Health Plan Networks and Specialty Hospitals

KEY TAKEAWAYS

Consumers have access to specialty hospitals through health plan contracts with these facilities, centers of excellence, and processes to access out-of-network care when necessary.

A recent AHIP analysis found striking differences between the average charges of specialty versus non-specialty hospitals for many routine procedures.

Maintaining flexibility for health plans to design their provider networks is essential to promoting access, affordability, and value for consumers.
Background

Provider networks have been a mainstay of private health insurance coverage for more than 35 years — providing consumers with access to a broad range of hospitals, physicians, and other health care providers, along with financial incentives for members to obtain care within the plan’s provider network. Virtually all private health insurance coverage — including benefits administered by private plans in public programs such as Medicare, Medicaid, and CHIP — utilizes provider networks to deliver health care benefits and services. It is estimated that 90% of all hospitals and physicians participate in health plan networks.¹

Provider networks serve the dual purposes of promoting safe, quality care, as well as affordability. By including hospitals, physicians, and other key care providers who have met standards set by established accrediting organizations in their networks, health plans work to ensure that consumers have access to high-quality, effective care. Provider networks also enable health plans to make care more affordable for consumers by negotiating better prices with physicians and hospitals and protecting consumers from “balance billing” by network providers.

Recent Developments on Provider Networks and Specialty Hospitals

With the establishment of new health insurance marketplaces in 2014, consumers have become more involved in directly purchasing health insurance. This higher level of engagement has led to increased attention to health plan networks, including the extent to which certain types of providers are included in the networks. For example, certain specialty hospitals have called for more expansive inclusion in plan networks.

There have been several new developments and ongoing efforts related to assessing health plan networks and making sure that consumers have sufficient access to the providers and facilities they need. For example, qualified health plans (QHPs) operating in the new health insurance marketplaces need to meet a variety of access requirements, one of which relates to the inclusion of “essential community providers.” Essential community providers (ECPs) are defined to encompass six major ECP categories:

- federally-qualified health centers
- Ryan White providers
- family planning providers
- Indian health providers
- hospitals
- other ECP providers that serve predominately low-income, medically underserved individuals

Most recently, in the 2016 Notice of Benefit and Payment Parameters, the Centers for Medicare & Medicaid Services (CMS) indicated its intention to disaggregate several of the ECP categories over time, potentially creating a separate ECP category each for children’s hospitals and free-standing cancer centers beginning in 2017.

There is also work underway at the National Association of Insurance Commissioners (NAIC) to update its model act addressing the adequacy of health plan networks. The NAIC’s current Network Adequacy Model Act includes suggested areas for states to examine when assessing health plan networks, such as the ratios of primary care and specialty providers to enrollees, geographic accessibility, appointment waiting times, and provider hours of operation. Discussions on updating the model.
act have focused on how to assess network access given advancements in technology (e.g., telemedicine), the increase in the use of teams of clinicians, and the availability of non-traditional sites of care, such as urgent care and retail clinics. In addition, there has been a movement among several specialty hospital groups, including those that represent children’s hospitals and cancer centers, to promote their inclusion in health plan networks by carrying over the concept of “essential community provider” used in the new health insurance marketplaces and being designated as such under the NAIC Model Act.

Health Plan Approaches to Providing Access to Specialty Hospitals

Evaluation of health plan provider networks shows that consumers already have access to specialty hospitals through a variety of health plan approaches. One of the most common is the traditional approach, where health plans negotiate directly with specialty hospitals in their service areas to contract for affordable quality care for their customers. Health plan networks have to meet a variety of standards set by existing state and federal regulations, private accreditation organizations, group purchasers, and government programs administered by health plans. Moreover, health plans regularly evaluate how well their provider networks are meeting consumers’ needs. As part of these efforts, health plans design networks that provide consumers with access to specialty services that are safe, effective, evidence-based, and affordable through a variety of additional approaches.

Centers of Excellence Designation

One of the additional ways health plans provide access to specialty hospital care is by designating facilities that meet specific criteria as Centers of Excellence (COEs). The criteria are often similar across plans and include achievement of high levels of performance on evidence-based quality metrics. In addition to clinical quality data, these criteria typically include professional consensus, patient experience, and infrastructure capabilities (Figure A). Plans routinely evaluate and re-evaluate their designated COE facilities to ensure these COEs continue to meet quality standards.

Many plans identify specific COEs for certain conditions or procedures, such as organ transplants, bariatric surgery, cardiac care, complex and rare cancers, infertility, and specialty pediatric care (Figure B, page 4).

