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Major Concerns with Narrow Networks

“The Economic Imperative and the Ethical Challenges”

In the USA Narrow Networks have grown in popularity because cheaper premiums appeal to price sensitive consumers.

According to a study by the consulting firm McKinsey and Company, in 2014 the USA featured limited Networks and the premiums were up to 17% cheaper than plans with broader Networks. With the escalation of health care costs, payors are leaning to Narrow Networks to keep health care costs down. These Networks are inclusive of FPs, specialists and hospitals.

Regardless of what happens legally and politically with health care reform law, Narrow Network plans are likely to continue proliferating because of price advantage. There is a general consensus that Narrow Networks lead to reduction in health care utilization and spending. These Networks save money by selecting lower cost providers into the Network. Here is where the first argument surfaces. Are these providers providing quality care?

The notion of Narrow Networks is not a new one in the health care industry landscape. The notion of selective contracting dates back to 1982 in the USA. There was a development of exclusive networks of providers at predetermined reimbursement rates and this led to lower prices. There was also the use of incentives that aided the uptake. Employees were offered “premium holdings” if they enrolled in one of the several Narrow Network plans.

From the USA there are reports of up to 25% reduction in premiums. This induced 11% of workers to enrol. Further Narrow Network plans are associated in some areas with a 40% lower spending. There was a reduction in emergency department use and reduction in visits to specialist providers. In these programs there was no evidence of adverse outcomes that were determined.

In addition, Gruber and McKnight (2016) in a study of Massachusetts State and Municipal employees found an increase in Primary Care utilization. However this is in relation to the few providers in the Network and a relative increase in Primary Care utilization. The savings and alleged benefits of Narrow Networks is also described by Alicia Wood, Anthony T Lo Sasso in the Journal of Health Economics 50 (2014) 86 – 98.

However on closer investigation spending reductions suggest that selection of lower cost providers who on average also tended to provide somewhat fewer services, accounted for 96% of the average savings. We need to examine the issues that must be addressed with Narrow Networks and what are the consumer and provider concerns.

The first issue is the choice of providers who are invited to participate. Essentially there is no transparency, what criteria are used to select Network providers be it Primary Care Specialist,
hospitals or other professionals. Is it simply costs? Does Quality enter the selection process? This is a grey area. Often there is inadequate access to this information.

The argument is we need evidence that these doctors who are invited into the Network are assessed for Quality, Cost, working hours, and are accredited to provide the necessary care.

What criteria are used to determine the Network size? What is meant by adequate Network size?

Many providers oppose this trend including those who are involuntarily terminated or excluded from existing broader Networks. This program will impact on the survival of small but efficient Family Practices if they are excluded without reason.

What are some of the consumer grievances?

There is a loud consumer ground swell against these Networks. Some of the issues raised:

1. Disruption of continuity of care. This is especially if a patient has a long relationship with a doctor and is well managed. Also the entire family has a bond with the doctor.
2. Violates patient’s autonomy and his/her democratic right to choose the provider of his choice. This is more pertinent if the provider is ethical and professionally competent.
3. It is a clear case of supersession.
4. The co-pays for out of Network visits are not affordable to low income earners no matter what the argument is to justify a “small” co-pay.
5. Often in rural and suburban areas the Network doctors are not easily assessable. The time and cost of travel is a deterrent to seek care.
6. Instead of going to a Network doctor for one disease entity, patients may be forced to take their whole family to the new Network practices and this impacts the original family doctor who will often see an attrition of their practices.
7. Patients are not always aware of any premium decreases and may not see their premiums drop.
8. Who benefits from all these reported savings?

These are issues raised in first world countries with fairly well informed patients. One must factor this into any third world environment that this will become a major challenge. What are some of the other provider concerns? Here again we need to learn from the USA where these programs are part of the Accessible Care Organization and part of Obamacare.

Physicians oppose these Narrow Networks, when there is no clarity of how and what criteria is used to choose Narrow Networks participants. Narrow Networks have consequences for both included and excluded physicians. Excluded physicians may face a smaller pool of potential patients and a drastic fall in income. While included physicians may experience financial challenges as the reimbursement rates in those plans tend to be lower than the others.

To counteract the negative effects of Narrow Networks physicians must think strategically. If physicians simply react or try to react against the Insurance Company that is going to use Narrow Networks as a negotiating tool, they are going to find themselves on a defensive and never be able to be effective.
Alternatively physicians and partners should partner to create high performing groups that improve care and quality while reducing costs.

Physicians need the process of healthcare change and they need to be the innovators and implementers of technological solutions.

Physicians must come together and create, some form of an “Accountable Care Organization” or some sort of multi-speciality medical group or in some other alternative.

We need an alternative to an insurance company driven Narrow Network. We need to embrace and develop Integrated Care.

If physicians do this successfully they can use this as a negotiating tool with payers that are attempting to exclude them from certain networks. We, the providers have allowed this to happen. If they are the premier provider of care in the community, then the Insurance Companies will be hard pressed to exclude them from coverage and that could lead to increasing the negotiating leverage.

It is felt that physicians are the best individuals to step forward. They know their patients. They know patient care, they have commitment to Quality. Physicians are best qualified and positioned to lead the process. Physicians sadly have not stepped forward as often as they should and often they are battered down.

From a provider perspective, we must accept that healthcare costs are escalating beyond control. To survive this, funders need to look at alternate reimbursement arrangements and strategies. In hindsight, providers have never been proactive. We react. We also react without an alternate plan. Maybe the emergence of Narrow Networks will galvanize us to become lateral thinkers, think strategically, develop alternate and better programs and use this as a bargaining chip. Funders will adopt this as it takes away the need to invest into developing alternate programs and often times controversial alternatives.

**Legislation**

Thus far in the USA Federal and State regulations on Narrow Networks are vague and inconsistent. Narrow Networks are described by some as being reminiscent of the HMO style plans that spurred a backlash in the USA in the 1990s.

In the USA there will be soon growing political pressure to regulate Narrow Networks as they begin to grow. We are poised to hear loud consumer groundswell against this practice.

Some observers predict that insurers will have to ease up on how “skinny” they make their Networks.

After controversies on Narrow Network adequacy, it led to several lawsuits against insurers.

In Montana in the USA, the Insurers were urged through the Insurance Commissioner to include 80% of providers in their plans. The Insurers did not take to easily.

In South Africa we may see Narrow Network guidelines in the revised Managed Care Act.
The other arguments that emerged is, how should an adequate Network be defined and should the insurers offer their terms and adopt an “any willing provider” network option. This was opposed by Insurers as it was going back to the concept of a broader network program.

**Consideration for the future**

1. Providers must be proactive and not reactive. We need to think laterally and not just oppose programs but have an alternate business model to bargain with.
2. We need to have a strong Integrated Care model that will be a solution that Funders are trying to achieve.
3. Providers need to “up their game” and work in teams.
4. Insurers in making decisions regarding premiums, reimbursement rates and network provider’s contracts, increasingly should assess whether consumers and regulators are more “sensitive” to price or to network size.
5. Insurers can mitigate the regulatory and litigation risks associated with Narrow Networks by increasing transparency to consumers.

It is important to remember in any innovative healthcare program, that you cannot bend the “cost curve” by manipulating the “clinical curve”.

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