

Issue Brief

Findings from HSC



PROVIDER NETWORK INSTABILITY: IMPLICATIONS FOR CHOICE, COSTS AND CONTINUITY OF CARE

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Many health care issues of greatest concern to consumers—including provider choice, costs and continuity of care—depend on health plans' ability to maintain adequate networks of hospitals, physicians and other caregivers. When providers drop out of plan networks, consumers may suddenly face the choice of changing caregivers or paying more for out-of-network care. Network instability is increasingly common in health care markets across the country and can arise from health plan-provider contract disputes and provider organization insolvencies. This Issue Brief, which is based on the Center for Studying Health System Change's (HSC) 2000-01 site visits to 12 nationally representative communities, examines this growing trend and the implications for consumers, including diminished choice and higher costs.

Sources of Instability

Choice of caregivers is a longstanding concern for consumers in managed care plans. Historically, plans have tried to contain costs by steering members to networks of contracted providers, leading consumers to fear their providers of choice would be excluded from plan networks. Concerns about restricted provider choice have lessened over the past few years as health plans bowed to market demand for large and inclusive provider networks.

Recently, however, consumers in many communities have found provider choice threatened again—this time due to network instability problems. Network instability occurs when providers drop out of plans' networks—or threaten to—when health plans unexpectedly drop providers. These changes create uncertainty for con-

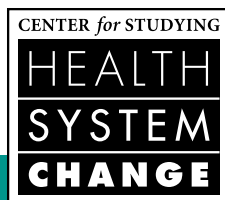
sumers about whether their health plan will cover their providers of choice. Indeed, when changes to plan networks occur, consumers often must change caregivers suddenly or pay more to continue seeing their usual providers.

In contrast to two years ago, network instability is now a major concern in many local health care markets. HSC found evidence of significant network instability affecting many consumers in more than half of the study sites: Boston, Greenville, S.C., Miami, Northern New Jersey, Orange County, Calif., Phoenix and Seattle.

Contract disputes between health plans and providers are the most common cause of network instability and typically center on disagreements about payment levels, financial risk-

sharing arrangements and accuracy or timeliness of payments. While disputes between health plans and individual providers over these issues are common, recently some large and prominent provider organizations have taken a hard-line stance, threatening contract terminations that would disrupt care for many consumers.¹ In addition, many disputes have occurred, not at the point of contract renewal, but when existing contracts were still in force, lending a new sense of urgency to the problem. These scenarios leave health plans with the difficult choice of reconciling with providers or engaging in a costly legal process to enforce existing contracts.

Insolvencies of large provider organizations, such as physician practice management companies (PPMCs),



physician-hospital organizations (PHOs) and independent practice associations (IPAs), also have caused considerable disruption in plan networks because these organizations, rather than individual physicians, typically hold health plan contracts. As a result, when these organizations fail, plans must quickly develop new contracts with individual physicians to avoid periods when the physicians are not included in a plan's network. This was a major issue in Orange County, for example, when KPC Medical Management, a large PPMC, closed 38 clinics in late 2000 and filed for bankruptcy. KPC's failure generated fears about continuity of care and access to patient records for up to 300,000 people.

Finally, HSC found instances where health plans caused network instability themselves by making wholesale changes to the size or composition of networks with little or no warning to employers and consumers who already had purchased coverage. Health plans took these actions after identifying high-cost providers viewed as nonessential to plans' current product offerings and dropping the providers when contracts expired.

Consumer Consequences

When a provider leaves a plan network, patients can:

- continue to see the provider and pay higher out-of-pocket costs;
- form a new relationship with a remaining network provider; or
- switch to a different plan that contracts with the original provider, if this option is available.

These choices are especially difficult for patients who have longstanding relationships with particular caregivers or those receiving care for serious or chronic conditions. The sickest patients, who are most in need of uninterrupted care, also are most likely to find the costs of out-of-network care prohibitive, particularly if they are enrolled in traditional health maintenance organizations (HMOs) lacking out-of-network coverage.

Network disruptions occurring after an employer's annual open-enrollment period pose the greatest threat to continuity of care because consumers typically cannot switch plans immediately to follow their providers of choice. Given the relatively brief open enrollment periods offered by most employers, many disruptions occur outside this narrow window.

Patients who choose to remain in their plan's network may encounter disruptions in continuity of care and administrative hassles, as was the case with KPC patients in Orange County. In response to KPC's dissolution, some plans assigned whole groups of patients to new providers through "block transfers" that failed to take into account prior patient preferences or patterns of care for families. For example, one employer reported that family members sometimes were transferred to different physicians.

