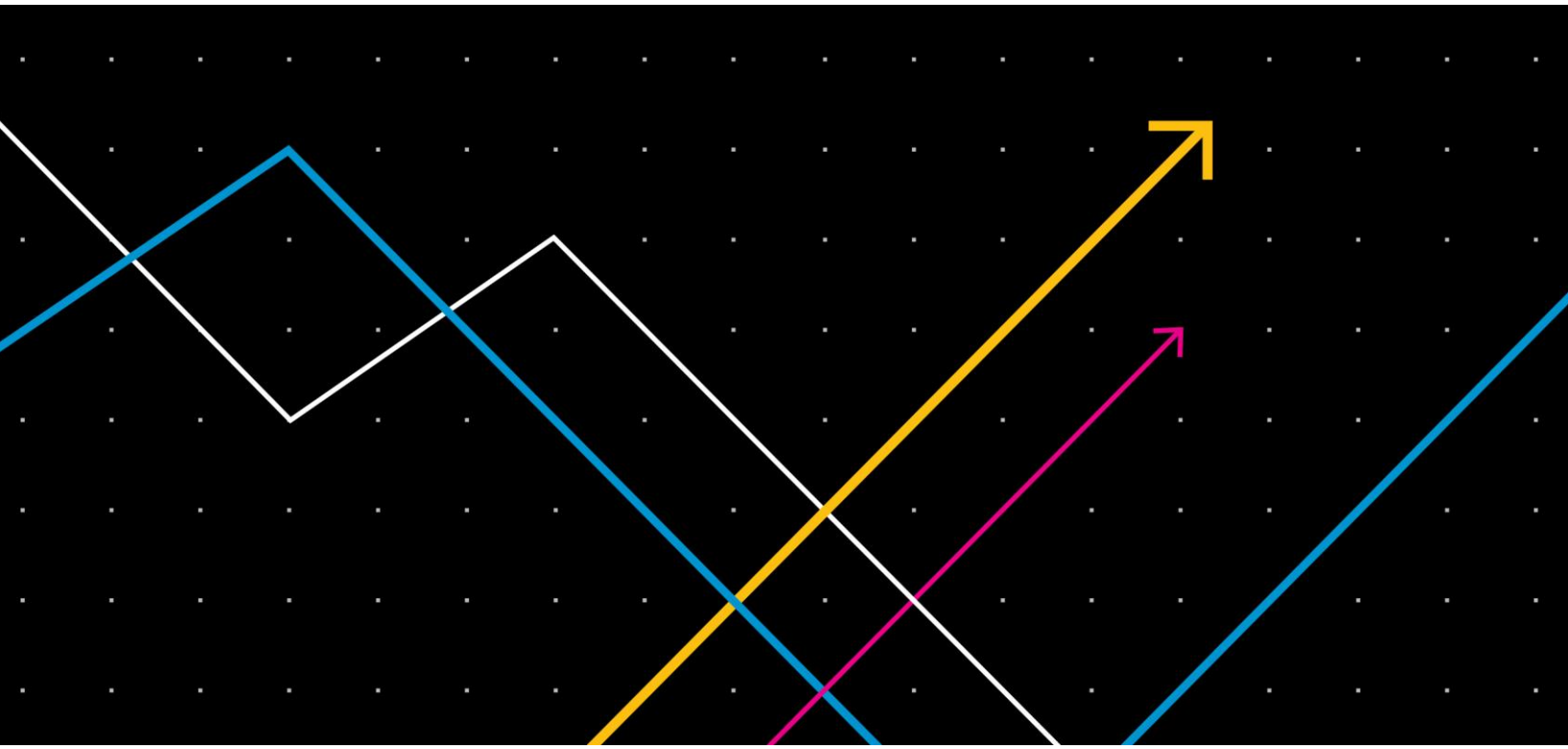

RESEARCH REPORT

Why Do Medicare Advantage Plans Have Narrow Networks?

