Do's and Don'ts of Narrow Networks

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Today’s Presentation

- Overview
- Consumers’ / Insurance Agents’ Perspective
- Providers’ Perspective

Narrow Network Aliases

- HMO
- High Performance Network
- Directed Care Network
- Provider-centric Network

History

- HMOs
- Managed Care
- Our 1990s Experience

Why Have Narrow Networks Returned?

- It's Mostly About the Money
  - Payers
  - Employers
  - Patients
  - Providers
- Clinical Integration

Insurance Agents'/Consumers' Perspective

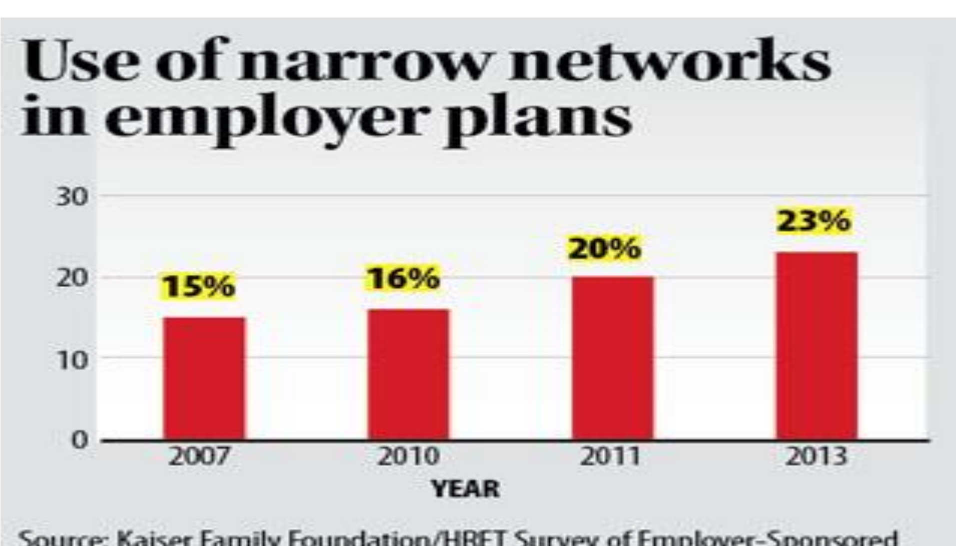
Well…here's another

Nice Mess

You've gotten me into

Plan Design

- Commercial Plans / Individual Plans/ Marketplace
- Traditional, PPO, HDHP
- HMO: the beginning of the Narrow Network Concept
- Medicare
- Medicare Advantage; the next evolution of Narrow Network



Premiums; Differences Between Narrow Network and Broad Network Products

- Plan Difference
- Marketplace
- Medicare Advantage

Blue Care Direct Silver with Advocate	Blue Precision Silver HMO	Blue Care Direct Gold with Advocate
$434.19	$482.43	$494.56

Agents

- Selling on Price, Not Choice
- Reduce Cost Without Increasing Out-of-Pocket Costs
- Employer Pressure
- Deeper Discount Better for Consumer

Consumers

- Price Shopping; Shiny Objects Attract
- Networks; More Concerned About the Doctor Being in Network than the Hospital
- Who is Really Making the Choice For Coverage Being Purchased?
- Employer
- State Programs

An Educated Consumer

- Does Your Website Clearly Illustrate the Plans You Participate In?
- Primary Care and Specialty Physician Links to Participating Plans?
- Certified Application Specialist- Navigators
- Healthcare.gov
- Medicare.gov

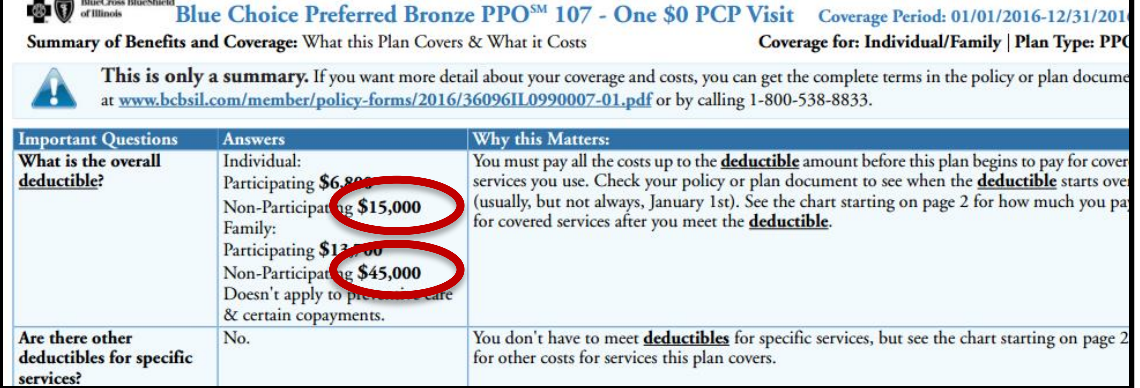
Providers' Perspective

How to Spot a Narrow Network

- You need to know the players and their product names!

