TAHP
The Texas Association of Health Plans

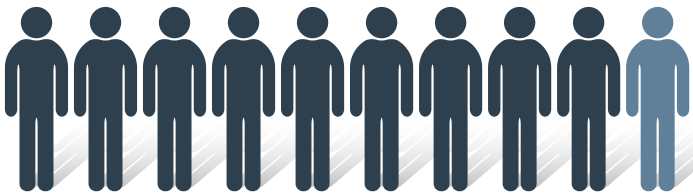
Representing health insurers, health maintenance organizations, and other related health care entities operating in Texas.

Consumers Voice Strong Approval of Health Plan Networks

Networks Improve Health Care Experience

Efforts by health plans to achieve high-quality provider networks are making a positive difference, according to new research from Kaiser Family Foundation. A poll released by Kaiser finds that 9 out of 10 insured Americans are satisfied with their choices of doctors and the value of their health plans.

Those choices are made possible through carefully assembled provider networks—a system of physicians, facilities and other providers that health plans develop to deliver affordable, accessible, quality medical care to their consumers. These networks not only ensure quality control and affordability, but they also provide predictability and protection for consumers in an age of growing, surprise, out-of-network medical charges due to the practice of "balance billing."



9 out of 10 Insured Adults
are Satisfied with Health Plan Networks

Health plans create provider networks by establishing agreements with a wide range of providers and facilities, including primary care physicians and specialists, hospitals, labs, radiology facilities, pharmacies and other providers. Roughly 90 percent of U.S. providers (hospitals and doctors) participate in health plan networks.

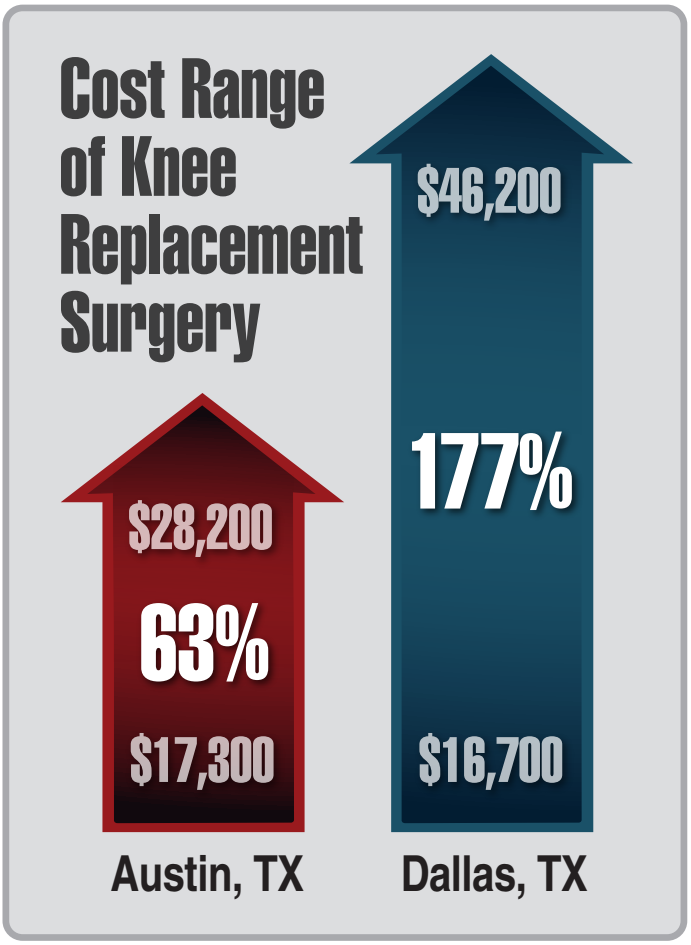
When a provider agrees to contract with a health plan and be a part of its network, the provider commits to that plan's quality and utilization management programs, and to accept contracted rates as payment in full for covered services, in exchange for the volume of covered patients and administrative efficiencies.

Health Plan Provider Networks Hold Down Costs

The negotiation process used in developing provider networks is the most important tool health plans have to help keep costs down for employers and individual consumers. Through private market competition, health plans negotiate a number of terms with providers; chief among them are affordable rates that in-network providers agree to charge covered consumers for their service. They agree not to bill patients for more than the amount negotiated with their contracted health plan. In exchange, providers receive a volume of health plan members as patients and administrative efficiencies.

The prices for medical care can vary widely even within the same market. Consider a recent study by a team of researchers from Yale, University of Pennsylvania and other elite institutions, which examined the prices for medical services across the country. The report found not only a wide range of prices for medical care across the country but even within the same community. For example, knee-replacement surgery in Austin, Texas, ranges anywhere from $17,300 to $28,200, depending on the hospital. In Dallas, the same procedure can range from as little as $16,700 to as much as $46,200, depending on the hospital.

Given this wide range, it is increasingly important for health plans to be able to negotiate affordable prices with providers and facilities that are in their networks to ensure lower premiums and more affordable rates for their consumers, as well as more predictability.