Figure A: Common Criteria for COE Designation

<table>
<thead>
<tr>
<th>Professional Consensus</th>
<th>Data and Evidence</th>
<th>Patient Experience</th>
<th>Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Input from the medical community*</td>
<td>• Review of the medical literature</td>
<td>• Patient satisfaction</td>
<td>• Number of procedures</td>
</tr>
<tr>
<td>• Analysis of past provider survey information</td>
<td>• Clinical outcomes</td>
<td>• Coordination of care and use of multidisciplinary approach</td>
<td>• The makeup and stability of the program team</td>
</tr>
<tr>
<td>• Input from quality measurement experts*</td>
<td>• Rates of complications and readmission rates</td>
<td>• Cost-effectiveness of care provided</td>
<td>• Program depth and breadth</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Research and education</td>
</tr>
</tbody>
</table>

* Plans often seek to gather opinions from both the medical community and quality measurement experts to better evaluate, qualitatively and quantitatively, if a facility merits a COE designation.
Access to Out-of-Network Specialty Hospitals in Certain Cases

Another way health plans provide access to needed specialty hospital care is through exceptions processes. As mentioned previously, provider networks serve the dual purposes of promoting safe, quality care as well as affordability. Thus, health plans promote the use of in-network facilities when appropriate and actively encourage consumers to use high-value facilities for care. In the rare instance where there is no appropriate facility within the plan’s network that can meet the unique medical need of the patient, a health plan’s exceptions process can be triggered by the covered member — or more typically their current provider on their behalf — to allow for covered benefits to be provided by an out-of-network provider. To request an out-of-network exception, the referring physician provides documentation of the medical necessity for out-of-network care and the request is reviewed and decided upon by health plan medical directors. This process is conducted on a case-by-case basis and can occur prospective or concurrent to the care provided.

Processes that promote continuity of care are additional ways consumers can access out-of-network care at in-network levels for a period of time. Health plans have continuity of care policies that provide for out-of-network exceptions in certain instances, such as when a patient is pregnant, or undergoing a course of treatment, such as radiation or chemotherapy, for a serious or terminal illness. Under a plan’s continuity of care policy, a patient may continue to receive care from a provider no longer in the network for a certain period of time at in-network cost-sharing rates. These policies help avoid disruption in care and, ultimately, aim to transition care to an in-network provider after the continuity of care period ends.

Recent Findings on Network Inclusion of Hospitals and Specialty Cancer Hospitals

There have been numerous studies conducted to evaluate the breadth and composition of health plan networks. In general, these studies have found that consumers have a wide range of health plan choices, including smaller, more selective provider networks, as well as larger provider networks that typically cost consumers more. A recent McKinsey study found that 90% of consumers purchasing coverage through the new health insurance marketplaces had access to both narrow and broad network plans in 2015. Hospital inclusion in both narrow and broad provider networks continues to be robust. In fact, the same McKinsey

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**Figure B: List of Commonly Used COEs by Condition or Procedure**

<table>
<thead>
<tr>
<th>Transplant surgery</th>
<th>Bariatric surgery</th>
<th>Cardiac care (including pediatrics)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knee and hip replacement surgery</td>
<td>Spine surgery</td>
<td>Complex and rare cancer (including pediatrics)</td>
</tr>
<tr>
<td>Infertility</td>
<td>Orthopedic care</td>
<td>General surgery</td>
</tr>
<tr>
<td>Guillain-Barré syndrome</td>
<td>Uterine fibroids</td>
<td>Chronic kidney disease</td>
</tr>
</tbody>
</table>
study found that the overall number of hospitals participating in Exchange networks rose in 2015, with 64% of all hospitals participating in at least one narrow network and 93% participating in at least one broad network. A recent analysis of provider networks in California found that geographic access to hospitals was comparable across narrow and broad networks in the new Exchange market and commercial market, respectively. Equally noteworthy, the narrow networks in the Exchange market had comparable and in some cases higher average quality than the broader networks in the commercial market.³

This finding of robust hospital participation in plan provider networks applies to cancer hospitals as well. A recent survey of 20 leading cancer centers found that 75% were included in at least some of the Exchange plan provider networks in their respective states. Among those included in the Exchange networks, 13% had in-network agreements with every plan in their state.⁴

Health Plan Flexibility in Designing Networks Promotes Value for Consumers

While the aforementioned studies show strong hospital and cancer hospital participation in plan networks, it is important to point out that health plans select hospitals for their networks based on a number of factors, and not every hospital necessarily is included in a health plan’s network. In addition to considering geographic location, credentials, safety, and quality, health plans try to design networks that are more affordable for consumers. In many instances, care delivered at specialty hospitals can be significantly more expensive than care delivered at non-specialty hospitals. Maintaining health plan flexibility to design networks that best meet the needs of consumers is essential to providing both access and affordability.

A recent analysis of 2012 and 2013 hospital discharge data released by OSHPD (California’s Office of Statewide Health Planning and Development) conducted by analysts at AHIP’s Center for Policy and Research found striking differences between average charges of specialty and non-specialty hospitals⁵ for the same medical procedures, identified by Diagnosis Related Group (DRG), performed by hospitals within the same county in California. Children hospitalized for treatment of their bronchitis or asthma at a children’s specialty hospital were billed, on average, over $5,400 (47%) more than children suffering from the same conditions but seeking care at a nearby, non-specialty hospital. Similarly, patients diagnosed with breast cancer were billed thousands of dollars more — over $3,000 (5%–15%) more — if they underwent mastectomy surgery at a specialty cancer hospital rather than having the exact same procedure at a non-specialty hospital.

