

## **Narrow Networks & Reference-Based Pricing Gain Interest by Emphasizing Quality Care at a Cost-Effective Price**

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In the current health care environment, insurers and Employers continue to look for ways to control premium increases and lower health care costs, and network construction is at the center of cost containment and care quality discussions. Emphasis is being placed on steering employees toward the best performing and most cost-effective Providers.

At the heart of the network discussion is the Affordable Care Act (ACA) and the desire to keep public exchange Plans affordable, but the focus on network management impacts self-funded groups as well, as they work to contain costs, while providing their employees with quality health benefits at a manageable price point.

### **The Narrowing of Networks**

Just as Plan sponsors turn to self-funding to gain a sense of control, they look to networks to further regulate price and achieve desired results. The benefit of establishing narrow Provider and hospital networks is to meet Patient needs while delivering quality outcomes at a lower cost. Narrow networks can provide cost-saving alternatives to the more traditional PPO and fee-for-service payment systems in the market. But there is a trade-off when walking away from a broader network – narrow networks tend to restrict choice in order to potentially achieve greater cost savings or lower premium rates.

The total potential savings and ability to change utilization patterns to capture potential savings are what drive the success of a narrow network in terms of results. Overall savings are tied to the scope of the narrowing, in terms of being hospitals only, hospitals and specialists, outpatient services, labs, etc. Cost differences between what is “in-network” or “out-of-network” and other factors contribute as well.

Utilization is tied to the available capacity in the narrow network, such as the network’s ability to handle care demand from members. Other considerations include whether the network is geographically accessible and if members are willing to make a switch. There also should be both member and Provider incentives in the Plan design contracts to encourage participation. Brokers and groups should take all of these factors into account when evaluating a network.

The concept of narrow networks has been around for years, but interest has grown since the implementation of the ACA-related exchanges. Many find the use of narrow networks to be far more relevant as a care quality and cost-saving tactic. Many networks take a tiered approach to introducing a narrowed set of Providers, while others choose a full network replacement in the form of an Exclusive Provider Organization (EPO) Plan in an attempt to shift care to more cost-effective Providers. The member Plan design is critical in these situations, as there must be a significant financial incentive in order to change people’s behavior.

To Stop Loss carriers, the importance of Plan design is magnified even further in such a situation. A financial incentive may be enough to entice members to utilize narrow network Providers for normal services, but if they are facing a serious illness with more complicated procedures or treatment Plans, they may be willing to pay more money to go outside of the network to what they perceive to be a better doctor or facility. Therefore, for narrow networks to have an impact on specific stop loss claims, a closed panel/EPO approach would provide the most influence.

### **A Move to Reference-Based Pricing**

More and more vendors and TPAs also are starting to participate in networks that use reference-based pricing (Medicare-plus contracting) to control costs at the source – what hospitals, facilities and Providers charge for their services. Many

feel reference-based pricing can reduce medical spending by defining what the Plan will pay for services based on prevailing Provider charges or industry benchmarks.

Plans can define what they will pay in relation to the customary charges for certain high-volume services. This could be for something like a hip or knee replacement or specified diagnostic services. Plan members can then choose a Provider that will accept the reference amount as payment in full, or one that charges more. Choosing one that costs more, however, can result in the Plan member being responsible for the balance of the charges.

Another approach uses reference-based reimbursements instead of a traditional PPO network. Typically, this is used more with hospital or facility claims, and a Physician network remains in place for managing Physician-related charges. Plan sponsors work with Plan administrators to establish a Plan that specifies the level of Provider reimbursements in the Plan document and then use a repricing vendor to reprice the claims. Payment levels are either defined by the Medicare fee schedule or another acceptable reference in the industry, such as the Centers for Medicare and Medicaid Services (CMS) Cost Ratio. Plan language then specifies the payment level as the Medicare reimbursement amount or the defined "cost" plus a certain percent.

From a reimbursement perspective, there is a clear advantage to the stop loss carrier paying Medicare-plus rates on high-dollar claims, as opposed to paying based on traditional PPO contracts. However, there are still some issues that need to be addressed in these areas.

Due to the lack of a contract with the facility or Provider in the reference-based pricing model, there is the risk of negotiations for reimbursement exceeding the Medicare percentage that was agreed upon in the pricing process. Also, negotiations or litigation may extend well beyond the date of the contract, which can present reserving issues.

Should a member receive services from a Provider unwilling to accept the arrangement, stop loss carriers would need to determine how the member was able to gain access to that Provider based on the Plan guidelines and/or what solutions can be put into place to protect members from being balanced billed by Providers that are unwilling to accept this arrangement. Further, not all services are addressed by Medicare, so the determination of a full menu of prices based on one source may not be feasible depending on the components of the Plan. The payment structure must first be determined for the claimants, and then it should be compared to current PPO contracts.

### **Research, Review and Education Essential to Success**

Knowing costs ahead of procedures can help Plan members and Plan sponsors make the most cost-effective decisions about treatment options within a health Plan. Narrow networks and reference-based pricing both offer options to help control costs, but they are not the right fit for every organization. Both methods require employee education and additional work on the part of the Plan administrator in coordinating agreements with Providers. When considering both tools, Plan sponsors should be comfortable with the additional work, research and review involved in order to manage the growing costs of providing health benefits to their employees.

### **About HM Insurance Group**

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