Other potentially more serious problems emerged from the delayed transfer of

medical records that threatened continuity of care. Moreover, plans often had difficulty finding physicians to accept new patients. Some Orange County physicians were reluctant to accept KPC patients because the physicians either lacked capacity for new patients or were concerned about pent-up demand for costly services some believed patients did not receive in the final months before KPC went out of business.

Finally, the extensive publicity surrounding network instability generates consumer anxiety. Through the news media, communities have watched provider organizations dissolve, terminate contracts and contest payments. Plans and providers in recent contract show-downs have used the media, advertisements, mass mailings and other direct appeals to patients to tell their side of the story. Such tactics, combined with reports of actual disruptions, fuel consumer anxiety about the security of their own provider relationships.

Network Instability in Medicare and Medicaid

Medicare and Medicaid beneficiaries relying on managed care have encountered even more pronounced problems with network instability than privately insured patients. Since Medicare and Medicaid plans receive fixed government payments, they have less leeway than their commercial counterparts to negotiate payments with providers, leaving them especially vulnerable to network instability. In Medicare, plans can charge beneficiary premiums, but plans often perceive limits on what they can charge to remain competitive. In many communities, health plans have been unable to maintain adequate networks for Medicare and Medicaid products, leading them to drop these products, thereby reducing plan options for beneficiaries. For example, difficulties maintaining provider networks reportedly led Seattle's Regence Blue Shield to discontinue Medicaid contracting at the end of 2000, forcing 50,000 Medicaid members to find new plans.

When network disruptions occur in Medicare and Medicaid, enrollees face the same set of decisions as commercially insured people about switching providers or paying more out of pocket to see their usual caregivers, but with some distinct differences. For example, unlike many commercial managed care products, Medicare and Medicaid HMOs typically provide no out-of-network coverage, so enrollees remaining with a provider who has dropped out of a network must bear the entire cost of care. This option is unrealistic for many Medicare beneficiaries and certainly for most Medicaid enrollees.

On the other hand, Medicare managed care enrollees—and in some states, Medicaid beneficiaries—can switch health plans once a month, which may allow them to maintain access to their providers but leaves health plans vulnerable to major enrollment shifts. Medicare plans to eliminate this option, however, in 2002, by phasing in an enrollment lock-in period similar to commercial insurance plans.

Employers, Plans and Policy Makers Respond

Network instability leaves employers and health plans with a difficult trade-off. While instability threatens to erode the broad networks consumers have strongly valued in recent years, costs will increase if health plans avert disruptions by offering providers higher payments. In Orange County, the newly negotiated rates of a dominant hospital system—St. Joseph Health System—are expected to contribute to double-digit premium increases in 2002. Network instability also puts policy makers in a difficult position, forcing them to balance consumer protection against the workings of the market.

For now, faced with a relatively tight labor market and consumer demand for broad provider networks, some employers are pressing plans to prevent disruptions. Likewise, policy makers in some sites have acted to curb the effects of instability on consumers.

Responding to Immediate Threats.

While some employers prefer not to become embroiled in contract disputes, others have intervened to advocate resolution. Large employers can pressure plans to maintain broad networks by threatening to drop plans that lose key provider groups. In Boston, Tufts Health Plan, for example, faced intense pressure from employers that threatened to go elsewhere if Tufts did not retain Partners HealthCare System, a prestigious hospital system with more than 4,000 affiliated physicians. In Seattle, GTE mediated a dispute between a large provider group and health plans, and, in Miami, one plan found that employers were willing to contact providers on the plan's behalf.

Policy makers, too, have used their influence to avert disruptions. For example, California regulators tried to protect members of KPC's ailing predecessor, MedPartners, by placing the company into receivership. When KPC began to flounder, the state asked plans to lend temporary financial assistance, a strategy that ultimately failed. Network instability also caught the attention of the Massachusetts attorney general. When talks between Partners and Tufts stalled last year, the attorney general encouraged the parties to resume negotiations to prevent disruptions to consumers. More recently, concerns about Partners' negotiating power reportedly

prompted the attorney general to weigh in on the now-resolved dispute between the system and Harvard Pilgrim, a financially troubled plan that was shored up last year by the state.²

Guarding against Future Instability.