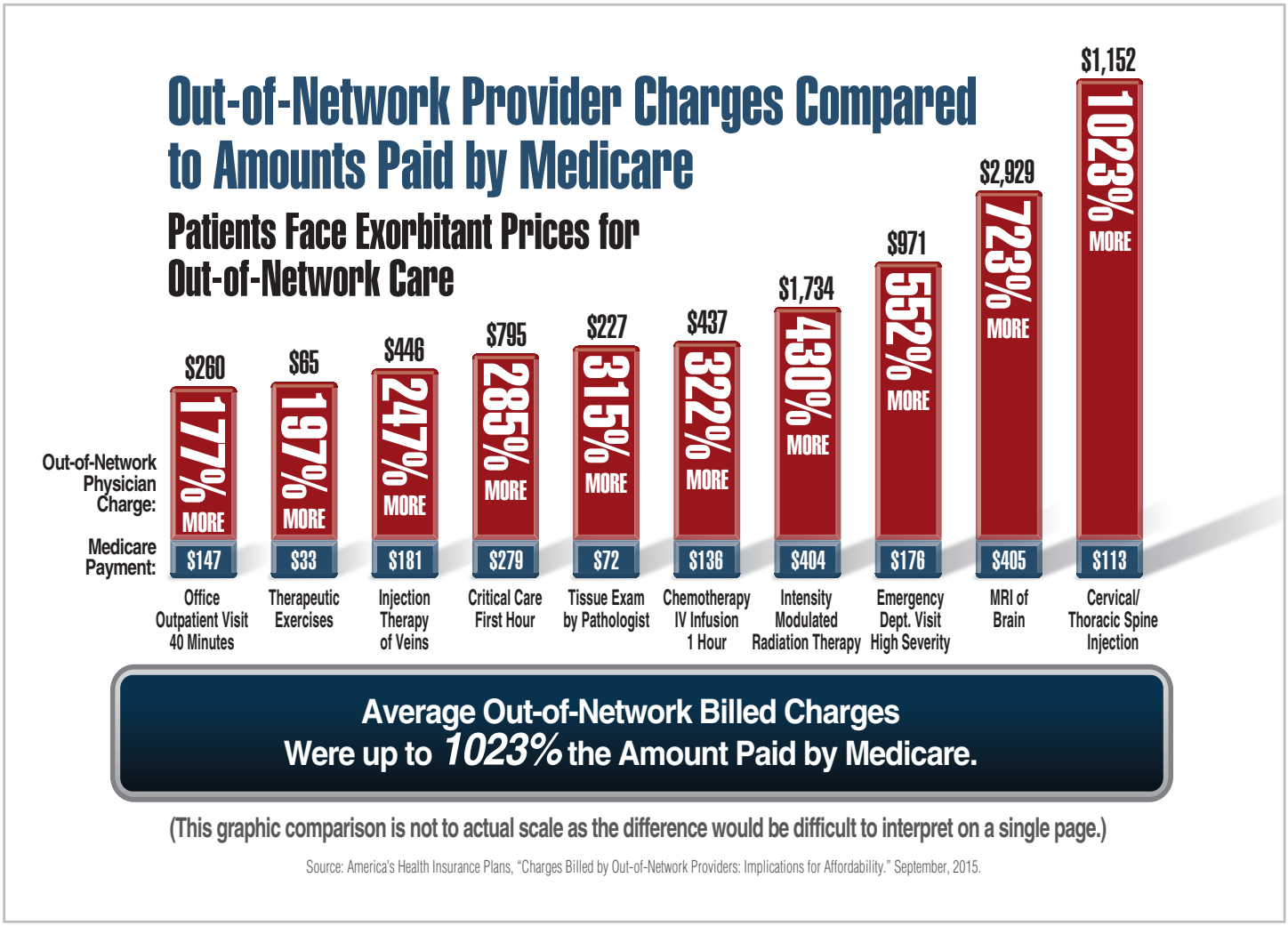
Health Plan Provider Networks Promote Quality

Health plans evaluate doctors, hospitals, and other providers for quality and safety before including them in their networks. This involves ensuring that facilities and providers meet patient safety goals and credentialing standards. By doing so, networks guide consumers to high-performing doctors and hospitals that provide cost-effective and high-quality care. These efforts by health plans help to ensure consumers receive the best value for their health care dollars.

Health Plan Provider Networks Protect Consumers from Balance Billing

When providers choose not to participate in a health plan's network or do not meet the requirements for that network, they are considered "out-of-network" and may charge whatever fee they choose for the care they provide, called "billed charges." Billed charges often have little or no connection to actual underlying costs or market prices. Some out-of-network providers charge amounts that can be several hundred or even thousands of times greater than the Medicare payment rate for the same service. These charges often come as an unwelcome and surprise medical bill for patients, most frequently in emergency care situations. This process is called "balance billing."

