How administrative professionals see the effects of narrow networks and complex benefits

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Overview

In **two in-depth diary studies**, Public Agenda gave voice to the challenges that people with marketplace insurance plans face when trying to access in-network health care providers. Administrative professionals witness those challenges firsthand as they help both patients and clinicians navigate networks and benefits. This brief report provides a perspective from administrative professionals on how narrow networks and complex benefits affect patients and shape their own work.

The scope and scale of this report – based on interviews with twelve practice managers or office staff members from primary care, mental health care, and diabetes care practices – is limited, and the findings are not generalizable. All twelve interviewees reported that they were employed in offices that treat people covered by marketplace plans, including nine who reported that half or more of their patients were covered by marketplace plans. Interviewees were initially asked to reflect on their experiences with patients and plans in general, with selected follow-up questions focusing specifically on marketplace plans. These findings therefore do not pertain solely to marketplace plans. The methodology section provides details about this research.

Findings in Brief

1. The administrative professionals interviewed discussed how difficult it can be for patients to keep up with changes in networks and insurance status.
2. Interviewees described how patients' care can be delayed when plans require referrals and how the process of getting referrals authorized creates burdens for administrative staff.
3. Interviewees felt that prior authorization requirements for medical services negatively impact patients and make their own work unnecessarily complicated.

To learn more about these findings, go to **https://publicagenda.org/report/netad-2023/** or email **research@publicagenda.org**.

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1 The administrative professionals interviewed discussed how difficult it can be for patients to keep up with changes in networks and insurance status.

In Public Agenda's **diary studies**, people trying to access care described the frustrations of trying – and often failing – to find in-network providers who were located close to them and had appointments available in a reasonable timeframe. The administrative professionals interviewed for this report observed that, in their experience, most patients try to figure out on their own whether a provider is in network or not.[1]

But interviewees noted that patients may have inaccurate or out-of-date information from their insurers about which providers are in network. These interviewees noted that contracting relationships between providers and plans change frequently. And they felt that marketplace plans are particularly slow to update their directories compared to other commercial plans, a hypothesis that further research could explore. However, interviewees also blamed practices for not providing insurers with the information needed to keep directories up to date.

> ***"A patient may find a doctor in that insurance book, and they no longer take that plan. That happens all the time. The providers have to renew their membership with the plan. But a lot of times the physicians won't renew. They'll say, 'We're not taking that plan any more, I'm sorry.'"***
>
> – Practice manager in a primary care provider's office[2]

An interviewee who worked for a large health system explained that his system regularly goes in and out of network with various insurers. Therefore, some patients whose providers are in network one year may become out of network the next. He said these continuous changes are why practices do not clearly list which insurance plans they accept on their websites, but rather make broad statements, such as "We accept most major insurance," and leave it to patients to confirm whether their care will be covered.

> ***"We were in Humana one year, and then the next year Humana says they're not happy paying us the rates we're asking for, and the other system picks up Humana or Cigna or something like that. It's very challenging to stay abreast of what we're in and not in network for."***
>
> – Practice manager in a primary care provider's office

An interviewee described how inaccurate insurance directories can delay access to timely care because patients have to spend time calling offices to try to figure out which providers will accept their coverage. Interviewees mentioned the added complexity for patients of providers having practices in multiple locations. When providers practice in multiple locations, they may be in network in one location and out of network for the same insurance plan at another location.

[1] Differences between primary care, mental health care, and diabetes care office staff experiences and views are specifically noted. Otherwise, experiences and views are shared across the three types of practices.

[2] Quotes have been minimally edited for clarity.

“Sometimes the patient will have an insurance that we don’t accept but the doctor accepts in the outside private office. And then we’ll just tell them, ‘Yeah, he does work here, but he accepts only these policies at this location.’”

