McKinsey Center for U.S. Health System Reform

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Hospital networks: Perspective from three years of exchanges

As of 03.05.2016

Hospital networks: Perspective from three years of exchanges

We analyzed every hospital network across the country and uncovered the following insights:

1. Proportion of narrowed networks has remained relatively constant, yet the overall number of networks has declined
2. Median premiums for narrowed-network plans have declined even further compared to broad-network plans
3. Consumers' choice of networks has declined, with more consumers only having access to narrowed networks in 2016
4. Margins are higher for exchange carriers with narrowed networks than those with broad networks
5. Co-branded provider/carrier relationships have become increasingly common

SOURCE: McKinsey Center for U.S. Health System Reform

DEFINITIONS

Network types vary in their hospital participation:

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 network: Narrow, ultra-narrow, and tiered network, unless otherwise noted.

Note: Only hospital networks are considered in these analyses. Physician networks are not covered.

Plan types 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 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 co-payment.

POS (point-of-service plan): a hybrid of an HMO and a PPO; offering an open-access model that may assign members to a primary care physician and usually provides partial coverage for out-of-network services.

Other terms:

Competitively priced plan: Any plan within 10% of the lowest-price plan within the relevant market and on the relevant metal tier.

Co-branded plan: Any insurance plan offered by a carrier that includes the brand name of or refers to the brand of a healthcare provider.

SOURCE: McKinsey Center for U.S. Health System Reform

Distribution of individual exchange hospital networks by breadth

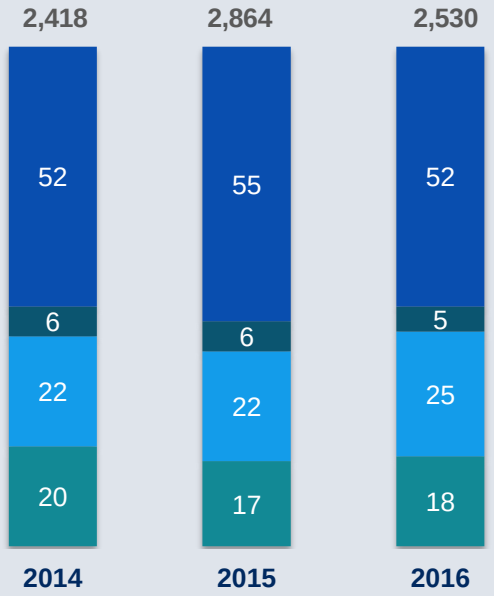
- The proportion of narrowed networks has remained relatively flat.
- Yet, total number of networks decreased over 10% from 2015 to 2016, primarily driven by carrier exits[1]. 66% of terminated networks were broad, while 45% of newly added networks were broad.[2]

Across the U.S.

% of hospital networks across all metal tiers

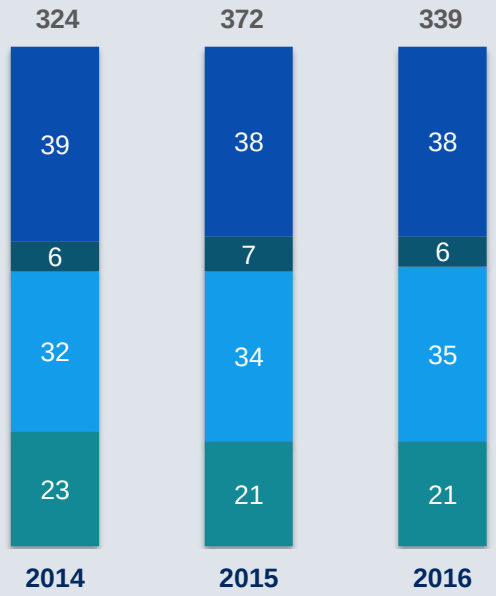
100% = Number of network-rating area combinations[1]

KEY:
- Broad
- Tiered
- Narrow
- Ultra-narrow



In the largest city of each U.S. state

% of hospital networks across all metal tiers



1 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, potentially with different network breadths).

2 437 networks were lost in 2016 due to carrier exits; of these, 73% were broad.

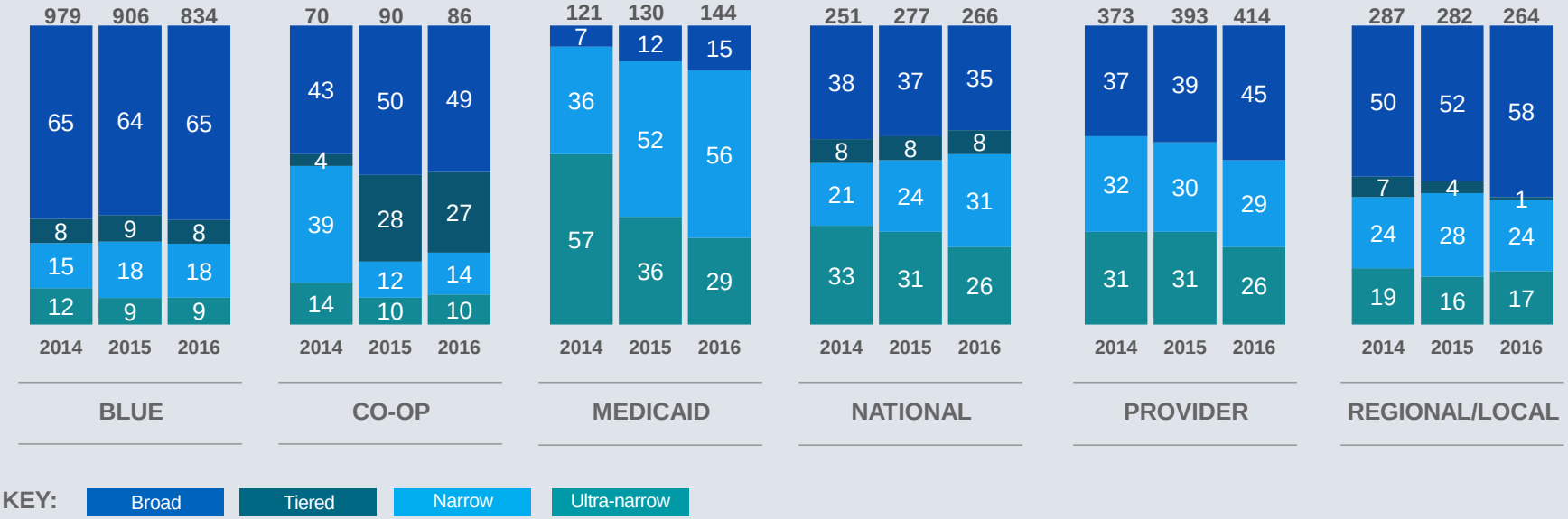
SOURCE: McKinsey Center for U.S. Health System Reform

