Narrow Networks and Rationed Health Care, Version 2017

written by Theresa Hush | July 13, 2017

For decades, our nation's health care system has been highly valued for its bounty. Access to the most advanced technology, surgery and expertise has been a point of pride.

The concept of rationing health care, by contrast, has been taboo. We accused the British of rationing in their universal health system when people had to wait for care or couldn't get specialty services. We proudly counted the number of Canadians crossing the border to get cardiac surgery in this country. Oregon was accused of rationing when it released a list of prioritized health services under its health system, and the label of "death squads" was attached to attempts to evaluate medical effectiveness in the original Affordable Care Act (ACA) proposals.

But that was before health care became impossibly expensive for business and consumers.

Health Care is Now Being Rationed by Default and Obscure Design

Today the health care system's bounty is in process of contracting. That's because rationing has slipped in under the radar. Not all rationing is understood by providers in the industry, and much is hidden from consumers and employers.

At one level, most of the public is waking up to the debate about consumer access to affordable coverage. Repeal of the ACA could effectively ration services based on the individual's ability to pay. But at least (in theory) a public forum will determine the outcome of the Congressional debate. Consumers essentially voted in favor of this policy shift, whether they fully understood it or not.

Less clear is how services will be rationed as a result of limiting benefits and loosening requirements for health insurers to cover pre-existing conditions. This issue is not limited to individuals seeking health insurance coverage through exchanges, since employer-provided insurance coverage is subject to ACA rules. But if that insurance excludes certain benefits that the employee suddenly needs, the employee no longer has access to those services.

Narrow provider networks also represent rationing, and this is largely invisible to consumers. Invented by health plans to exclude certain providers solely on cost, narrow networks, by definition, include lower cost hospitals and physicians. But we shouldn't mistakenly confuse this with value—by defining the network on the basis of cost alone, many academic systems and specialty providers are excluded.

Narrow networks are accomplished by negotiations between health plans and provider networks, which are consummated throughout the year. Consumers may be caught unaware that their choices are being limited in the process, or may not understand the implications of limited provider choice in their benefit plan, especially since they can't always predict future service needs. A health plan may also change its benefit network after a company's consumer benefits choice period is completed. There is often no easily available information for consumers to compare provider networks, and no guarantees of care for those whose needs change outside of benefits choice periods.

New Narrow Networks Limit Providers More Severely

Under the ACA, Health Plans' narrow networks became more prominent as a way of creating lower premiums. Employers were quick to identify potential savings by adopting them, since ACA plans are sold to employers, too. Significantly, the majority of plans offered in exchanges

are now associated with “narrow networks,” or lower cost providers. In fact, 75 percent of ACA plans in 18 states were projected to have narrow network plans in 2017. According to one study, however, 26 percent of those who purchased coverage from the exchange policies *did not understand that they were purchasing coverage with a narrow network.*

The trend has its proponents. Blue Cross plan officials support the shift toward narrow networks because research does not demonstrate that high-priced hospitals score better in quality measures. However, quality measures reflect only the most basic data and do not adjust for vastly different populations across providers. Performance measures historically do a poor job of realistically differentiating between results for highly complex patients and poor socioeconomic populations.

Nonetheless, the push for narrow networks appears to be gaining momentum, at the expense of access to specialized care. A recent study by University of Pennsylvania researches indicates that narrow networks may drop coverage of providers at National Cancer Institute Designated Cancer Centers in order to control costs. Academic and specialized hospitals with higher cost structures are also often on the chopping block as narrow networks are created. The survival of research and teaching institutions will be called into question if solutions cannot be found in the system or these organizations.

For employers and consumers alike, one of the most confounding problems is comparing networks and benefit plans during the annual insurance renewal process. As mentioned earlier, the provider list is hard to obtain and it is almost impossible to compare the full scope of coverage. Narrow networks implicitly limit services because not all services are available from all providers; furthermore, in many cases, the need for certain subspecialty services can’t be identified ahead of time. Insurers do not track providers at this level—and actually would prefer that their networks not be so attractive to patients who would need very costly care.

Best Provider Strategy for Managing Network Participation

Providers must have not only a negotiating strategy, but also an underlying cost and quality performance strategy for your market. The days are gone when any provider can command network participation simply because you offer unique services, such as pediatric specialty care. Most employers require employees to choose between a tightly constricted plan or a higher price plan—and will offer both. But that ensures a sicker population of patients for higher cost providers. If you are that provider, you will also have a harder time achieving attractiveness to narrow networks in the future, since your costs will go up.

How to respond? Create a systematic plan that will improve your long-term position in a market that is quickly distinguishing providers based on cost:

- Establish cost performance measures for both facility and professional costs.
- Increase your quality performance by a broad system of quality measurement and improvement—you need your profile to reflect not just cost, but also the full spectrum of your efforts to improve outcomes.
- Negotiate with health plan to capture full claims information on primary patients whenever feasible, as well as other comparable cost data, and populate this data in technology for analysis.
- Participate in the full MACRA MIPS suite using a QCDR, for maximum flexibility and power to target quality and cost performance. If a provider does particularly well, this success can be leveraged in negotiations with commercial payers.
- Establish marketable bundles of care to consumers who are price-conscious and looking for information, such as care and procedural episodes, provision of price and cost data.
- Engage and solicit consumer input and develop shared decision-making processes. Help your patients ask questions and participate in the process on their terms.

How Can Consumers Navigate Network Choices?

Consumers have a much more difficult task because you must make decisions among predetermined coverage options. But you should be vocal about what you need both before and after the choice process. Become more active in both coverage selection and managing health care choices after coverage:

- Organize or participate in health plan selection processes. Request information in detail about network providers, access to highly specialized services, and options in the event you need essential care that is not available under the plan.
- Become knowledgeable about your health care status and conditions. Ask providers to be involved in a dialogue about tests and treatment that will lower costs.
- Request quality measure data, including specifics on quality measure results that apply to you. You should know how your major health outcomes compare to other patients—and what you can do about them.
- Ask for cost information and prices. You have a right to know what you will have to pay, and what might not be covered.

Providers and consumers can work together to create benefit plans that focus on both quality and costs. Unlike the previous era of managed care, where data was sparse and increases in health care costs were more willingly borne by employers, there is a clear possibility that both

groups of stakeholders will have greater motivation to collaborate on solutions that will achieve lower costs and greater flexibility to achieve better outcomes for patients.

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Image Credit: Paul Dufour