to consumers. Hospital network data between 2014 and 2017 was collected from carrier websites. Our analysis focused only on acute care facilities that are defined by the American Hospital Association (AHA) as general medical and surgical; surgical; cancer; heart; eye, ear, nose, and throat; orthopedic; or children's general hospitals. In order to effectively compare hospital inclusion in networks, we also identified each hospital's unique AHA ID through a combination of geospatial distance matching, approximate string matching, and manual verification.

Networks: Network breadth is calculated for each CMS rating area, where available, by taking the number of hospitals that are in-network for the lowest-actuarial-value cost-sharing network tier (only applicable for tiered networks) in a given rating area, divided by the total number of hospitals that are in the rating area. Network breadth definitions are outlined in the glossary. Adjustments were made to CMS rating area definitions for Arkansas, Idaho, Massachusetts, and Nebraska to convert their 3-digit zip rating area definitions to a county-based definition. These rating area adjustments were made to be identical to (for Arkansas, Idaho, and Nebraska), or as close as possible to (for Massachusetts), the adjustments made in the healthcare.gov exchange database files. In general, counties were assigned to the rating area in which a plurality of the county's population reside.

Financials: All our financial findings are based on publicly available sources. Individual performance and financials were obtained from MLR reports, SHCE filings, DMHC filings, and CMS 2014 and 2015 3R reports. We analyzed all available data for 2014 and 2015 carriers with more than 1,000 individual lives. Profitability is based on reported post-tax, post-3R (reinsurance, risk corridor, and risk adjustment) operating margin. Risk adjustment and reinsurance were obtained directly from the CMS September 17, 2015, reports titled "Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2014 Benefit Year." Risk corridor details were obtained from carrier reports. Carrier-level risk corridor information in the quarterly reports was occasionally found to be outdated with regard to CMS's most recent risk corridor announcement. We independently calculated to verify and update the amounts at the carrier level.

Plan types: Plan types reported were taken directly from exchange websites and Summary of Benefits and Coverage (SBC) documents. Plan type definitions are outlined in the glossary

Previous publications

- Hospital networks: Perspective from three years of exchanges
- Hospital networks: Evolution of the configurations on the 2015 exchanges
- Hospital networks: Updated national view of configurations on the 2014 exchanges