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Reasons why the private health insurance provider network system needs reform

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Why this paper?

The author of this paper has 31 years' experience across all forms of insurance, including health insurance, in many countries. His last 10 years have been specifically focused on health system financing in developing countries in the Middle East and Africa. The author's work has included working for a "Big 4" advisory firm, a GCC government and providing *pro bono* advice to other regulators in the Middle East and Africa. He has also provided health system financing and regulation advisory and consulting services to clients of other consulting companies.

In many parts of the world where private health insurance is prevalent, insurers (but more often their Third Party Administrators (TPAs)) will provide a list of healthcare providers (known as a "network") at which insured members may receive treatment.

For product marketing purposes, the insurer will want this network to be as broad as possible, but from a claims cost containment perspective it will want to restrict the network. This can lead to accessibility problems for members and sometimes lower quality outcomes where they are restricted to less costly facilities that may not have the financial resources to invest in new medical technology. In some countries, pressure to contain costs is the result of employers seeking to limit premium increases on their group medical schemes. The easiest way for an insurer to do this is to reduce benefits (not welcomed by its employees) or to restrict network access to lower priced facilities.

In all cases, because of the way the network system works, that is, it is "price of service driven", there is a negative impact on accessibility as well as inconsistency in and sub-optimal quality of outcomes compared to premium paid.

This paper details the problems with the network system and proposes a reform of the system which can only be achieved with the support of regulators.

Limitations on scope

This paper does not represent a full assessment of the various healthcare network systems around the world such as those arrangements prevalent in the United States of America known as "Preferred Provider Organisations" (PPOs) or "Health Management Organisations" (HMOs) which differ in a number of ways to the insurer/TPA networks discussed here.

Importantly, this particular paper draws its opinions primarily from network systems as they operate in a number of Arabian Gulf and other Middle East countries where private health insurance dominates the healthcare financing system.

Disclaimer

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Reasons why the private health insurance provider network system needs reform

Reason 1 - The healthcare network provider system itself

Most private health insurance policies will allow an insured member to seek treatment at specific healthcare providers. Health insurers (more often their Third Party Administrators) will build networks of providers and link these networks (on the basis of their relative price for services or their geographic reach) to levels of plan benefits. Basically, a network of providers accepting lower prices for their services can be offered to members at cheaper premiums. The problem is that quite often, although not in every case, quality of health outcome is determined by price paid with the result that those who can afford only lower premiums usually end up with access to providers where quality of care or health outcomes or both are lower.

Quality of care is not necessarily a difficult one to measure, unfortunately in the world of private healthcare, some regulators are reluctant to publish data on quality of care, particularly in countries where foreign direct investment in healthcare is of key economic importance.

So, we are left with a system where, in the absence of data on quality of care, quality in the eyes of the consumer is linked to price, notwithstanding the fact that the price may include the luxurious curtains, gourmet menus or valet parking provided to patients and visitors.

So, what the network system does is to allow insurers to say to consumers: “If your resources for private health insurance are limited, we will offer you limited access to healthcare facilities” and possibly with lower quality of outcomes.

Reason 2 - Consumer preference

The other problem with the network system is that individual consumers will want the best access, will (in the absence of a quality of health outcomes system) perceive the “best” as being linked to price and will therefore demand access to networks that include the “best” hospitals. This results in consumers seeking “better” networks in their health insurance plans but being unwilling or unable to pay the extra cost. This in turn results in pressure on insurers and TPAs, in order to retain business, to include the more expensive healthcare providers which either pushes up premiums (which consumers will push against) or will result in reduced profitability for the insurer.

On the other hand, employers, who often are required to pay the premiums for their employees’ group private health insurance plans, will seek to contain (or even reduce) the cost of cover. This can be done in one of two ways: either reduce benefits or restrict member access to cheaper healthcare providers.

Reason 3 - Volume rebates

The volume rebate system is an arrangement whereby, in return for achieving certain levels of claims approvals for a specific healthcare provider, the TPA will receive a rebate from the healthcare provider which, theoretically, should be returned to the insurance company which the TPA serves and who paid for the claims approved. But this is not always the case, with the TPA retaining some or all of this rebate as an addition to their profit.

It is not known how widely, if at all, this is practiced in the Gulf and wider Middle East but it certainly constitutes a leakage from the healthcare financing system as a consequence of the TPA network system.