– Office staff in a diabetes care provider’s office

These interviewees said that existing patients who anticipate switching insurance plans may ask them for help figuring out whether their current provider will still be in network under a potential new plan. They also described instances in which patients switch insurance, only to find a current provider is no longer covered. They said that doctors may continue to treat those patients at discounted out-of-pocket rates until they can switch plans again or establish care at another practice. Some interviewees spoke of patients electing to receive care from an out-of-network practice because other providers are geographically too far away or because they believe they will not be able to find care of comparable quality from an in-network provider, a trade-off that some **diary study** participants described making.

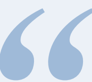
2 Interviewees described how patients’ care can be delayed when plans require referrals and how the process of getting referrals authorized creates burdens for administrative staff.

Some insurance plans require patients to get referrals from primary care providers in order to see specialists – theoretically so that patients are seeing the right type of specialist and so that primary care providers can coordinate care. The administrative professionals interviewed for this report understood why referrals are required but felt that they negatively impact patients.

Interviewees explained that requiring patients to go through multiple steps – making an appointment with a primary care physician to get a referral to see a specialist, then making an appointment with that specialist, and then needing to get prior authorization for a test or other service – all make it difficult for patients to access care.

“I understand that insurers want to make sure patients are going to the right person. Like you have a problem with your kidneys, do you go to the nephrologist or to the urologist? Sometimes patients don’t know, and I think that’s good to have a primary care provider to check in with so they can give a suggestion on who and where you should be going. But I don’t necessarily know that that needs to be dictated by insurance.”

– Office staff in a diabetes care provider’s office



I think the referral system is very redundant. Most people don’t make an appointment to see a brain surgeon unless they need one.”

– Office staff in a diabetes care provider’s office

An interviewee specifically felt that requiring referrals can deter people from traditionally marginalized communities from seeking care, since the process requires so many touch points with a system that they already view as untrustworthy.

People already had major trust issues, but especially in the Black community, it has made trust issues worse. People don't even want to come. As a grown-up, to need a permission slip?"

– Office staff in a diabetes care provider's office

For pressing medical needs, many interviewees noted that they can place urgent referral requests, but those take hours or even a full day to process. They also described the work they must do to manage patients' frustration by trying to explain how much time processing referrals can take.

Someone comes in and we may need to refer to an emergency retinal specialist for loss of vision. We can't wait around. That happened yesterday. You have a patient sitting in your office who has a loss of vision and needs to get a retinal specialist immediately. And with the insurance they have, they have to see us first. It takes time. And it's stressful. And you don't want to send somebody home with a retinal detachment without seeing the retinal specialist because it is going to get worse."

– Practice manager in a primary care provider's office

Additionally, interviewees criticized referrals and the process of getting them authorized as burdensome for them as administrative professionals. They described processing referrals as a hassle, eating up time that could be used for other work. Some mentioned relying on antiquated technologies to manage referrals.

The fax, phone. Did you receive it? Patient's saying you don't have it. That kind of back and forth really requires a lot of office time."

– Office staff in a diabetes care provider's office

We could use that time to be doing other things."

– Office staff in a diabetes care provider's office

Interviewees specifically called out referrals that remain valid for only six months, which may allow for only two appointments before a patient needs to go back to their primary care provider to get another referral. They also noted that patients who switch insurance may need to get new referrals, creating additional work for administrative staff and further delaying patients' care.

Some interviewees also complained that other practices do not always check patients' coverage when referring to their practice. But interviewees also varied in their own approaches to making recommendations to patients about specialists. Some only recommend providers who will be in network. But others said they recommend whichever provider they feel is best and leave it to patients to figure out whether the provider will accept their coverage or whether they want to pay for out-of-network care.

> ***We don't really try to recommend a place unless it's in network. We refer them to their insurance. They will have a better idea of where they can go."***
>
> – Practice manager in a primary care provider's office

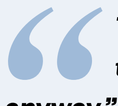
> ***When I make a recommendation, it's based on who I feel is most likely to provide the patient what they are looking for. It's not necessarily in network or out of network. I don't take a look at the insurance when making a recommendation because each practice is going to have their own way of handling a situation whether a patient is in network, out of network, and what their options are."***
>
> – Office staff in a mental health care provider's office

3 Interviewees felt that prior authorization requirements for medical services negatively impact patients and make their own work unnecessarily complicated.

