

Health Plans: Balancing Affordability and Network Adequacy

**LEAD
the WAY**

Building a People-Centered Health System



Trinity Health is one of the largest multi-institutional Catholic health care delivery systems in the nation, serving diverse communities that include more than 30 million people across 22 states. We advocate for public policies that promote care for the common good including expanding health care coverage and care, investing in public health, paying for high-value care, and improving the health of communities.

Health plans should offer products that aim to achieve high-quality, affordable coverage and better health outcomes – while balancing access to a broad range of providers and care settings. Federal and state governments play an important role in ensuring that adequate consumer protections and transparency are in place.

Policymakers must balance legitimate concerns that high-performance networks may limit patient choice and reduce access to necessary services with recent research demonstrating the potential of these networks to hold down costs while ensuring high-quality care. According to a report by Milliman, these networks help reduce premiums by up to 20 percent or more, and encourage higher-quality care than more expensive health insurance products built using broad networks.¹ Another study found that spending fell by an estimated 40 percent for state employees who switched to a high-performance network plan from lower spending on specialists, hospital care and emergency department visits.²

Providers Are Critical in Health Plans

Trinity Health participates in 18 high-performance networks across the country, 13 of which are offered on the health insurance marketplaces. This number, across Trinity Health, will likely grow 2 to 3 times by 2018.

Providers engaged in these networks are being clearly held accountable for health outcomes and improving people's health. Individuals in these networks are receiving coordinated, clinically integrated care.

Monitoring network adequacy is a critical consumer protection. To ensure health plans are focused on better health, better care and lower cost, states should adopt and implement key components of the recently updated "Health Benefit Plan Network Access and Adequacy Model Act" developed—with broad stakeholder input—by the National Association of Insurance Commissioners (NAIC). Trinity Health believes that networks, which are not only high in performance but also facilitate care coordination among providers and across settings, are critical to building a People-Centered Health System. These plans are more consumer-centric and facilitate engagement of consumers in their health and health care decisions. The plans are also sustainable because well-managed populations lead to less premium increases year over year.

What Can Policymakers Do?

Balance State and Federal Roles in Developing Consistent, Quantitative Standards

Consistency and transparency are important in the development and enforcement of network adequacy standards that balance access with coordination and affordability. There is a role for both the federal and state governments in this process. State insurance commissioners need to be actively engaged in order to best balance cost, access and geographic considerations when developing appropriate network adequacy standards for qualified health plans (QHPs) and/or Affordable Care Act (ACA) compliant plans. Merely forcing plans across all markets to broaden their networks will

¹ High-Value Healthcare Provider Networks, Milliman, July 2, 2014.

² Controlling Health Care Costs Through Limited Network Insurance Plans: Evidence from Massachusetts State Employees, Gruber, J. & McKnight, R. [NBER Working Paper No. 20462](#). September 2014.

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not guarantee that a consumer's preferred provider would even be included within a network, or that the consumers' experience of finding an available provider will be any easier. People-centered health plans will include a network of providers who are clearly accountable for health outcomes. Transparency around which providers are in the network as well as pricing transparency are critically important to ensuring that consumers are engaged and making educated decisions.

Recommendations:

- Advance the recently revised NAIC Model Act—the "Health Benefit Plan Network Access and Adequacy Model Act"—as a discussion starter and improve upon it with the addition of quantitative measures and a longer-term "surprise billing" solution.
- Support the inclusion of consistent, quantitative network adequacy measures that are developed in a timely and transparent process. The county classification system used in Medicare Advantage (MA) is a good model for states to replicate. This will also ease the administrative burden and ensure consistency.

Ensure Robust Education and Transparency for Consumers

High-performance networks are effective at reducing the price of coverage but this comes with a tradeoff – the choice of providers is reduced. It is important that consumers recognize this tradeoff at the point of purchase. Education and transparency are important to ensuring that consumers are well informed in order to make the appropriate decisions about their coverage options. It is critical that the patient be aware of their out of pocket liability before services are provided so patients have a clear understanding of their in- and out-of-network costs in order to make more informed decisions. With real-time insurance verification and access to information on the patient's premium and co-pay obligations, providers can play an important role in assisting consumers at the time of service.

Recommendations:

- Ensure that clear and comprehensive information about health plan options, including covered benefits, prescription drug formularies, provider networks, cost, out-of-pocket liability and quality ratings are easy to understand, accurately displayed, and updated regularly.

Address Surprise/Balance Billing Concerns

Increasingly patients are receiving emergency and some non-emergency care at in-network facilities from out-of-network providers, which often results in patients receiving "surprise bills"—a result of balance billing—from the out-of-network providers. Because most of the out-of-network providers do not have the same contractual obligations as those in-network, the out-of-network providers are able to balance bill the patient for the difference between the health plan negotiated allowed charge and the full charge. Everyone plays a role in helping consumers to navigate the care delivery system, including health plans, hospitals and providers. The education and transparency discussed above is critical to these efforts, but additional policy on surprise/balance billing is necessary. The structured mediation process suggested in the NAIC Model Act, however, has not demonstrated effectiveness in addressing these issues and should not be adopted.

Recommendations:

- Apply the coverage structure for those enrollees who receive out-of-network emergency care, to those receiving non-emergency services as well. In these emergency cases, a plan must pay out-of-network providers the highest of: 1) the median in-network rates; 2) UCR (usual, customary and reasonable) rates; or 3) Medicare rates for that service. This will enable providers to work collaboratively with payers to address surprise/balance billing of consumers.
- Develop a consumer protection model which provides for enhanced transparency, further disclosures and notifications from insurers and providers, and restrictions on surprise/balance billing of patients. The policy implemented in 2015 in the state of New York serves as an example.

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Mission: We, Trinity Health, serve together in the spirit of the Gospel as a compassionate and transforming healing presence within our communities.

Core Values: Reverence • Commitment to Those Who Are Poor • Justice • Stewardship • Integrity