Reason 4 - Capitation schemes and Health Management Organisation type operations

Sometimes, an insurer or TPA may say to a healthcare provider or group of providers (a subset of its network) that it will pay a maximum amount per capita for the expected number of patients annually. Once the aggregate cap is reached, the insurer will pay no more claims for treatment. If applied at the individual patient level this is egregious and often outlawed. At the general level it poses problems. If the provider has reached

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(or is close to reaching) its cap for a particular group or insurer it may start to restrict services. Once the cap is reached it may even stop providing services. The only alternative the provider has is to bear treatment costs itself.

Similar arrangements exist where insurers have capitation agreements with their TPAs in which case the TPA will assume a degree of risk and possibly seek to deny claims once the capitation limit is reached or is close to being reached.

An argument against capitation schemes is that it transfers the *insurable* risk to an entity that is not licensed as an insurance company. However, a counter argument is that the insurer is not transferring *insurable* risk but that the healthcare provider is assuming a *business* risk. I see nothing inherently wrong with capitation and in some countries in Africa it is increasing. The issues arise when regulators do not regulate it in order to protect patients. Without proper regulation, the danger is that patients will see access to care restricted.

Effects on the sustainability of private health insurance

Effect 1 - A price-driven network system distorts the market

An effect of the network system is that it drives the tendency towards oligopoly. In several countries, third party administrators that have developed large portfolios of insured members can negotiate large discounts with private healthcare providers who are desperate to be included in the TPA's network of providers as this is a key revenue source for the provider. The effect enables the TPA to be more competitive when trying to attract insurance company clients, leading to an even larger portfolio of insured members under management and so the cycle continues. On the other hand, smaller TPAs are in no position to negotiate such large discounts against provider fees leading to the opposite effect and the diminution of their portfolios.

On the provider side, the larger providers can resist such negotiating pressures from large TPAs (to an extent) and certainly the smaller TPAs have little bargaining power with large providers since the volumes of business that will result from their smaller insured member portfolios are not as important to large providers. But in order to satisfy the needs of their insurance clients, these smaller TPAs still need these providers in their network.

Accordingly, the network system drives a distorted market, in the following way. To attract clients, insurers want the broadest networks possible, these can be achieved at a better cost by the larger TPAs who thereby grow larger and even more powerful. Some would argue that driving down costs of provider services is a good thing, but this is only if the TPA passes on the reduced prices rather than retain the benefit for itself. Additionally, excessive downward pressure on provider prices produces the danger of reduced standards of service provision by the provider. Another argument in favour of this system is that the savings can be used by the TPA to improve its technology to reduce claims processing costs and also to invest in systems to detect errors, fraud, waste and abuse (EFWA). The resulting savings in overall claims costs should ultimately benefit the insurance company.

Yet the insurers have to pay a price for the services of the TPA and the more powerful TPAs will always use that power to maximize their own profits.

For employers and individuals who cannot afford to pay insurance premium rates which reflect the inclusion of the largest and most expensive hospitals, they are left with selecting plans which have restricted networks with healthcare providers who, possibly, provide lower levels of quality patient outcomes.

Therefore, it is the network system itself which is the driver towards oligopoly and results in those with restrictive financial resources having lesser access to healthcare facilities and possibly poorer health outcomes. This is neither sustainable nor desirable.

Effect 2 - Marginalisation of smaller insurers

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Health insurance is generally offered by insurance companies alongside many other lines of business such as motor, property and casualty, life insurance and others. Then there are some insurers, particularly the large health insurers in the United States who specialize only in health insurance. Elsewhere, you may also find a few locally based “monoline” health insurers who do not offer any other type of insurance other than health insurance.

The effect is that the large, health insurance focused companies or larger multiline insurers with large health portfolios tend to achieve buying power that smaller, multiline insurers cannot command. This in turn leads to pressure on pricing which eventually produces a situation seen in a number of Middle East countries where multiline insurers are forced to run their health business at little or no profit, or even a loss. They do this to protect their other business lines in markets where private health insurance is mandatory and not offering it might result in the loss of other business from corporate clients. As a result, such insurers are confined to the margins of the health insurance business and become reliant upon using the services of TPAs (at a cost) to give them a little more access to provider groups that they could otherwise not access or afford.