Laura Skopec *Robert A. Berenson* *Judith Feder*

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Why Do Medicare Advantage Plans Have Narrow Networks?

Overview

In contrast to commercial markets, narrow networks in Medicare Advantage (MA) markets are neither motivated by nor generate significant unit-price discounts for insurers in exchange for higher patient volume for health systems. Through 15 interviews with MA experts, MA insurers, and health systems, we confirmed that the Medicare fee schedule is the basis for most provider payments in MA regardless of network breadth. Cost savings from narrow networks in MA derive instead from established health systems' lower utilization and higher quality. MA star ratings are a key consideration when forming networks, as high star ratings provide financial benefits through reimbursement bonuses and the ability to offer year-round open enrollment. Because most star-ratings rely to some degree on clinician performance, our interviewees noted that it is all but impossible to get a five-star rating without a narrow network.

Introduction

Narrow-network plans have become common in commercial health insurance, particularly in the Affordable Care Act's Health Insurance Marketplaces (McKinsey&Company 2017; Polsky, Weiner, and Zhang 2017). These plans limit enrollees to a narrow set of clinicians and hospitals in a geographic area in exchange for a lower premium. Though there is no consensus definition of a narrow network, prior research on these plans shows that many cover fewer than a third of eligible clinicians (Jacobson et al. 2017; Polsky, Weiner, and Zhang 2017) or hospitals in an area (Jacobson et al. 2016; McKinsey&Company 2017). Insurers form narrow-network plans to negotiate lower provider payment rates in return for directing high patient volume to in-network providers.[1] Only some of this price benefit is passed on to enrollees through lower premiums (Dafny et al. 2017; Dafny, Hendel, and Wilson 2015).

Some evidence shows narrow-network plans taking hold in the Medicare Advantage (MA) market, which allows Medicare beneficiaries to receive their benefits through private plans (Jacobson et al. 2016, 2017). One study found that 35 percent of MA enrollees have plans with a narrow physician network, meaning less than 30 percent of the county's physicians were in the plan's network (Jacobson

et al. 2017), and another study found that 16 percent of MA plans had a narrow hospital network (Jacobson et al. 2016). However, negotiating lower provider payment rates is not a significant consideration in the MA market because most MA insurers already pay providers at or near the traditional Medicare provider payment amounts, a significant discount over commercial prices (Berenson et al. 2015; Pelech 2018; Trish et al. 2017). The Social Security Act prevents Medicare providers from balance billing Medicare enrollees for out-of-network care at rates higher than the traditional Medicare provider payment amounts, giving MA insurers the negotiating leverage to pay traditional Medicare prices for care received by their enrollees both in and out of network. Without the price-reduction incentive that underlies narrow networks in commercial insurance, it is unclear why insurers are forming narrow networks in MA. This qualitative study explores that question through interviews with MA insurers, health systems participating in MA plans, and MA experts.

Approach

We conducted 15 interviews with a convenience sample of five MA experts, five MA insurers, and five health systems participating in MA. The MA insurers we interviewed provided coverage for more than a third of MA enrollees in 2017. We also interviewed at least one health system in each of the country's four census regions (Northeast, Midwest, South, and West). Our MA experts were drawn from industry, academia, and government. All interviewees were granted anonymity for themselves and their organizations, and all findings in this report reflect the views of multiple respondents unless otherwise noted. Despite our small sample, we heard several consistent themes across interviews, which we present here.

Our interviewees' views do not necessarily represent all possible reasons for MA plans to form narrow networks. Our MA insurer interviews focused on large national and state organizations, which may not be representative of how smaller insurers use narrow networks or how local health systems form MA plans. However, two of our health system interviewees were full or part owners of a narrow-network MA plan, partially bridging this gap. Finally, health maintenance organization (HMO) plans are popular in MA, covering two-thirds of enrollees in 2017 (Jacobson, Damico, and Neuman 2017), and our focus on larger national insurers may underrepresent the approaches used by local or provider-owned HMOs to narrow primary care physician networks. We also did not conduct any quantitative analyses to verify our interviewees' assertions, but we note where our findings comport with or differ from prior research.