In developing provider networks, health plans help protect consumers from balance billing. In-network providers have agreed to accept a health plan's contracted rate, which helps keep coverage affordable, and they have agreed to not charge consumers in excess of this rate.



Source: America's Health Insurance Plans, "Charges Billed by Out-of-Network Providers: Implications for Affordability." September, 2015.

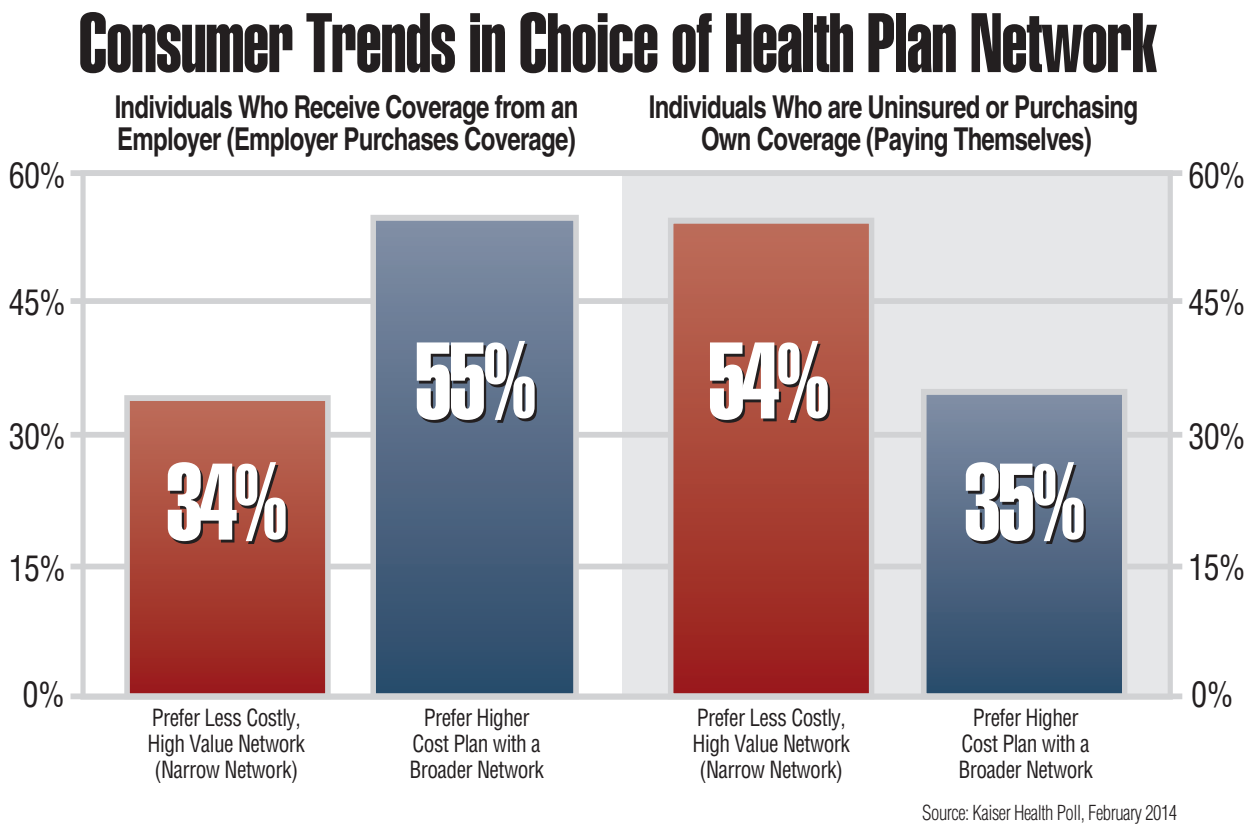
Health Plan Provider Networks Provide Choice

Health insurers continue to offer traditional, broader provider networks in addition to high-value, or narrow, networks in order to provide a wider choice for their consumers.

The use of high-value or narrow networks typically results in noticeably lower premium costs compared to broader networks. National research firm Milliman found that premiums are 5 to 20 percent lower in high-value networks.

Study Reveals Consumer Trends in Health Plan Network Preferences

A recent Kaiser poll found that the uninsured and consumers who purchase individual coverage for themselves are more like to prefer less costly, narrow network plans over more expensive plans with broader networks (54 percent versus 35 percent). Those who are currently getting their insurance through an employer (who is protecting them from the cost of coverage) have the opposite preference: 55 percent prefer a more expensive plan with a broader network, while 34 percent would rather have a less expensive narrow network plan.



Health plans provide a range of network size options for consumers and employers to choose from according to their preferences. Broader networks are available to roughly 90 percent of consumers, and more narrow networks are available to 92 percent. (Source: McKinsey)

Today, consumers are benefiting from the steps health plans take to negotiate and contract with providers in developing competitive networks. With 9 out of 10 insured Americans expressing satisfaction with their health plan networks and the choices of providers available to them, there is clear support for health plans to continue their efforts to build quality networks that connect consumers with high-performing doctors and facilities that will make the most out of their health care dollars.

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