Aetna Aexcel	*Anthem Exchange Plan*
Aetna Carelink	*UnitedHealthcare Charter*
Blue Cross Blue Shield Blue Choice	*UnitedHealthcare Core*

- Narrow or ultra-narrow network- look at the benefit plan design and the provider directory. There are a limited number of providers, and out-of-network benefit has a huge deductible



BlueCross BlueShield of Illinois

Blue Choice Preferred Bronze PPO℠ 107 - One $0 PCP Visit Coverage Period: 01/01/2016-12/31/201

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for: Individual/Family | Plan Type: PP**

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan docume at www.bcbsil.com/member/policy-forms/2016/36096IL0990007-01.pdf or by calling 1-800-538-8833.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Individual: Participating **$6,8** Non-Participating **$15,000** Family: Participating **$13** Non-Participating **$45,000** Doesn't apply to pre... care & certain copayments.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for cover services you use. Check your policy or plan document to see when the **deductible** starts ove (usually, but not always, January 1st). See the chart starting on page 2 for how much you pa for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.

How to Spot a Narrow Network

- Tiered network- the benefit plan offers different benefits for a Tier 1 and Tier 2 provider, with different deductibles, and then has an additional out-of-network benefit level.

- A patient centered medical home (PCMH) may indicate a narrow network. The PCMH serves as central point of care coordination for a patient. PCMH refers patients requiring additional services to specific providers who meet quality or cost thresholds. An accountable care organization (ACO) may indicate a narrow network.

	IHP Preferred Partner In-Network Tier 1	Land of Lincoln In-Network Tier 2	Out-of-Network Tier 3
Deductible [1] (individual/family)	$500 / $1,000		$6,000 / $12,000
Coinsurance [2]	20%	40%	50%
Out-of-Pocket Maximum [3] (individual/family)	$6,800 / $13,600		Unlimited / Unlimited
MEDICAL BENEFITS			
Physician	$10 copay/visit	$45 copay/visit	50%
Specialist Visit	$40 copay/visit	$60 copay/visit	50%

What to Look for in Provider Contracts

- Terms that allow plans to create narrow networks: no guarantee of inclusion in all networks in the contract, or separate contracts or rate amendments for each product line.

Examples

- ***Nothing in this Agreement shall require that Company identify, designate or include Hospital as a participant or preferred participant in any specific Specialty Program, Product (or Product variation), generally, or for any specific Payers/customer(s).***
- ***Additional Products: Plan reserves the right to introduce new products in addition to the current Managed Care Products while this Agreement is in effect and to designate Hospital as a Participating or Non-Participating Provider in any such new product.***

What to Look for in Provider Contracts

- Important terms if you want to be in a narrow network: look at rates, quality bonuses for efficiency or outcome, bad debt protection, performance reporting required of providers, term provisions indicate if how easily you can be removed from a narrow network.

Example

- ***HOSPITAL agrees to cooperate with all reasonable utilization management and quality improvement activities of Blue Choice… HOSPITAL agrees that the Blue Choice may use performance data relating to the Blue Choice's provision of service as the Blue Choice deems appropriate to assist Members and groups.***

- ***Hospital will promptly deliver to Health Plan, upon request and/or as may be required by Law… any information, statistical data, Encounter Data, or patient treatment information pertaining to Members served by Hospital, including but not limited to, any and all information requested by Health Plan in conjunction with utilization review and management, grievances, peer review, HEDIS studies, Health Plan's Quality Improvement Program, Consumer Assessment of Healthcare Providers and Systems (CAHPS) or Claims payment… Health Plan will have the right to withhold compensation from Hospital in the event that Hospital fails or refuses to promptly provide any such information to Health Plan. This section will survive the termination of this Agreement.***

What to Look for in Provider Contracts

- Pay attention to what quality measures plans are reporting! If you don't start looking at what plans are telling patients about you now, you may find yourself out of a network in the future.

Example

Home ›› Choose a Directory ›› Find a Doctor, Dentist or Facility ›› Search Results ›› Details

MERCY HOSPITAL & MEDICAL CENTER

BACK TO SEARCH RESULTS

SELECT YOUR PLAN TO VIEW ACCEPTING LOCATIONS:

Plans differ by location.