Network breadth by carrier type

- While most carrier types offered fewer networks this year than in 2015, many Medicaid carriers and providers increased the number of networks they offered.
- Medicaid and national carriers, in aggregate, have increased their proportion of narrow networks (from 52% to 56% and 24% to 31%, respectively).
- Blues continue to offer the highest proportion of broad networks — about two-thirds.

% of networks across tiers by network breadth, for carriers participating across 2014–2016[1]

100% = Number of network-rating area combinations



KEY: Broad | Tiered | Narrow | Ultra-narrow

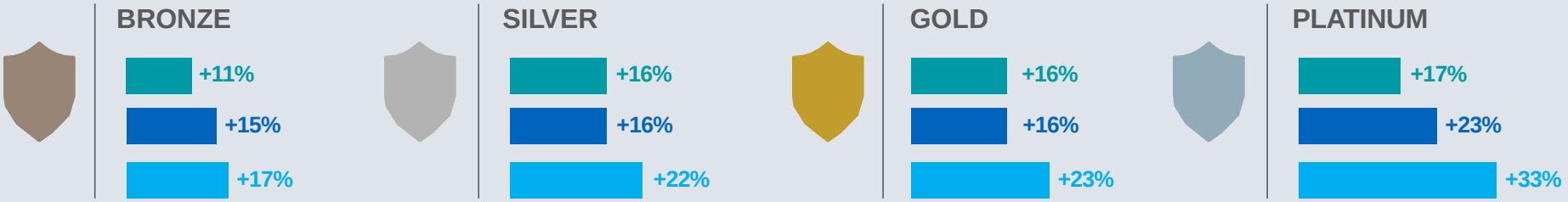
1 Only carriers who participated in their state for all 3 years are shown, in order to exclude effects of carrier exits and entrances.

SOURCE: McKinsey Center for U.S. Health System Reform

Premium difference between broad and narrowed networks

- **In 2016, premium differences between narrowed and broad networks have widened across all metal tiers, although factors beyond hospital network breadth may have played a part.**
- **On the silver tier, the most commonly purchased, broad networks are now 22% higher priced than narrowed ones, compared to 16% in 2014 and 2015.**

% difference between median premium for broad and narrowed networks from the same carrier and plan type[1,2,3]



KEY: 2014 | 2015 | 2016

1 Narrowed networks comprise ultra-narrow and narrow networks in this analysis, i.e., any with network breadth less than or equal to 70%. Tiered networks are excluded from the analysis.

2 Plan types include PPO, HMO, EPO, and POS.

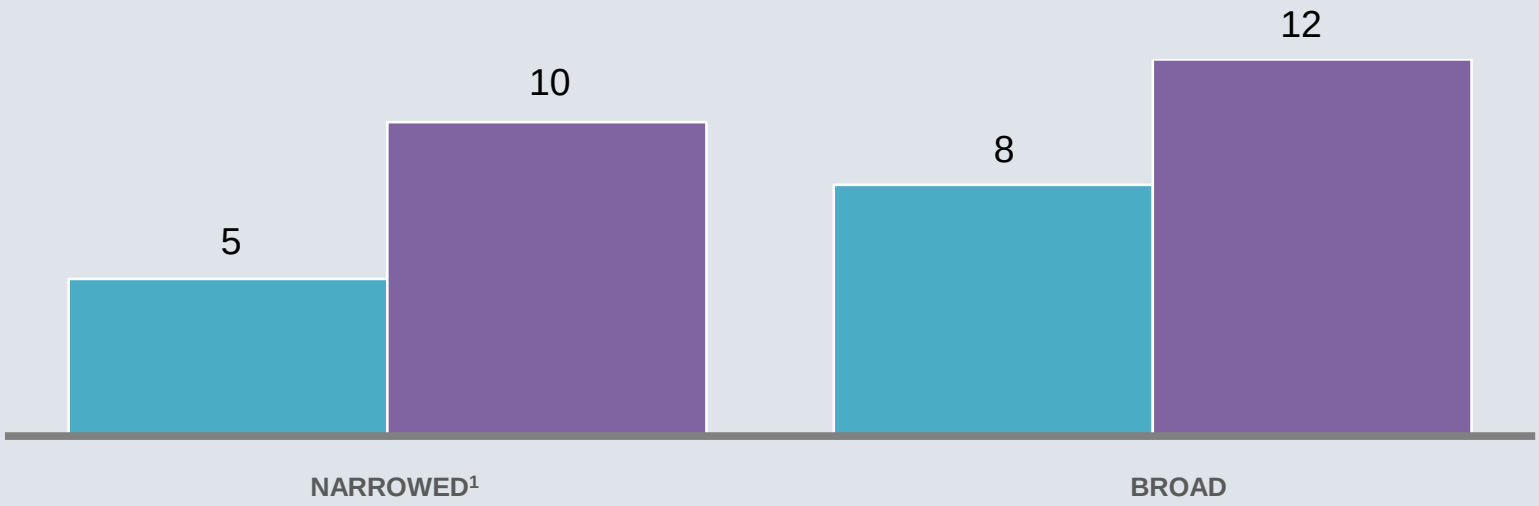
3 Median prices are based on premiums for a 40–year-old single non-smoker. When a network has multiple plans, the lowest-price plan is used as price of the network. If there are multiple networks available for selection as "narrowed," the narrowest is selected. If there are multiple networks available for selection as broad, the broadest is selected.