Employers, plans and policy makers are moving to stave off future disruptions by putting in place performance guarantees and policies aimed at ensuring continuity of care and provider organization solvency. In some communities, employers have established performance guarantees requiring plans to minimize physician turnover, maintain adequate numbers of providers and/or provide notice of contract terminations or face a financial penalty. Employers and some public purchasers also are exploring arrangements requiring plans to disclose provider contract expiration dates or guarantee that providers listed in plan directories will care for enrollees for the entire contract year.

While these types of requirements may encourage plans to work harder to keep networks intact, they also promise to increase administrative costs and further undermine plans' negotiating leverage with providers.

Some health plans have begun to reexamine contracting models and network management strategies to reduce exposure to network instability. In Miami, for example, several plans are discontinuing full-risk contracts with PHOs and other contracting intermediaries that account for a large number of providers in the plans' networks. Instead, they are using direct fee-for-service contracts with individual physicians and hospitals, leaving the plans less likely to lose large numbers of providers at once. Additionally, health plans in several markets have started monitoring the financial health of contracted providers and offering consultation to providers facing financial difficulties to avoid disruptions from insolvencies.

Policy makers also are starting to keep a closer eye on providers' financial status. For example, spurred by provider organization failures and the resulting chaos, the California Department of Managed Health Care recently announced regulations requiring provider organizations accepting risk to furnish detailed financial information quarterly. In Medicare, Congress provided Medicare+Choice plans with increased funds under the Benefits Improvement and Protection Act (BIPA) in December 2000, allowing plans to use the money to improve provider networks. In



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from significant
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fact, this was the most common use of the funds, with plans representing 65 percent of Medicare+Choice beneficiaries using the money solely to enhance provider networks.³

Policy responses also include steps to protect consumers when providers drop out of networks. Many of these efforts have centered on preventing network instability from disrupting continuity of care for patients who are in an active course of treatment. For example, policies in use or under consideration in some states include contract termination regulations requiring providers to continue treating active patients under the terms of the previous contract for a specified time and contract notification regulations requiring plans and providers to give a specified notice period before terminating or not renewing contracts.

Implications

Network instability has fueled consumer confusion about health care choices and costs and threatened to disrupt established physician-patient relationships and continuity of care. Unfortunately, these events may become increasingly frequent and widespread, particularly if rising medical costs continue to draw providers and plans into conflict over payments and employers step up pressure on plans to control costs.

Several market developments may help lessen the problem of growing network instability, but each has associated costs. Employers may move away from plans relying on large, single-signature contracts with intermediary organizations such as PHOs, since these arrangements are particularly vulnerable to wide-scale disruption from network instability problems. However, without these arrangements, plans will be hard-pressed to engage in risk contracting that gives providers a financial incentive to manage medical costs. Alternatively, employers may move toward staff- and group-model HMOs that are inherently more stable, albeit at the price of a more limited provider network. Indeed, both Kaiser Permanente in Orange County and Group Health Cooperative in Seattle expect to gain membership as a result of network instability problems faced by competitors.

Network instability also may lead consumers and employers to favor preferred provider organization and point-of-service products offering out-of-network coverage. With this approach, consumers would not be immune from network instability but would gain peace of mind that they would have some coverage for providers of choice if a disruption occurs. In exchange for greater stability, they would give up the added benefits typically covered by HMOs and might face higher premiums and greater out-of-pocket costs.

Employers and consumers also may opt for new types of products that help to minimize network instability. For example, health plans in several communities expect to introduce new products allowing employers and consumers to choose among multiple tiers of provider networks, each with different premium and cost-sharing levels based on the providers' payment rates. Some anticipate this type of product will help keep networks intact by allowing plans more flexibility in the rates they can offer providers. However, these products may put some providers out of reach for employers and consumers who cannot afford the higher-priced hospitals and physicians and may complicate efforts to manage care.

As employers, plans and consumers grapple with network instability, policy makers increasingly will be pressed to protect consumers from significant care disruptions. Several states are already experimenting with policy options ranging from mediation and informal problem solving to regulatory standards establishing rules of engagement and disengagement between plans and providers. Ultimately, the successes and shortcomings of these interventions will provide insight into how policy makers can address network instability meaningfully without imposing undue costs on the health insurance market. ●

Notes

1. Strunk, Bradley C., Kelly J. Devers and Robert E. Hurley, *Health Plan-Provider Showdowns on the Rise*, Issue Brief No. 40 (June 2001).
2. Ibid.
3. www.hcfa.gov/medicare/bipafact.htm