Results

What Is a Narrow Network?

We did not offer nor did our interviewees provide a specific definition of narrow networks, but all were familiar with the concept and characterized the narrowness of their networks and those of other insurers. We also did not ask specifically about hospital networks and, separately, physician networks, as has been the approach in quantitative studies (Jacobson et al. 2016, 2017; McKinsey&Company 2017; Polsky, Weiner, and Zhang 2017), but instead asked interviewees about their networks as a whole.

Prior research has shown that network breadth is a continuum (Jacobson et al. 2016, 2017; McKinsey&Company 2017; Polsky, Weiner, and Zhang 2017). Our interviewees confirmed that approaches to networks vary broadly based on local market factors and health plan goals. Two large national insurers and one expert indicated that narrow networks are only possible in mature MA markets with multiple competing provider systems. Another MA insurer thought that narrowing networks has limited value in localities where broader networks perform well. One regional MA insurer focused on narrowing primary care networks but covers all hospitals, which keeps with research that has found that 35 percent of MA plans in 20 selected counties have narrow physician networks (Jacobson et al. 2017), but only 16 percent of MA plans in those counties have a narrow hospital network (Jacobson et al. 2016). This regional insurer confirmed that the HMO gatekeeper model allows them to control hospital costs through primary care referral patterns rather than excluding hospitals from the network.[2]

Narrow Networks Capitalize on Local Opportunities

The large national insurers we interviewed have formed narrow networks in targeted MA markets, but narrowing networks is not a national or core business strategy in MA. The large national insurers indicated that they do not have any markets in which they only offer a narrow-network plan. Instead, interviewees reported offering narrow HMO networks alongside their broad PPO networks as a lower-premium alternative.

The large national MA insurers have generally formed their narrow networks around health systems with which they have an existing relationship. These systems tend to be "high-value" with high quality and lower total costs than competitors. One MA insurer noted that they need to leverage the brand of an existing provider system to make a narrow network attractive to Medicare beneficiaries.

Two national MA insurers noted that the formation of narrow networks is often driven by local plan managers identifying an opportunity to partner more closely with a local health system, rather than a strategic decision by central headquarters.

We interviewed two health systems that own or partially own narrow-network MA plans centered around their system. These systems continue to be in-network with other MA insurers but operate their own MA plan alongside those relationships. Both health systems formed their own MA plans after many years of risk-based payment arrangements with large MA insurers, so they were experienced with managing utilization for Medicare patients. They described the attraction of starting an MA plan as gaining more of the premium dollar, which they were already partially managing through their capitation contracts with MA insurers.

It's being able to get 'well' money. Historically, hospitals get 'sick' money, but part of their 'well' dollars in that premium is up for grabs.
—Interviewee

Narrow Networks in Medicare Advantage Do Not Yield Price Discounts but Do Have Lower Total Costs

Unlike narrow networks in commercial plans, our interviewees confirmed that narrow networks in MA are not primarily formed to yield discounts on unit prices for plans in exchange for patient volume for providers. Both prior research and our interviewees indicated that unit prices in MA are generally based on the Medicare fee schedule and diagnosis-related group payment levels (Berenson et al. 2015; Pelech 2018; Trish et al. 2017), though our interviewees noted that post–acute care payments are generally lower than the Medicare fee schedule. However, three interviewees noted that Medicare inpatient payment system prices vary across hospitals because of graduate medical education payments, disproportionate-share hospital payments, and wage index and other geographic adjustments. The hospital wage index and geographic adjustments are particularly important in border counties between two metropolitan areas or between states.[3] Therefore, even in Medicare, MA plans are incentivized to avoid specific hospitals or geographic areas that receive large adjustment payments and therefore have higher prices.