SOURCE: McKinsey Center for U.S. Health System Reform

Premium increases for broad and narrowed networks

Narrowed network plans had lower premium increases than broad network plans for the past two years.

% median silver premium increases among re-filed 2014 and 2015 plans



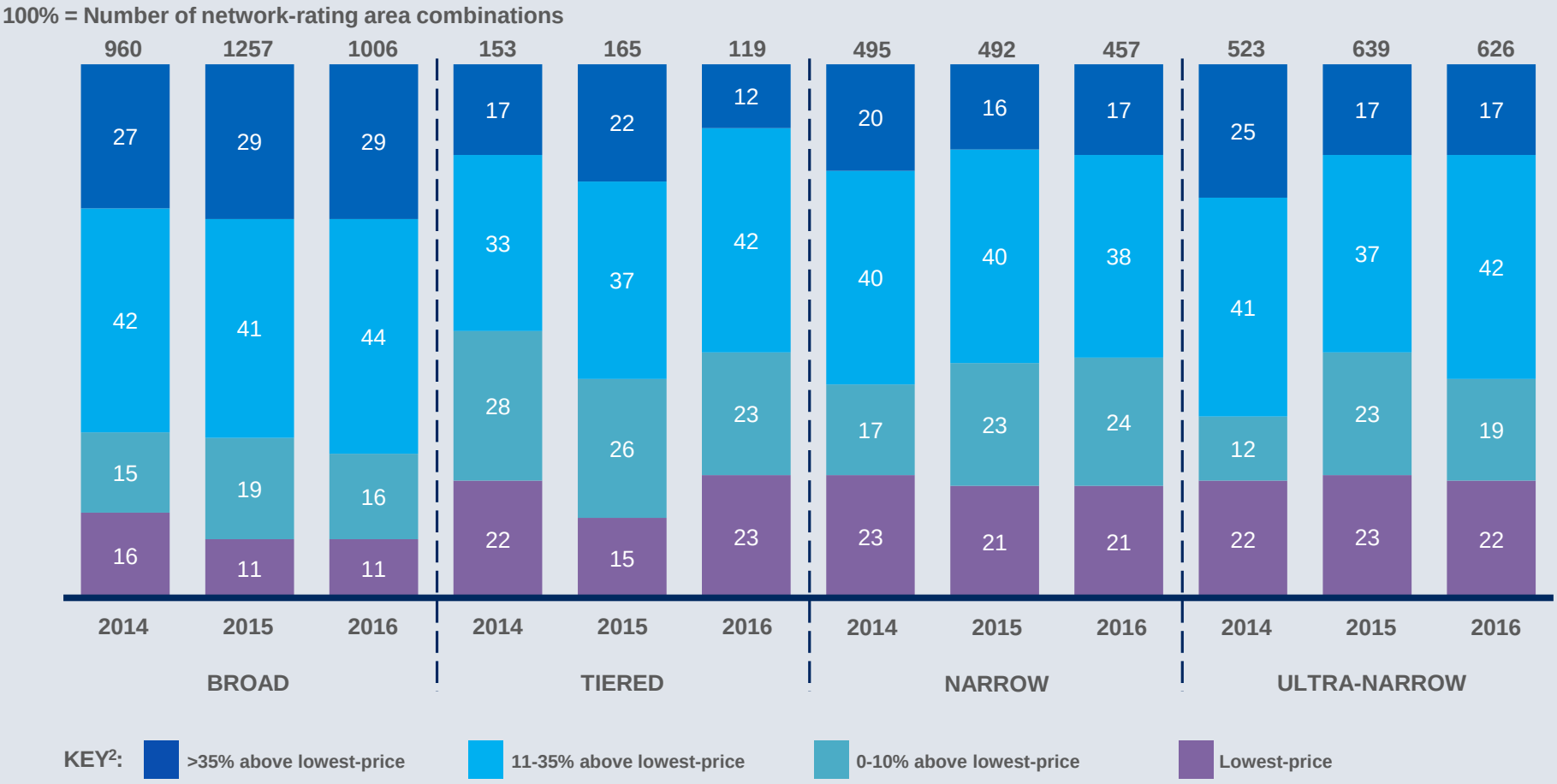
1 Includes ultra-narrow, narrow and tiered networks.

SOURCE: McKinsey Center for U.S. Health System Reform

Price gap to lowest-price plan by network breadth

- Close to half of narrow and ultra-narrow networks are priced competitively (within 10% of lowest price) in 2016, compared with less than a third of broad networks.
- Price competitiveness of narrowed networks is increasing, while price competitiveness of broad is declining.

% of networks by price category[1] in regions with at least one narrowed network



1 Price category 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. For networks with multiple plans at different prices within the same tier and rating area, the lowest-price plan is used.