Authorization for medications, tests, imaging, and other services theoretically protect patients from unnecessary or inappropriate care. But these administrative professionals saw prior authorization requirements as limiting patients' access to care.

> ***When your doctor says you need to have an ultrasound or whatever, the patient wants to be able to get that the same day. But we can't unless it's approved. If they could get it the same day, if they didn't have to wait for these authorizations, it really would make them feel better. Because now they've got to wait for a week or two to find out if there is something there. I think that it just makes them more anxious. And they call us and want us to explain how this happened."***
>
> – Practice manager in a primary care provider's office

Some interviewees spoke of past years when doctors were able to see a patient, and then the patient could complete tests, imaging, or other services on the same day, without needing to make another appointment, take time off work, and travel back and forth to a medical facility again. Now, they said, patients can wait days to get those services approved. In some cases, they said it can be unclear whether a service actually needs authorization, and they are unable get timely answers from insurers. Patients can then be left having to decide whether to get those services and risk them not being approved later.



The patient is stuck with, 'Well, do I do it or do I not do it? How much is it going to cost me if they don't cover it? Where am I going to be stuck?' A lot of times we'll go ahead and do the test anyway."

– Practice manager in a primary care provider's office

Interviewees saw the process of requesting authorizations as time consuming and frustrating for them in their work. They also felt that the insurance company personnel who review prior authorization requests are disconnected from the reality of patients' lives.

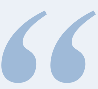
The people that are looking at the authorization requests are not hands-on. They don't see what we're seeing. They don't see the need. They don't see the urgency. They don't see the patient. There's a difference between sitting behind a desk and looking at numbers and sitting with a patient watching them cry because they're in pain."

– Office staff in a primary care provider's office

We can be on the phone waiting just to get ahold of a live person for over an hour. And we don't really have that time to just sit on the phone to wait to get a hold of someone. Most of our communication with insurance companies is done via paper, electronically, or fax. That process takes a while and insurance companies can be slow giving a response back, especially when items are sent either via fax or paper. During that time the patient is virtually in limbo waiting on their insurance company to make a decision on their care."

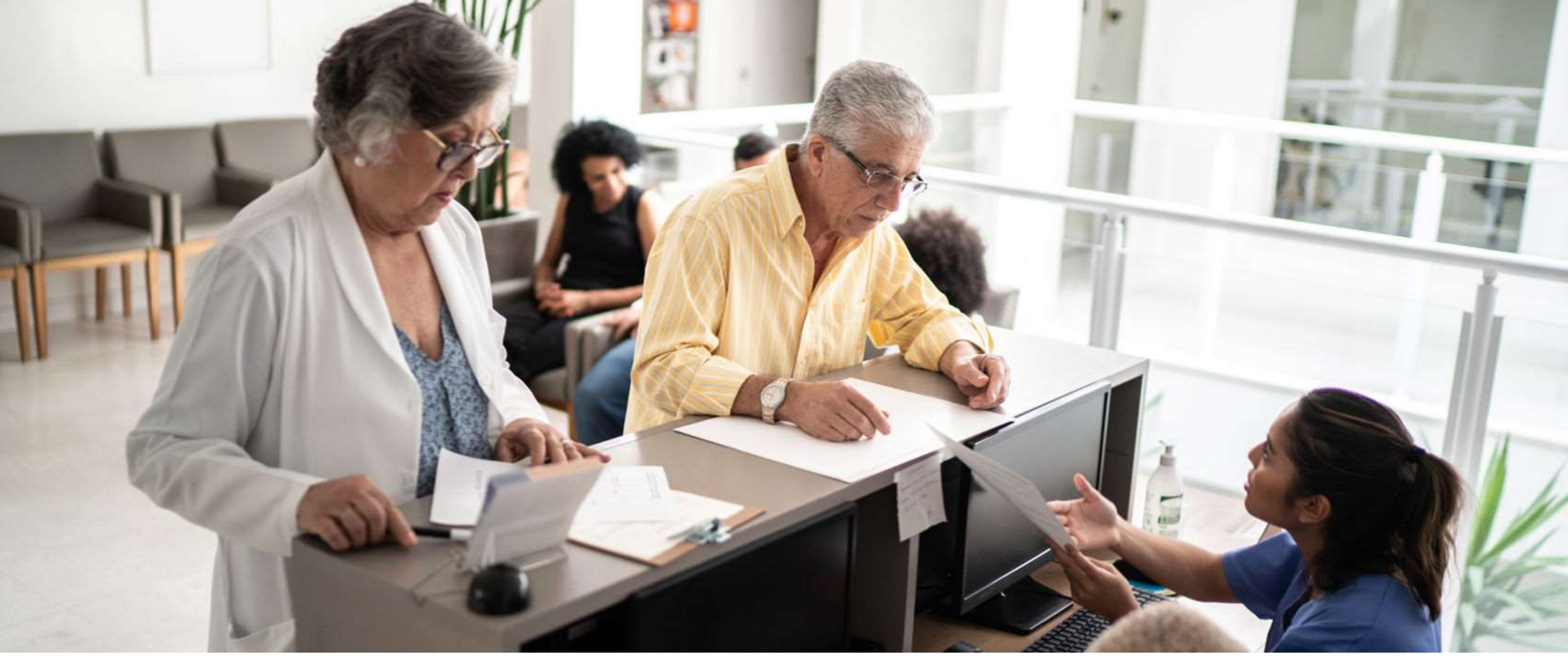
– Office staff in a mental health care provider's office