It's trying to use low-cost drugs; not getting a specialist if it's not needed; not every headache needs an MRI; trying to keep people out of the hospital as much as possible, and when they get in, get them out as quickly as possible.
—Interviewee

Rather than focusing on unit price discounts, interviewees said that networks control use to address their primary concern: total costs, the result of use and price. Our interviews indicated that health systems based on a narrow network of providers have lower utilization than excluded providers. One health-system-owned MA plan described their approach to utilization as follows: "It's trying to use low-cost drugs; not getting a specialist if it's not needed; not every headache needs an MRI; trying to keep people out of the hospital as much as possible, and when they get in, get them out as quickly as possible."

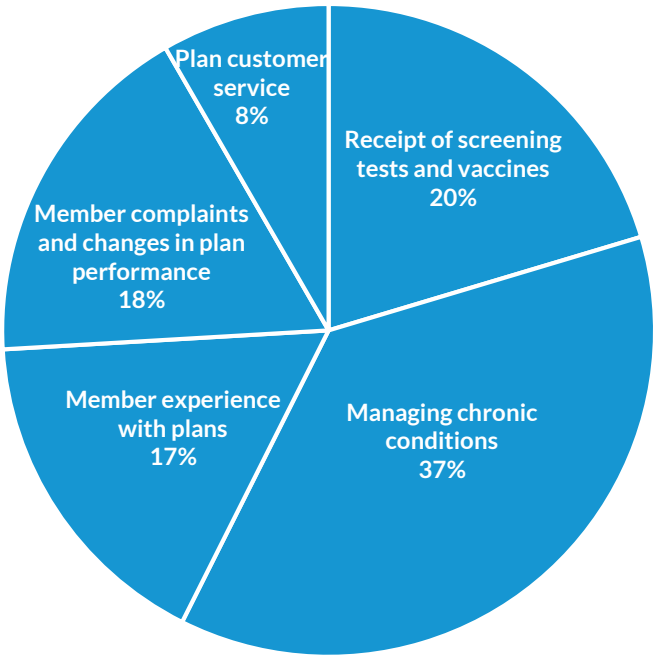
Star Ratings and Quality Are Major Considerations

All our MA insurer, health systems, and four expert interviewees indicated that star ratings were a major reason for forming narrow networks; MA plans' star ratings affect payment and enrollment patterns, and increasing star ratings is integral to increasing plans' revenues and enrollment.[4] MA plans with high star ratings receive bonuses to their benchmarks and payments from Centers for Medicare & Medicaid Services (CMS), and five-star plans can enroll Medicare beneficiaries at any time, not just during open enrollment or initial eligibility,[5] a significant competitive advantage.

Over half of MA plans' star ratings depend on physicians delivering appropriate services, including providing screening tests and vaccines and managing chronic conditions (figure 1).[6] Such clinical measures cannot easily be improved by plans without significant cooperation from primary care physicians and other clinicians.[7] Therefore, significant provider cooperation and buy-in are necessary for improving star ratings. One MA insurer said that it is all but impossible to get a five-star rating without a narrow network, and CMS data show that only vertically integrated and provider-led narrow networks received five-star ratings in 2018.[8]

FIGURE 1

Composition of Medicare Advantage Star Ratings, 2018



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Sources: Centers for Medicare & Medicaid Services. A list of measures included in each category is available at https://www.medicare.gov/find-a-plan/staticpages/rating/planrating-help.aspx, and weighting for each measure is available at https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/Downloads/2018MeasureList.pdf.
Notes: The estimates above do not include the Part D measures for Medicare Advantage plans that cover prescription drugs. Weights were applied to each measure to reflect their effect on overall star ratings. Thirty-four measures are included. With weights applied, the shares are calculated based on a maximum score of 54.