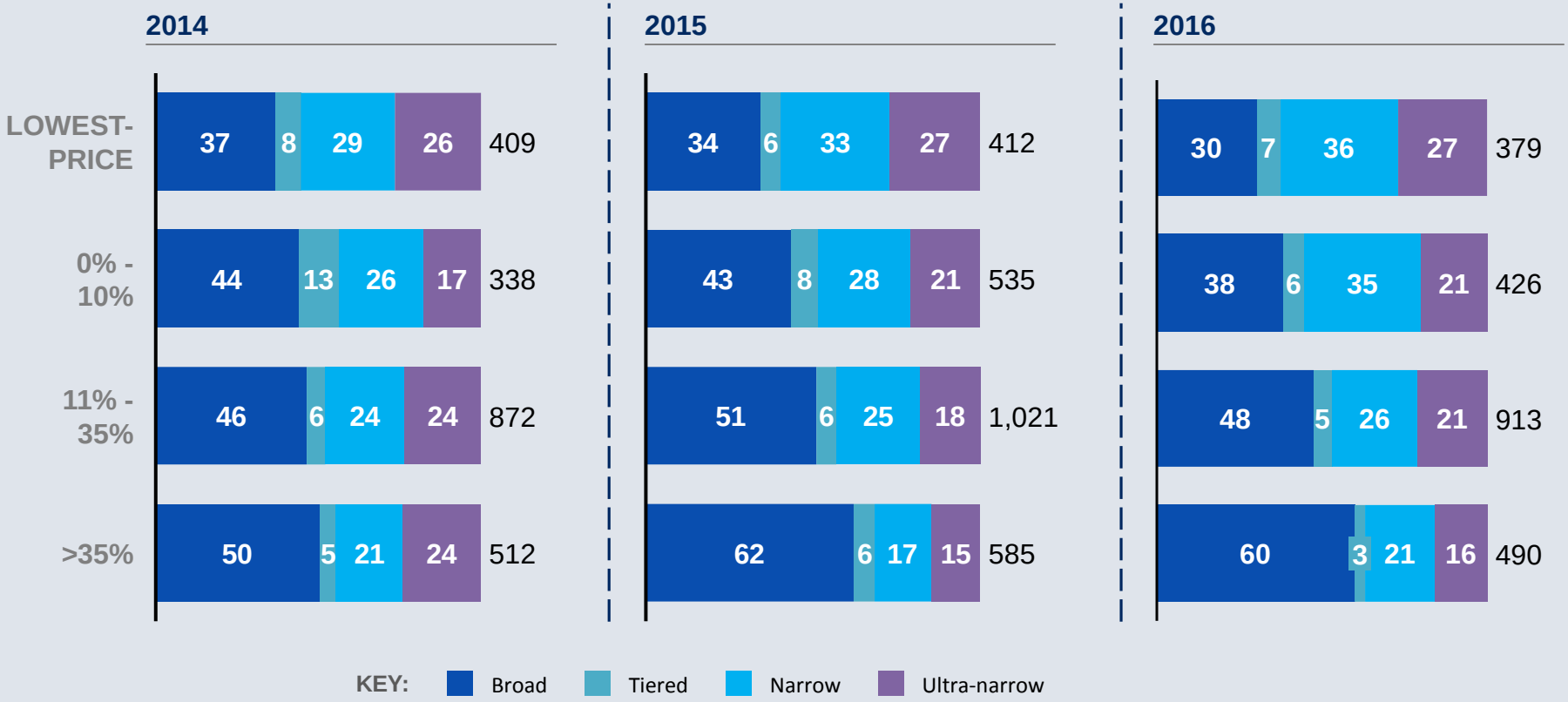
SOURCE: McKinsey Center for U.S. Health System Reform

Price category by network breadth

Narrowed networks continue to be more common among lower-price plans; the proportion of narrowed networks among price leaders increased from 66% to 70% in 2016.

% of networks in each price category[1] by breadth in rating areas with at least one narrowed network

100% = Number of network-rating area combinations



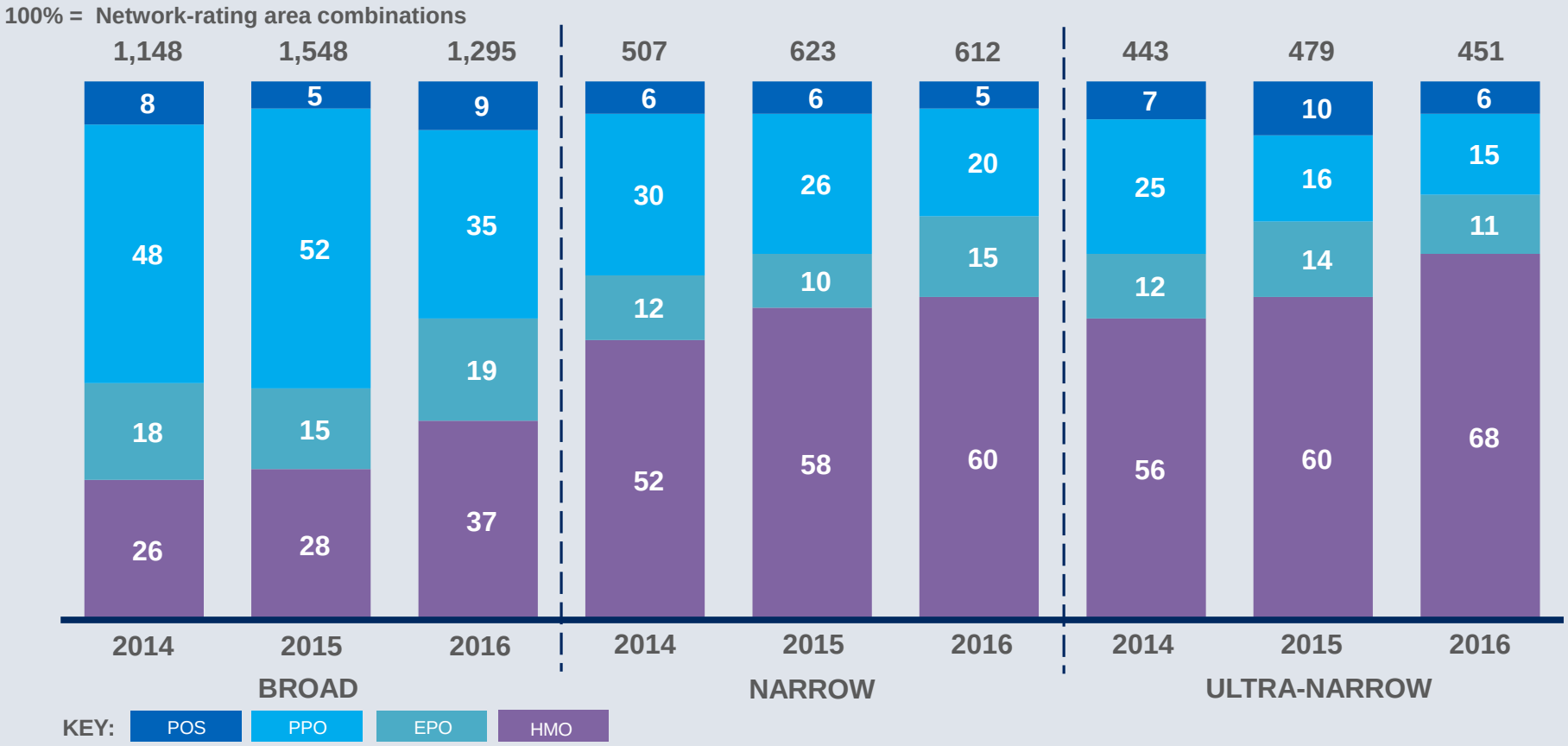
1 Price category is defined as the premium gap to the lowest-price product. This is the difference between a network's lowest-priced plan and the lowest-priced plan within the same metal tier in the same rating area. For networks with multiple tiers, the tier used for the network price is chosen in priority 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 is used.