These differences in charges are not entirely unexpected as previous studies have documented the underlying economic inefficiencies of specialty hospitals relative to general community hospitals. Cary, Burgess, and Young, in their 2008 study comparing hospital costs between cardiac, orthopedic, and surgical specialty hospitals versus full-service general hospitals, found that the average hospital costs among the 43 specialty hospitals studied were 42.5% higher than the expected costs for these facilities — much higher than the 27.4% inefficiency observed for the 975 general, full-service hospital comparators.⁶ In a recent study, these same authors noted that the specialty hospitals are particularly disadvantaged in their ability to exploit economies of scope, and that greater cost efficiencies could be realized by shifting more work to general hospitals.⁷ By restricting their efforts to the provision of only select, highly-profitable services,⁸,⁹ specialty hospitals are challenged to realize many of the economies of scale and scope that general, full-service hospitals can. Thus, they cannot always capture many of the cost savings available to those institutions offering a variety of services, irrespective of profitability.

Interestingly, despite the higher amounts charged by specialty hospitals, studies have demonstrated that patients treated at specialty hospitals designated by the National Cancer Institute (NCI) do not necessarily have superior outcomes to those treated at general, non-designated hospitals. Birkmeyer, et al. found that while NCI-designated cancer centers had statistically
significantly lower adjusted surgical mortality rates than non-designated hospitals for patients diagnosed with lung cancer (4.4% vs. 5.6%), esophageal cancer (7.7% vs. 12.3%), gastric cancer (6.5% vs. 10.5%), or colon cancer (4.7% vs. 5.5%); however, there were no significant differences in five-year survival rates.\textsuperscript{10} Similarly, in their study of NCI-designated cancer centers versus non-designated hospitals, Merkow, \textit{et al.} found that patients undergoing colorectal surgery at NCI-designated cancer hospitals had slightly lower 30-day mortality outcomes than those treated at non-designated hospitals (1.2% vs. 1.9% of patients).\textsuperscript{11} However, for those patients undergoing surgical procedures for their pancreatic or esophagogastric cancer, no significant differences in 30-day mortality were observed.

Conclusion

Examination of health plan provider networks shows that consumers currently have access to specialty hospitals. Health plan internal efforts to designate centers of excellence, as well as standards set by regulatory and accrediting bodies, help ensure that plan networks meet the specialty care needs of consumers. And in the relatively rare instances where no network specialty hospital is available, health plan exceptions processes assure out-of-network services can be covered, and continuity of care policies can provide access to out-of-network facilities at in-network cost-sharing rates for patients undergoing a course of treatment.

Because of the important role that provider networks play in promoting quality and affordability, network design flexibility is important to the development of provider networks that offer value to consumers. Existing flexibility, balanced with standards for adequacy, have resulted in consumers having access to a wide range of health plan network choices. Equally important, members’ satisfaction with their health plans continues to rise.\textsuperscript{12} Policymakers and regulators must consider this need for flexibility in their overall efforts to improve care and affordability, and permit health plans to partner with providers that will help them develop innovative programs and payment models. Some of the proposals being promoted that would take away existing flexibility by specifying provider network composition at a more granular level will undermine health plans’ ability to manage networks, and limit the development of successful programs and tools that promote and provide quality, efficiency, safety, and affordability.
End Notes


3 Haeder SF, Weimer DL, Mukamel DB. California Hospital Networks are Narrower in Marketplace than in Commercial Plans, But Access and Quality are Similar. Health Affairs. May 2015. 34:5; 741-748.

4 Avalere. Leading Cancer Centers May Be More Widely Included in Exchange Networks than Expected. April 2015.

5 For the purposes of this study, specialty hospitals were identified from a list of children’s hospitals and cancer hospitals that have petitioned the National Association of Insurance Commissioners to be considered for designation as “essential community providers”. From this list, a “Top 25 Diagnosis Summary Report” was generated for each California based hospital, by county, using the reporting tool found on the Healthcare Information Division section of the OSHPD website (www.oshpd.ca.gov). The same reports were then generated for each of the other hospitals in that county and were considered non-specialty hospitals. When multiple, non-specialty hospitals were located in the same county, a simple average was calculated per DRG. Each report listed the average amount charged by that facility for that particular medical procedure for all discharges occurring between 01 Oct 2012 and 30 Sep 2013.


11 Merkow RP, Bentrem DJ, Chung JW, et al. Differences in Patients, Surgical Complexity, and Outcomes After Cancer Surgery at National Cancer Institute-designated Cancer Centers Compared to Other Hospitals. Medical Care 2013; 51(7): 606-613.


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