All MA insurers we interviewed focused on star ratings when forming narrow networks, though different insurers took different approaches. One MA insurer that focuses on HMO products said that they narrow primary care networks because they believe primary care drives star ratings. The large national MA insurers said they generally form narrow networks around already high-performing physician groups or hospital systems that have proven track records on quality and utilization.

[Star ratings are] the fulcrum of competition in these markets, and plans make decisions on which providers are in or out on the basis of stars.
—Interviewee

All the health systems echoed the MA insurers' emphasis on star ratings, and the two health systems that partially or fully own an MA plan said their high star ratings were integral to their success in MA. All but one MA expert also agreed that star ratings are a crucial consideration for MA insurers when forming networks. As one MA expert said, "I cannot emphasize enough how stars punches above its weight. It is the fulcrum of competition in these markets, and plans make decisions on which providers are in or out on the basis of stars."

Narrow Networks Can Improve Efficiency and Diagnosis Coding

Consistent with basing networks on preexisting, high-performing systems, all the MA insurers and two experts we interviewed said that narrow networks have lower administrative costs because there is less need for the plan to manage utilization and spending through prior authorization, step therapy, or denial of claims. MA insurers also said that narrower networks foster a deeper relationship between the plan and the selected providers, creating better coordination. MA insurers also noted that provider education on issues like diagnosis coding is simpler with a narrower provider panel that sees a higher concentration of MA patients.

Our interviewees also noted that narrow networks can ease diagnosis coding for risk adjustment, but that risk-adjustment coding is a critical component of MA revenue, regardless of network breadth. Narrow networks can limit the number of physicians and health plan administrators that plans need to coordinate with on medical record reviews and educate about diagnosis coding for risk adjustment, which increases plan revenue by increasing the apparent severity of their patients' conditions relative to traditional Medicare.[9] Narrow networks formed around a high-performing health system generally see more of their patients for annual wellness visits every year, which increases the opportunity for finding relevant diagnosis codes. As noted by one MA insurer that focuses on HMO products, "In Medicare, it is absolutely critical that the PCP [primary care physician] sees the member because everything flows from there, including care management, quality, documentation, and risk adjustment." However, all the MA insurers said that they work on coding with all their providers. One health system noted that providers are required by regulation to comply with MA plans' medical record review requests,[10] regardless of a plan's approach to networks and contracting.

Finally, none of our interviewees indicated that narrow networks are used systematically to select healthier patients from the Medicare risk pool. Two health systems indicated that networks formed around their system tend to have higher-than-average risk. One health system emphasized that having only healthy Medicare beneficiaries would significantly limit revenue, given the risk adjustment system,

making sicker enrollees more potentially profitable if plans and providers can effectively manage enrollees' conditions.

Sponsoring a Narrow-Network Medicare Advantage Plan Financially Benefits Health Systems

Of the five health systems interviewed, only one strongly preferred traditional Medicare to MA. The remaining systems either only took MA patients, owned or partially owned an MA plan, were seeking "percent of premium" arrangements with MA insurers, or some combination of the three. The two health systems that own narrow-network MA plans centered on their system emphasized that the attraction of starting an MA plan is getting access to a greater share of the premium dollar. These systems said they were confident they could manage Medicare patients better in MA than under traditional Medicare, and that starting their own MA plan allowed them to work with the full premium dollar rather than the smaller share of premium arrangements offered by large MA insurers.

Two interviewees noted that, financially, starting an MA plan may be more attractive than starting an Accountable Care Organization. One health system said that the shifting rules of Accountable Care Organizations make success difficult, making MA more attractive. One expert noted that clinically integrated systems that became Accountable Care Organizations are interested in starting MA plans to take on long-term risk without Accountable Care Organizations' frequent policy changes.