SOURCE: McKinsey Center for U.S. Health System Reform

Trends across network breadth and plan type

Plans are becoming more managed (i.e., HMO's, EPO's) across all network breadth types, which can lead to less consumer choice at the point of care.

% of silver network offerings by plan type[1,2]



1 Plan types reported were taken directly from exchange websites and Summary of Benefits and Coverage (SBC) documents.

2 When multiple silver plans are available on a single network we use the plan type associated with the lowest-price silver plan in that network.

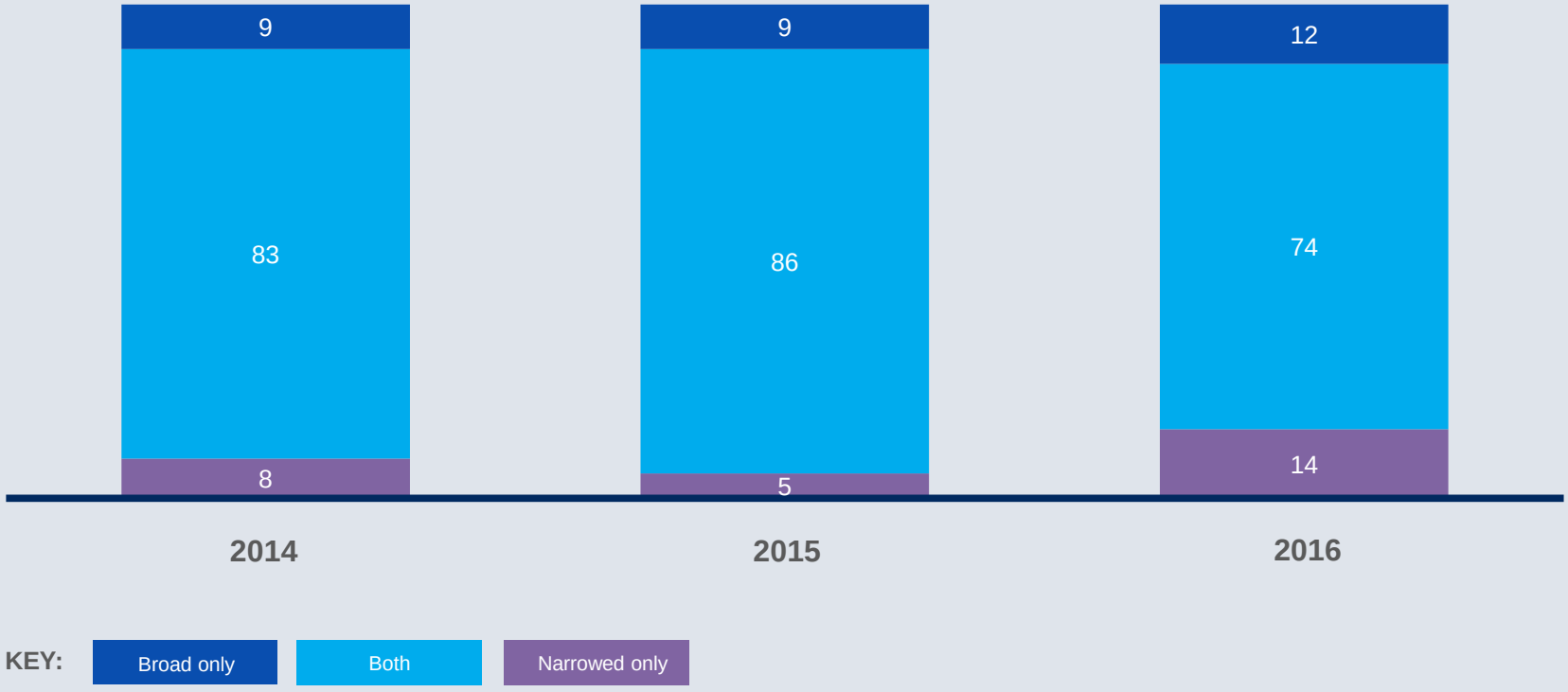
SOURCE: McKinsey Center for U.S. Health System Reform

Consumer access to network types

- Consumer choice of network breadth at the point of purchase is declining in some places.
- There is a nearly three-fold increase in the percentage of consumers who have access to only narrowed networks.
- Access to both broad and narrowed networks declined for most urban consumers (89% to 74% from 2015-16) but increased for rural consumers (45% to 69%).

