

Provider Networks

Your plan may contract with doctors, dentists and other healthcare practitioners; hospitals; labs; radiology facilities; pharmacies and other types of providers. These are the providers in your “network.” Each provider has agreed to take your plan’s rate as payment in full for medical services. You can usually find a directory of your network on your plan’s website.

If you visit providers outside your plan’s network, you will likely have higher costs, for two reasons. First, these providers have not contracted with your insurer, and may charge more than what your insurer pays. Second, your plan may require higher copays, deductibles and coinsurance for out-of-network care. Often, you’ll have to pay those higher costs. You also will have to pay any difference between what your insurer pays and what the provider charges. Certain types of health plans with “closed networks”, such as an EPO, will not cover any care outside the provider network at all. This means you will have to pay the full cost yourself.

Some people may choose to see doctors outside their plans. But much more often, patients get surprised by an out-of-network bill when they thought they had only used in-network providers. This happens most often with complex services, like surgeries. In those cases, many providers are involved in your care. They may include out-of-network docs at in-network facilities.

If your insurer offers a choice of different plans, look up the network in each. Make sure you are able to get the care you need. Find out:

- Are all of your current doctors in the network?
- Does the network include the hospitals with which your doctors are affiliated?
- How many network providers are close to where you live and work?
- How much would the plan pay for out-of-network care?

Before scheduling a visit with a new provider, ask if he or she takes part in your plan. Also, ask if he or she takes part in the specific network you belong to in that plan (PPO, POS, EPO or HMO). If you choose to go out of network, ask the provider’s staff how much he or she will charge. You can see if it’s in line with other providers’ fees in your area. To do that, use this website.

You probably see a lot of references to in-network and out-of-network care on your insurer’s website or in your plan materials. But you may be wondering, how do plans choose their networks? And, how are they making sure you get the care you need?

What Are the Different Kinds of Networks?

If you belong to an HMO or EPO plan, you generally have a “closed” or “exclusive” network panel of providers. That means you need to go to in-network providers for all of your care. If you

go out of your network, you generally have to pay the full cost yourself. If you belong to a PPO or POS plan, you generally have an “open panel.” That means that you can either stay in your plan’s network, or go to any other provider you choose. But, if you visit providers who are not in your network, you will usually have limits on your coverage, and higher cost-sharing. [You can read more about the different types of plans here.](#)

How Do Plans Choose Providers?

Health plans have to weigh many issues when they select providers for their networks, like:

- The quality of their network
- Giving members enough choices for their care
- Cost

Quality

Plans need to make sure that their providers all meet certain standards. Typically, these include appropriate education, relevant work history, admitting privileges at a network hospital and at least a minimum level of malpractice insurance. There are many more common criteria, and your insurer may have other criteria of their own, too. Before accepting providers into the network, plans evaluate all this information and more through a process called “credentialing.” There are also outside criteria, set by independent organizations that measure the quality of a plan’s provider networks. For instance, the National Committee for Quality Assurance (NCQA) evaluates plans and grants an “accreditation”, or certification, if their provider networks are meeting certain quality standards and providing members with appropriate treatment and enough access to care.

Options for Members

When people change health plans, they often want to make sure they have access to their current doctors, as well as a range of different providers in many different specialties. Health plans are well aware of this, so, when they choose providers for their networks, they try to include enough providers in every specialty to meet consumer demand and give members choices for their care. In fact, if a large employer is considering switching to a new plan, they may work with the new insurer to make sure most of their employees’ providers are included in the new network.

Tiered Networks

Instead of limiting the number of providers in the network, some plans split their network into “tiers.” These tiers are based on several quality measures, like clinical outcomes and member satisfaction. They are also based on the cost-effectiveness of the provider’s care. With a tiered system, you will have different costs depending on your provider’s tier. For instance, you may pay a \$25 copayment to see a specialist in Tier 1, \$35 for Tier 2, and \$45 for Tier 3. This is similar to the way many prescription plans are set up, where you have a lower copay for generic medications, and a higher copay for brand-name drugs.

Cost

Your insurer uses most of the premiums it collects from you and your employer to pay for your care, and cover the costs of running the plan. Generally, any money left over is profit for shareholders (if you are in a for-profit plan) or surplus saved for future investments (if you are in a non-profit). So, your insurer must carefully weigh how much to pay its network providers,

because that amount may affect premium rates, as well as the number and type of providers in the network.

Regulatory Requirements

Most plans are regulated by state agencies that make sure they are meeting state insurance and health laws. Requirements vary widely by state, but in general, to meet regulations plans must show that they have an “adequate” number of network providers by type and geographic location. Some types of plans, like self-insured plans, are controlled by different regulations. Some states also have “any willing provider” laws. These laws require plans to accept any provider who practices in their service area, and who is willing to abide by their terms and conditions, into their network. In these states, any provider who agrees to the plan’s criteria can join the network.

Your Action Plan – Find a Network that Fits Your Needs

If your insurer offers a choice of different plans, evaluate the networks in each carefully to make sure you have access to the providers that you need. Ask your insurer:

- Are all your current doctors in the network?
- What hospitals are your doctors affiliated with? Are they in the network, too?
- If the plan is “tiered”, what tier are your doctors and their affiliated hospitals in?
- How much will you have to pay for providers in each tier?
- How many network providers are close to where you live and work?

Every plan is required to provide you with a complete plan description outlining all of its coverage, requirements and limitations. These are often available on your insurer’s website. Read this information carefully, and ask questions if there’s anything you don’t understand. And most importantly - remember that you are your own best advocate. Speaking up and asking questions up front will help you find the right provider network for you.