- Open Access Plus, OA Plus, ChoiceFund OA Plus
- Open Access Plus, OA Plus, ChoiceFund OA Plus with CareLink
- PPO, Choice Fund PPO

LOCATION(S) | RATINGS

RATINGS

CIGNA'S CENTER OF EXCELLENCE DESIGNATION

Hospitals are not all equal--one hospital may be well-known for its excellent cardiac (heart) care, another for its cancer care,and yet another for knee or hip replacements. Cigna reviews and rates its hospitals for many of the most common surgeries and illnesses. This review is based on two key things: patient outcomes,or how successful a hospital is at caring for patients undergoing a certain surgery or being treated for an illness, and cost-efficiency--the hospital's ability to deliver consistently excellent patient care while still keeping costs lower than average.

Patient Outcomes + Cost Efficiency (a combo of at least 5 stars) = Center of Excellence for the surgery/illness

This hospital has achieved the Center of Excellence designation for the following procedures or conditions:

Procedure/Condition	Patient Outcomes	Cost Efficiency	Center of Excellence
Bariatric Surgery, (Gastric Bypass, Weight Loss Surgery)	★★★	★★★	✪
Bariatric Surgery, (Gastric Bypass, Weight Loss Surgery)	★★★	★★★	✪
C-Section, Cesarean Section (Hospital only)	★★☆	★★★	✪
C-Section, Cesarean Section (Hospital only)			

Essential Community Providers

- Essential Community Providers (ECPs) are providers that serve predominately low-income, medically underserved individuals, and plans must have a sufficient number and geographic distribution of them. The ACA mandates that plans of the Health Insurance Marketplace must offer participation to ECPs. This usually means that if a plan is sold in a specific rating area, participation must be offered to ECPs in that rating region, but the plan only needs to have 30% of the designated ECPs in the rating region under contract. (there are other requirements as well)

- Illinois, Indiana and Wisconsin all use the CMS definition of ECPs: providers that serve predominantly low-income, medically underserved individuals, and specifically include providers described in section 340B of the Public Health Service (PHS) Act and the Social Security Act. CMS' ECP categories: (1) Federally Qualified Health Centers (FQHCs) and FQHC "Look-Alike" clinics; (2) Ryan White HIV/AIDS Program Providers; (3) Family Planning Providers; (4) Indian Health Providers; (5) Hospitals; and (6) Other ECP Providers including STD clinics, TB clinics, Hemophilia treatment centers, Black Lung clinics and other entities that serve predominately low-income, medically underserved individuals.

- Health plans set the terms and conditions of the participation (this means RATES!). If one provider accepts a low rate, that rate is offered to all ECPs.

  45 CFR 156.235 (d) Payment rates. Nothing in paragraph (a) of this section shall be construed to require a QHP issuer to contract with an essential community provider if such provider refuses to accept the generally applicable payment rates of such issuer.

How to Challenge Being Left Out

- Do you want to play by the rules? Providers need to offer low-cost, high-quality care. But there's more- plans look at geography and scope of services, too.
- Are you an ECP?
- "Access to Care" There is not a sufficient number of similar providers in the geographic area, and you will offer low-cost, high-quality care.

How to Challenge Being Left Out

- "Any Willing Provider"

  Kentucky Association of Health Plans v. Miller, 538 U.S. 329, 333 (2003) allowed states to pass Any Willing Provider laws. These laws require insurers who have come to terms with a specific provider to accept all providers who agree to those same terms. Do not apply to "self-funded" insurance plans, rarely applies to HMOs. Payers cannot limiting membership within their provider networks based upon geography or other characteristics, so long as a provider is willing and able to meet the conditions of network membership set by the carrier.

  AWPs in our region:

  Illinois, 215 ILCS 5/370h, Applies to non-institutional providers.

  Indiana, IC 27-8-11-3, Applies to all providers.

  Wisconsin, W.S.A. 628.36, Applies to health care professionals, services, facilities, and organizations.

As an Out-of-Network Provider, What to Do

- Avoid the SMB (Surprise Medical Bill)!
- Clearly post not only the payers you participate with, but the plan products.
- Educate Registration and Admitting staff- keep a current list of payers and payer products available to all staff. If you are not in a specific plan, you may want to specify that on the list.

As an Out-of-Network Provider, What to Do

- Regardless of whether you are in or out of a narrow network, you may want to have distinct financial class in your billing system for that narrow network plan- keep track of how much business comes through it to you.

- Do NOT have a policy of writing off the out-of-network portion. *It will bankrupt you*.

- Avoiding Bad Debt- collecting self-pay information up front is not a popular thing to do, but it may be the best way to make sure you get paid.

Thank you!

Any Questions?