% of QHP-eligible consumers with access to various network types[1]

100% = 39M QHP-eligible consumers



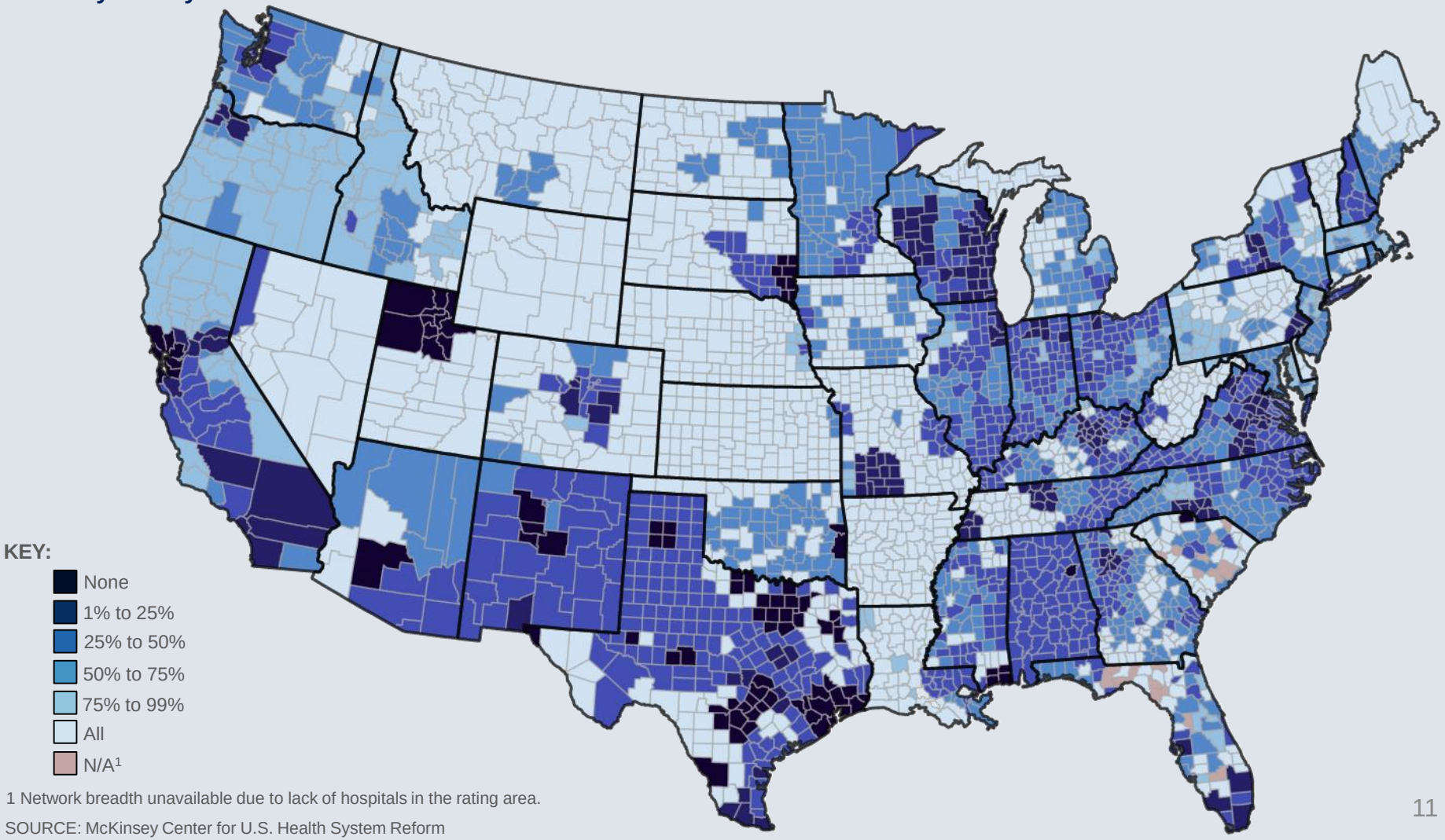
1 Whether broad, narrowed, or both breadth types were available was determined on a county level, and QHP-eligible consumers residing in county were counted toward given category.

SOURCE: McKinsey Center for U.S. Health System Reform

Geographic distribution of network composition in 2016

- **Between 2015 and 2016, median network breadth stayed relatively constant in urban counties, but increased in rural counties.**
- **Carriers in markets with higher carrier and provider fragmentation are more likely to offer narrowed networks.**

% of hospital networks classified as broad by county



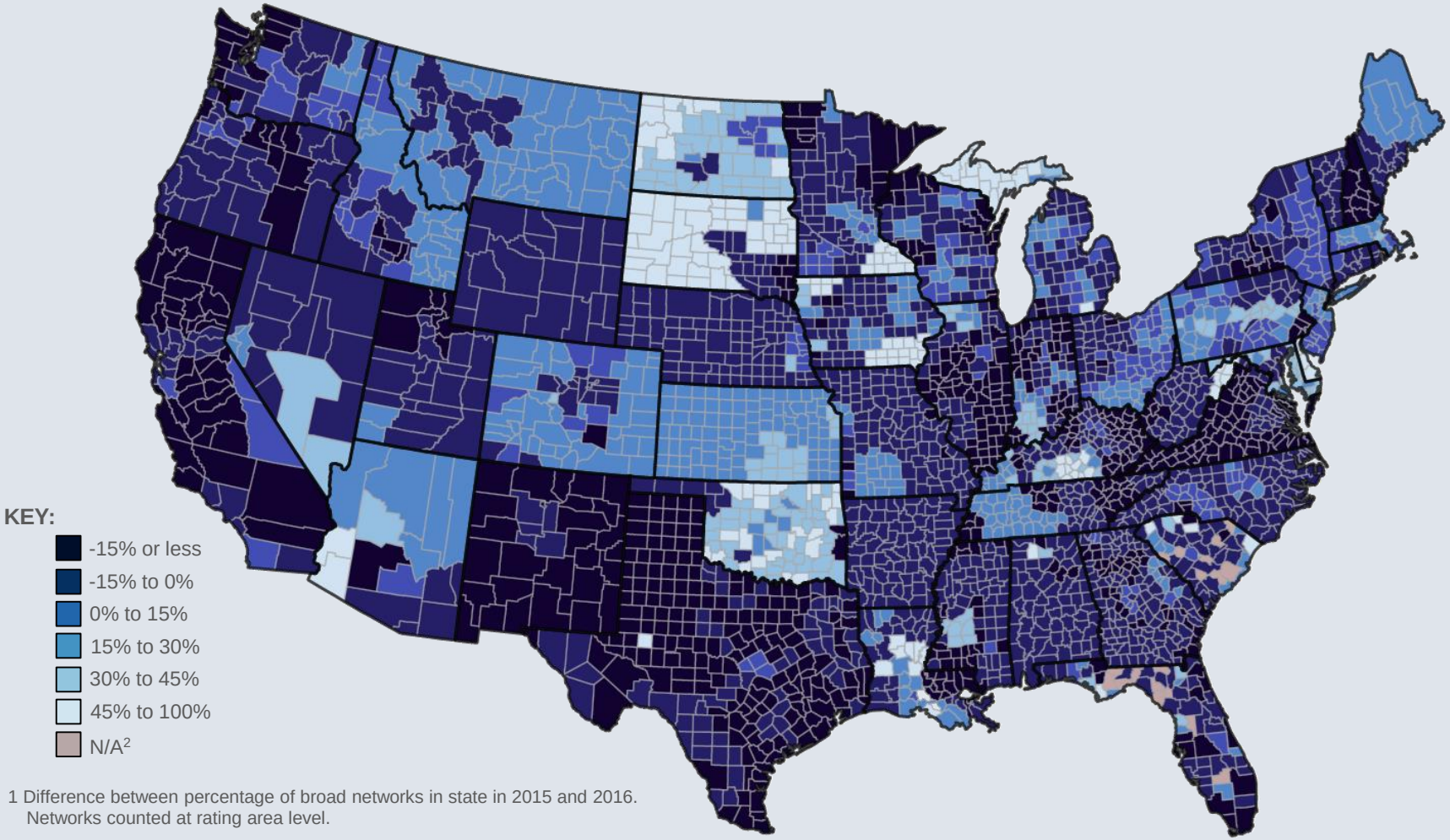
1 Network breadth unavailable due to lack of hospitals in the rating area.

