Making Narrow Networks Work

Narrow provider networks offered by health plans to patients directly or through their employers are one of the more frequently debated manifestations of the Patient Protection and Affordable Care Act. If done right, narrow networks can provide adequate access as well as provide better clinical outcomes at lower costs for patients.

The Four Ingredients for an Effective Narrow Network
1. High-value providers
2. Payer-provider collaboration
3. Access, cost and quality transparency
4. Effective technology

1. High-value providers only

At its most basic level, a narrow network gives patients a smaller range of providers to choose from, resulting in more predictable costs for the health plan. But the real potential of narrow networks is in a health plan's provider selection strategy, according to Mike Flanagan.

"Health plans must design their networks to include only those providers that demonstrate good clinical outcomes efficiently," he says. "With high-value providers, plans can not only control costs but deliver better pricing and ensure higher quality care to members."

The result is health plans are able to attract more enrollees with lower pricing, providers are able to service more patients in the areas they excel and patients are able to receive good care at a lower cost.

2. Payer-provider collaboration

In a narrow network, both payers and providers are focused on the specific value a provider brings to a health plans' business and their members. Plans want quality results and providers must produce those quality results in order to be selected for or stay in a particular narrow network.

"By collaborating, both parties — a health plan and a provider — make a commitment to better serve the population that the narrow network was intended to address," Flanagan says. "It's in the health plans' best interest to foster and scale its provider relationships through collaboration."

Payer-provider collaboration can take many forms, starting with an automated, exception-based utilization management arrangement. Ideally, that would lead to a health plan and provider sharing clinical and financial data and results to enable them, in concert, to determine the most cost-effective and clinically effective prevention and treatment strategies for patients.

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3. Access, cost and quality transparency

Narrow networks require buy-in from health plans, providers and patients if they're going to work for all involved. That buy-in requires trust, and that trust is built on transparency, according to Flanagan.

For health plans, that means not only being transparent about which providers are in the network but also how those providers were chosen to be in that network. Was it solely based on quality? Was it solely based on cost? Ideally, it would be a combination of the two, and providers, patients and payers need to know that.

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Health plans also need to be transparent about the benefits offered through a narrow network as well as the cost of that coverage. Premiums, deductibles and copayments should be known up front, and to the extent possible, patients should know about the total and out-of-pocket medical treatment costs upfront from both providers and payers before they receive care, according to Flanagan.

“With health care consumerism on the rise, transparency will become a competitive strategy for health plans using narrow networks,” Flanagan says.

4. Effective technology

Narrow networks won’t work for health plans unless they have the technological infrastructure to handle all the network, clinical and financial data needs that come with managing different provider panels for different sets of patient populations.

At the most basic level, technology is needed for capturing provider and contract affiliations for the narrow networks. That means keeping track of which member is in which network, whether they received care from an in-network provider, whether the correct contract and provider are used to determine reimbursement and whether the provider was paid the right amount.

“As health plans build more and more of these networks, it just proliferates the complexity associated with the accuracy of those decisions and payments,” Flanagan says.

Beyond claims handling is the need for technology to help health plans and providers share clinical and financial data for the purposes of determining value. Technology is the vessel through which collaboration is made possible. Payers and providers need to be able to collect and share the data, analyze the data and then put actionable information in the hands of payers and providers at the point of service to members, according to Flanagan.

That capability is important for all health plans and providers, but it’s a business imperative for collaborating through a narrow network.

Michael Flanagan is vice president of product management for McKesson Health Solutions. Flanagan oversees product management for the network and financial management solutions. His expertise encompasses the areas of credentialing, provider data management, contracting and reimbursement. His prior experience includes more than 10 years with Portico Systems, managing all software products targeting health plan network management. He serves on the board for the Philadelphia chapter of the Product Development and Management Association (PDMA).