Narrow Networks Face Barriers in Medicare Advantage

The large MA insurers generally viewed the CMS network adequacy requirements as a condition of market entry, though two noted network adequacy requirements as a barrier to creating narrow specialist or hospital networks in MA. CMS requires MA plan networks to meet minimum provider-to-enrollee ratios and time-and-distance standards for 27 practitioner types and 23 facility types.[11] One MA insurer noted paying as much as 900 percent of the Medicare fee schedule, with other insurers noting less extreme rates that still far exceed Medicare's to meet network adequacy requirements rather than abandon the market. However, the health-system-owned MA plans expressed more frustration with the network adequacy requirements than the large MA insurers, noting that they have struggled at times to expand their plans into more rural areas because of limited availability of clinicians, particularly physician specialists. One expert said that CMS has not updated its approach to network adequacy to account for telemedicine or quality initiatives.

All the MA insurers agreed that narrow networks do not appeal to all Medicare beneficiaries. Large MA insurers generally offer both wide- and narrow-network products in a given market, with the narrow-network products generally having lower prices, lower cost sharing, and more benefits. The MA insurers also noted regional variations in the popularity of both HMO and narrow-network products. For example, two interviewees noted that narrow networks and closed HMOs have limited appeal in colder areas of the country where many Medicare "snow birds" tend to move south for the winter.

Medicare Advantage Plans Have Other Ways to Increase Revenue or Lower Costs

If they can meet the CMS network adequacy requirements, MA plans have broad latitude to exclude physicians and hospitals from their networks. Though the large national MA insurers indicated that narrow-network plans are nearly always formed alongside broader-network plans and don't exist everywhere in the country, almost all MA plans have a selective network,[12] even if it is broad. Even within broad networks, MA plans exclude outliers in terms of utilization, costs, and quality—something traditional Medicare cannot do. Two MA insurers noted that in areas where broad networks are performing well with cost and quality, narrowing networks would likely not confer a significant advantage. One expert noted that removing high-use providers from MA networks could potentially generate significant savings without the added work of forming a CMS-compliant, narrow-network plan. The MA insurers indicated that total cost, including utilization, is an important factor for deciding which providers to include or exclude from a network.

MA insurers also have tools beyond networks to control spending. All but one health system interviewed have undertaken risk-based arrangements with MA plans, which can generate savings for plans even if networks are broad. These arrangements encourage improvement in quality measures that underlie star ratings, which increase plans' revenue. One health system also noted that, in areas without narrow networks, MA insurers still have the tools of prior authorization and claims denial to keep costs and utilization down.

Conclusions

In contrast to commercial markets, narrow networks in MA markets are neither motivated by nor generate significant unit-price discounts for insurers in exchange for higher patient volume for health systems. Our interviewees confirmed that the Medicare payment amounts are the basis for hospital and physician payments in MA regardless of network breadth, though post–acute care payments are

generally lower than the Medicare fee schedule. Cost savings from narrow networks in MA derive instead from established health systems' lower utilization and higher quality. Star ratings are a major consideration when forming networks because high star ratings provide financial benefits through reimbursement bonuses and allow for year-round open enrollment. Because most star ratings measures rely in part on clinician performance, our interviewees noted it is nearly impossible to get a five-star rating without a narrow network.[13]

Overall, our interviewees emphasized that narrow networks depend on local market conditions and therefore are not a national or core business strategy for large MA insurers. Large MA insurers also tend to offer broad PPO products alongside narrow-network products in markets where narrow networks are viable, leaving beneficiaries with a choice of network breadth. Provider-owned MA plans, in contrast, tend to be narrow by nature, but the health systems that own MA plans that we interviewed also participate in broader MA plans offered by other insurers. Though our interviews did not directly address the prevalence of narrow networks, the large national insurers indicated these products were not a significant portion of their business. Prior quantitative research suggested that narrow physician networks were fairly common in MA (Jacobson et al. 2017), but narrow hospital networks were more rare (Jacobson et al. 2016), and some of the discrepancy between our interviewees' impressions and those findings may owe to differences in narrow network definitions, which can be based on inclusion of hospitals, physicians, or both. Also, HMO models are quite popular in MA (Jacobson, Damico, and Neuman 2017), and these approaches can pair narrow primary care networks with wide hospital networks while relying on a gatekeeper model to keep hospital costs down.