SOURCE: McKinsey Center for U.S. Health System Reform

Difference in distribution of exchange networks between 2015 and 2016

- **The largest increases between 2015 and 2016 in the proportion of broad networks were seen in Delaware (50%) and Iowa (31%).**
- **The largest decreases in the proportion of broad networks were seen in Texas (-25%) and Utah (-25%).**

Change in the % of hospital networks classified as broad[1]



1 Difference between percentage of broad networks in state in 2015 and 2016. Networks counted at rating area level.

2 Network breadth unavailable due to lack of hospitals in the rating area.

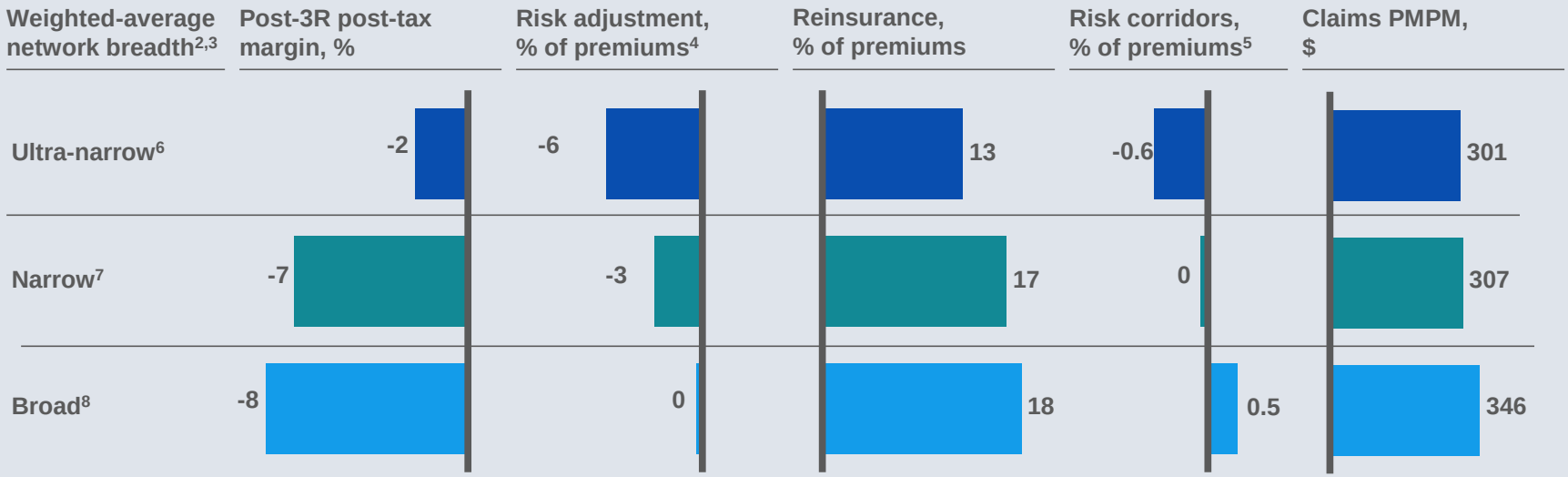
SOURCE: McKinsey Center for U.S. Health System Reform

2014 post-3R financial performance and network breadth

- In 2014, while overall, only 30% of carriers were profitable, exchange carriers[1] with narrowed networks [2,3] fared better: of these, 39% were profitable vs. 26% with broad networks[3].
- Exchange carriers with narrowed networks had better margins and lower claims, in aggregate, than those offering broad.
- Carriers[1] with narrowed networks also received less in reinsurance than other carriers did, and may be less affected by the program's termination in 2017.

Select 2014 post-3R, post-tax individual market financial metrics across exchange carriers[1]

QHP-members weighted-average



1 Carrier performance was determined at the NAIC/HIOS state-level entity level. Analysis only includes entities HIOS ID's associated with on-exchange plans in 2014, with >1K 2014 QHP members.

2 In this analysis, tiered networks are assigned to the ultra-narrow, narrow, or broad category based on the breadth of the first tier.

3 Network breadth for each entity is rolled-up to a state-level (from county) using QHP-eligible population and the 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.

4 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. In aggregate, risk adjustment for all exchange entities amounted to –1% of premiums.