One interviewee suggested that marketplace plans seem to require authorizations for procedures that other plans cover automatically and take longer to process authorization requests, which further research could explore.



A lot of things that commercial insurance covers without a prior authorization I find that I'm filling out prior authorizations for the state insurance plans or the marketplace plans."

– Office staff in a mental health care provider's office



Conclusion

The administrative professionals interviewed for this report cited challenges for patients in keeping up with changes in networks and insurance status. Although referrals and prior authorizations may have the potential to promote coordination and reduce inappropriate care, interviewees saw those requirements as negatively impacting patients and making their own work unnecessarily difficult.

While these interviewees all reported that they were employed in practices that treat significant proportions of people covered by marketplace plans, they spoke about working with patients covered by various types of insurance. In fact, narrow networks, referrals, and prior authorization requirements are common beyond marketplace plans and likely create challenges for patients with many types of coverage. Because administrative professionals interface so intensively with many types of patients, insurers, clinicians, and health systems, efforts to improve coverage and care may benefit from including their insights.

Methodology

Public Agenda conducted twelve in-depth, confidential online interviews from March 6 to March 24, 2023. All interviewees were either medical practice managers or office staff. Six interviewees identified the offices in which they were employed as a primary care or general practitioner's office; three identified themselves as working in the office of a psychologist, psychiatrist, therapist, counselor, or licensed clinical social worker; and three worked in the offices of endocrinologists or other diabetes specialists.

The interview protocol was designed by Public Agenda. A professional recruitment firm, Sago, recruited the participants to Public Agenda's specifications, seeking to recruit for a diversity of racial/ethnic identities and a balance of men and women. Public Agenda staff conducted interviews in English. Interviews lasted 45 minutes and participants were paid for their time. Interviews were recorded and transcribed by Kelsey Transcripts.

Through an iterative process, Public Agenda staff developed a codebook that included variables of interest based on the projects' objectives. Public Agenda staff coded each transcript using the Dedoose platform.

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Interviewee characteristics

Practice type

Practice type	Count
Primary care	6
Mental health care	3
Diabetes care	3

Role

Role	Count
Medical practice manager	7
Medical office staff	5

Gender

Gender	Count
Male	3
Female	9

Race/ethnicity

Race/ethnicity	Count
Asian	1
Black	5
Latino	1
White	5

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