Because of their operational style, narrow networks also lower MA plan administrative costs and can provide more detailed diagnosis coding. Though our MA insurer interviewees emphasized that diagnosis coding is not a significant consideration when forming a narrow network, they did say that educating a smaller panel of physicians and building a deeper relationship with a narrow network of providers allows for better coding.

Narrow networks are present and viable in MA, and they can have cost and revenue benefits for insurers. However, the incentives for forming narrow networks differ between MA and other private insurance markets. MA plans benefit from traditional Medicare's pricing structure, lowering pressure to achieve price concessions through network strategy, but they must compete for enrollees against traditional Medicare's open network. MA insurers also have opportunities to lower costs relative to traditional Medicare without narrowing networks, such as by excluding outlier providers or imposing utilization management requirements like prior authorization. Although our interviewees recognized narrow networks' importance to the MA market, particularly among provider-sponsored plans, they

indicated that narrow networks are not a predominant strategy in MA like in the Affordable Care Act Marketplaces.[14]

Notes

1 Andrea Elizabeth Caballero, Roslyn Murray, and Suzanne F. Delbanco, "Are limited networks what we hope and think they are?" *Health Affairs Blog*, February 12, 2018, https://www.healthaffairs.org/do/10.1377/hblog20180208.408967/full/.

2 In 2017, over two-thirds of MA enrollees were in HMO plans.

3 For example, the 2017 wage index for Washington, DC, was 1.0245 but was only 0.9525 for Baltimore, creating incentives for MA plans in Maryland to favor Baltimore-area hospitals over DC-area hospitals.

4 "The impact of star ratings on rapidly growing Medicare Advantage market," Navigant, February 27, 2018, https://www.navigant.com/insights/healthcare/2018/medicare-advantage-star-ratings-analysis.

5 "5-star plan ratings," Centers for Medicare & Medicaid Services, March 2014, https://www.cms.gov/Outreach-and-Education/Training/CMSNationalTrainingProgram/Downloads/2014-5-Star-Plan-Ratings-Overview-Job-Aid.pdf.

6 This also implies that an MA plan's performance may depend on the geographic location in which it operates, because some geographic areas have few higher-performing providers, even with narrow networks.

7 Richard Bajner, Eric Meinkow, Janet Munroe, James R. Smith, and John McHugh, "Impact of star ratings on Medicare Advantage plan success," Becker's Hospital CFO Report, March 15, 2018, https://www.beckershospitalreview.com/finance/impact-of-star-ratings-on-medicare-advantage-plan-success.html.

8 In 2018, only nine five-star MA contracts existed nationally, all of which have provider-owned, narrow-network models. Of these, four were Kaiser Permanente, one was Tufts, and four were local-system or provider-owned plans.

9 MA plans tend to code more diagnoses than traditional Medicare, resulting in higher risk-adjustment payments. This practice costs the Medicare program but benefits plans. CMS automatically lowers MA's risk adjustment payments to account for this higher "coding intensity," though MedPAC contends that the CMS coding adjustment does not fully account for plans' increased coding intensity or favorable selection even within a diagnosis (MedPAC 2017).

10 42 CFR § 422.310 Risk adjustment data (Aug. 19, 2008).

11 "Medicare Advantage network adequacy criteria guidance," Centers for Medicare & Medicaid Services, January 10, 2017, https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/Downloads/MA_Network_Adequacy_Criteria_Guidance_Document_1-10-17.pdf.

12 Private fee-for-service plans, which generally have an open network, only had about 200,000 MA enrollees nationwide in 2017 (Jacobson, Damico, and Neuman 2017).

13 See note 8.

14 In 2017, 49 percent of Marketplace plans included fewer than 70 percent of the hospitals in their rating area (McKinsey&Company 2017).

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