5 Net risk corridor payments across these carriers amount to -$17M.

6 The ultra-narrow category includes 38 entities (17 with positive margins), 12% of the premiums among exchange entities (post-3R, post-tax margin as percentage of premium ranged from -51% to 15%).

7 The narrow category includes 104 entities (39 with positive margins), 50% of the premiums among exchange entities (post-3R, post-tax margin as percentage of premium ranged from -77% to 17%).

8 The broad category includes 92 entities (24 with positive margins), 38% of the premiums among exchange entities (post-3R, post-tax margin as percentage of premium ranged from -146% to 26%).

SOURCE: McKinsey Center for U.S. Health System Reform

Offering and price competitiveness of co-branded and provider-led plans

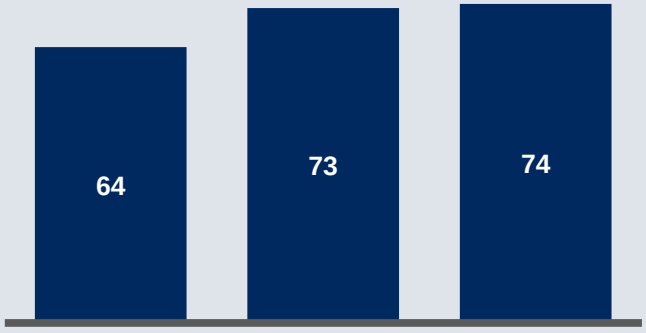
- In 2016, the number of co-branded relationships increased 13%, while the net number of provider-led carriers remained relatively flat.
- Yet, in 2016 only 18% of consumers have access[1] to a co-branded plan, compared to 60% who have access to a provider-led plan.
- Provider-led plans are the lowest-price option for more consumers this year – and, when compared to co-branded plans.

Co-branded relationships

Number of co-branded relationships[2]

Provider-led carriers

Number of carriers[2]



	2014	2015	2016
% of QHP-eligible with access[1]:	9%	18%	18%
% of QHP-eligible in a market where respective carrier is lowest-price:	28%	26%	24%

	2014	2015	2016
% of QHP-eligible with access[1]:	55%	59%	60%
% of QHP-eligible in a market where respective carrier is lowest-price:	18%	23%	31%

1 Access to plan type defined as the co-branded or provider-led plan being available in the given county.

2 Counted at state level.

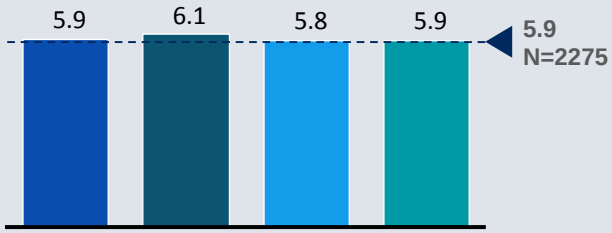
SOURCE: McKinsey Center for U.S. Health System Reform

2015 CMS hospital performance metrics and 2016 network breadth

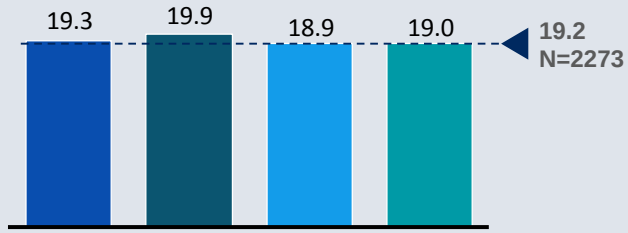
We continue to observe no signifcant difference in CMS hospital performance scores for narrowed vs. broad networks.

Weighted-average scores for all exchange hospital networks by breadth across four domains of total performance score[1,2]

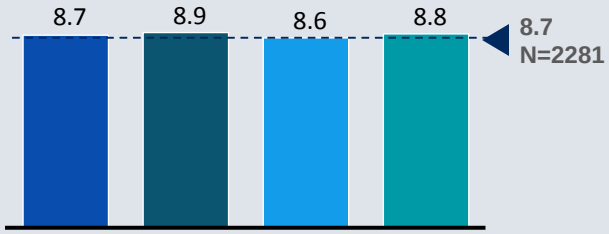
Clinical process domain score



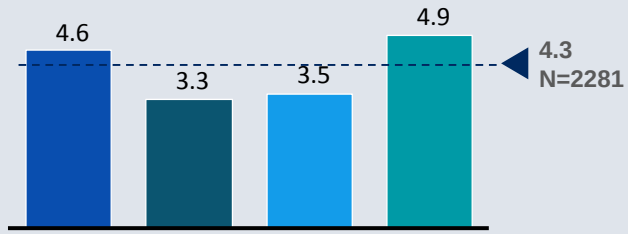
Outcome domain score



Patient experience domain score



Efficiency domain score



KEY: Broad | Tiered | Narrow | Ultra-Narrow

1 Across all hospital 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 scores for given network breadths, weighted by the number of inpatient admissions for each in-network hospital in a given network.

SOURCE: McKinsey Center for U.S. Health System Reform

METHODOLOGY AND SOURCES

The above findings are based on publicly available data.

Other relevant publications can be found at these sites:

http://healthcare.mckinsey.com/2015-hospital-networks

http://healthcare.mckinsey.com/2014-individual-market-post-3r-financial-performance

http://healthcare.mckinsey.com/2016-exchange-market-remains-flux-plan-type-trends

Pricing: Individual exchange premiums were obtained from state-based exchange websites and CMS / healthcare.gov public use files. For analyses involving comparison 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.

Hospitals: All hospital data was obtained, as is, from carrier website provider search tools available to consumers. Hospital network data over 2014–2016 was collected from carrier websites. Our analysis focuses 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-AV 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 front of the document. Adjustments were made to CMS rating area definitions for AK, ID, MA, and NE to convert their 3-digit zip rating area definitions to a county-based definition. These rating area adjustments are made to be as close as possible to (for MA), or identical to (for AK, ID and NE) 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 3R reports. We analyzed all available data for 2014 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, report 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 front of the document.

SOURCE: McKinsey Center for U.S. Health System Reform