The Value of Narrow Networks in Impacting Plan Costs

This article represents “commentary” and represents views of the authors.
We welcome other opinions on the subject

The more things change, the more they stay the same... Back in the olden days of managed care (mid-80s to mid-90s), HMOs and EPOs were the weapons of choice in the fight against skyrocketing healthcare and health insurance costs. As we moved into the late 90s and early 21st century, both lost favor in the market due to a lessening of healthcare cost pressures and a desire for patients to have open access to providers.

Fast forward to 2015. We once again find ourselves in the throes of significantly increasing healthcare and health insurance costs, the Affordable Care Act and the use of Medicare repricing as a replacement of traditional PPOs. And guess what?! The focused, restricted network is gaining significant interest and traction in the market. We’ve just changed the name to give it an appeal that the Exclusive Provider Organization (EPO), never really enjoyed. Today we speak interchangeably of Narrow Networks, Focused Networks, High Value and High Performance Networks.

Written by Corte Iarossi
How Do We Define These New Network Iterations?

There appears to be several standard elements, as well as some variation depending upon the network:

• Focused provider contracting within a geographic area with the intent of providing access to key providers and facilities.
• Desire to direct patients to select providers in return for extremely favorable reimbursement rates.
• Provider contracts can be based on varying payment mechanisms including but not limited to reference based pricing (e.g. Medicare), pay for performance, value-based and capitation.
• An intent to offer price and quality transparency and to engage the patient in the process of purchasing healthcare services so that they can be discriminating consumers.

The reality is that we're likely to see multiple variations on these themes over the next several years as the market matures and competitive innovation increases.

Now, let's put this in the perspective of current market trends: The following was taken from the Towers Watson 2015 Emerging Trends in Healthcare Survey. Companies seeking to achieve and sustain such high performance need to develop clearly defined, comprehensive and aggressive multiyear strategies for maximizing their health care investments.

• Health care costs for 2015 are projected to increase by 4% after plan changes, compared to the 4.5% employers previously projected for 2014. Without changes, the increase would have been 5.2%.
• The excise tax is a primary focus of companies' health care strategies. Two-thirds of employers (62%) say the 2018 excise tax will have a moderate to significant impact on their health care strategy. Two in five employers that have done extensive modeling of their plans say they will trigger the tax in 2018.
• Employers continue to partner with their vendors to link payment to value and enhance networking strategies. Use of COEs and narrow medical networks is expected to more than triple over the next three years.

What Does this All Mean in Terms of Options for Self-funded Health Plans?

• We anticipate that many carriers, ACOs and independent network organizations will develop their version of the Narrow/High Performance Networks.
• Multiple options will offer self-funded health plans greater choice and leverage in negotiating pricing.
• Many of the networks will utilize Medicare allowables to establish their contractual relationships in return for increased patient volume and the ability for a provider to carve out its competitors.

Which Specific Actions Do Self-insured Organization Have in Place or Are Considering Between Now and 2018 for Their Health Care Program?

<table>
<thead>
<tr>
<th>Network/Provider Strategies</th>
<th>In Place Today</th>
<th>Planned for 2016</th>
<th>Considering for 2017/2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Offer telemedicine (e.g., real-time interactive services that leverage mobile collaboration technologies)</td>
<td>38%</td>
<td>17%</td>
<td>26%</td>
</tr>
<tr>
<td>Expand use of centers of excellence either within your health plans or via a separate network</td>
<td>22%</td>
<td>16%</td>
<td>37%</td>
</tr>
<tr>
<td>Engage a third party to secure improved pricing on medical services</td>
<td>16%</td>
<td>5%</td>
<td>16%</td>
</tr>
<tr>
<td>Offer benefit differential for use of high-performance/narrow medical network</td>
<td>13%</td>
<td>9%</td>
<td>39%</td>
</tr>
<tr>
<td>Contract directly with physicians, hospitals, ACOs or patient-centered medical homes</td>
<td>10%</td>
<td>2%</td>
<td>19%</td>
</tr>
</tbody>
</table>

(Information taken from the Towers Watson 2015 Emerging Trends in Healthcare Survey)
IHC Risk Solutions would like to thank everyone that has allowed us to become their "Trusted Partner". With your help, we have reached new heights as one of the most accomplished direct stop-loss operations in the industry. We are committed to scaling new peaks together—ensuring our mutual success.
Smaller boutique companies will offer Client tailored network options allowing Plans to create a program that meets the needs of its employees. This could include:

- Exclusive use of the network with no out-of-network benefit.
- The ability to offer a Wrap PPO for out-of-area and out-of-network services.
- Three tiered options using a Narrow/High Performance Network, a Wrap PPO and a separate out-of-network benefit.

Pricing on a PEPM could vary greatly, depending on the network:

- Some independent rental PPOs may offer their own Narrow Network solution at a rate higher than the typical PPO option. Potentially $8-12 PEPM.
- Carriers offering Narrow/High Performance Networks may also increase the cost of accessing the network reflecting the greater savings anticipated.

There may be a push toward offering performance rewards to providers to enhance the quality of care and reduce utilization as appropriate. The end result could be additional Plan savings.

Health Plans utilizing a Medicare repricing alternative to a PPO may consider implementing this type of PPO option in lieu of the more draconian approach to eliminating the PPO altogether.

Conclusion

There are those that believe that the PPO will be replaced with a free-form use of Medicare or other Reference Based Pricing mechanism to discount medical bills. Though there may be a place for this solution, we contend that there will be a rebirth of the PPO in a form that can achieve significant savings, enhance the quality of care and provide employees/members/patients the peace of mind that the provider will accept the payment in full (less copays, deductibles and coinsurance). This appears to be supported by a recent FAQ by the Feds related to the Affordable Care Act (released October 10, 2014), that attempted to define “reasonable access” in terms of Reference Based Pricing:

Plans should have procedures to ensure that an adequate number of providers that accept the reference price are available to participants and beneficiaries. For this purpose, plans are encouraged to consider network adequacy approaches developed by States, as well as reasonable geographic distance measures and whether patient wait times are reasonable. (Insured coverage is also subject to any applicable requirements under State law.)

The underlying concept and one in which we feel supports the movement toward these Narrow/High Performance PPO’s is the reference to “networks”. Though time will tell, we believe the ground work is being laid through the Affordable Care Act to protect patients through network access and which will support reference based or value-based contracting with providers.

Corte B. Iarossi is the VP of Sales and Marketing at United Claims Solutions and can be reached at (866) 762-4455 x120 or via email at ciarossi@unitedclaim.com.

Network solutions with simple implementation and administration. Together, we offer more than a PPO.

Quality, Value, Accessibility and Service
Your National Choice for Network Solutions
Contact us at fhmarketing@firsthealth.com

First Health® is a brand name of First Health Group Corp., an indirect, wholly owned subsidiary of Aetna Inc. Cofinity® is a brand name of Aetna Inc. The services offered under the Cofinity brand are offered by Cofinity, Inc. and/or Aetna subsidiaries or Aetna-contracted parties. Aetna is a brand name used for products and services provided by one or more of the Aetna group of subsidiary companies.

©2015 First Health Group Corp.