Recommendations to achieve quality-driven not price-driven access

These recommendations aim to replace the *perception* that “price equates to quality” which underpins the network system with a system that is built on the *principle* that “health outcomes equate to price”. If implemented, there would be no need for networks. Instead, access to healthcare providers would be based upon how much individuals and employers are willing to pay to access providers who achieve different standards of quality of health outcomes.

Recommendation 1 - Develop a scientifically, outcome-based provider grading system

A price-driven network system is detrimental to access to and affordability of quality care and desirable health outcomes. Inclusion of a healthcare facility should be based on *quality* not on *price* of services or “perceived” quality linked to price.

It is difficult to argue that there is *not* a linkage between price of services and quality of services. Quite often, it is the more expensive facilities which have advanced technologies and they are more expensive partly because they have invested in such equipment. However, as argued above, inclusion of a facility should be on the basis of quality care and outcomes, not on price. This can only be achieved by a grading system which can identify these variables. This is easier said than done.

Two main problems affect the development of a reliable grading structure for healthcare facilities. The first is the availability and reliability of data, the second is applying a risk factor to take account of the fact that health outcomes may be lower at some facilities purely because of the nature of cases that they treat. A simple example of the second problem would be outcomes related to neurospinal treatment where a particular facility develops a reputation with treating more complex cases, receives more referrals but, due to the very nature of the cases being more complicated, has lower satisfactory outcomes than other facilities. This becomes even more of a problem where the specialism is dependent upon a particularly well experienced surgeon who moves from one facility to another.

Beyond *development* of a grading system, we then have a third problem of *implementation* of a quality grading structure. As noted earlier, there are both economic and commercial obstacles to publication of such a grading structure in some countries where influential shareholders’ interests in a poorer performing facility may create pressure against publication or where governments are trying to encourage foreign direct investment in healthcare provision. The author’s belief is that such considerations should be made subsidiary to the primary public health objective of delivering quality healthcare with quality health outcomes. This is the responsibility of government.

Current network systems based on commercial factors are not efficient in delivering equitable accessibility and affordability for many so the author argues that regulation of the system in some way will not solve the

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problem of insurers desperate (for marketing purposes) to have the "best" providers in their network and the problem of oligopolistic power that lies with some payers and providers. Instead, the network system should be scrapped and replaced with a system that is based upon a reliable healthcare provider grading system.

Recommendation 2 - Redesign health insurance policies with access based on quality of provider

So how would this work? Given a reliable grading system, the insurer could design a benchmark policy that provides treatment at *any* provider that reaches a specific quality standard, regardless of price of services. By itself however, this would not work as insured members would probably still choose the most expensive providers because of the "price equals quality" myth. They would also simply opt for the most highly graded facilities. But these problems can be handled with careful policy design.

The first issue can be handled by insurers stipulating that they will pay for treatment at a facility that meets the specified quality standard but apply a "reasonable and customary" standard to contain the claim cost. However, this "reasonable and customary" cost must be quantified and established on a scientific basis and not left to the whim of the insurer to determine on a case-by-case basis.

The second issue can be covered by insurers having different levels of "quality of provider" for different policies. Basically, if an insured member or an employer wants access to higher-graded facilities they must pay a higher premium. This is not the same as the current network "tiering" system as this new approach is based upon data, facts and a scientific approach to determining what facilities an insured member can access, at what level of quality and at what price. This approach will also go a long way to reversing the tendency towards oligopoly and re-educating the consumer about the "price equals quality" myth. Finally, this system would need government oversight and regulation.

Final thoughts

Thought 1 - Does this mean the end for TPAs?

Not at all. TPAs will still be needed to facilitate efficiency in pre-approvals, claims adjudication and processing and in claims settlement as well as many other areas including the good work that is being done with mobile applications in relation to general health awareness, patient support and claims processing. Because of their data banks and technology they will also continue to provide valuable support in the areas of identifying errors, fraud, waste and abuse.

Thought 2 - What will change for the TPA?

The most significant change will be that the concept of the provider "network" will disappear as insured members will be able to access any facility whose quality grade meets the standard specified in their health insurance policy. Currently, TPAs (and insurers who manage their claims internally) will sign bilateral contracts with hundreds of healthcare providers allowing those providers to offer services to insured members based upon whether or not they are in the network for a specific insurer or policy type. Clearly, contracts will cover other aspects such as financial matters and those of an operational nature but if every TPA will now be required to pay for the services that an insured member receives at potentially every healthcare provider in the country this creates a problem.

One solution would be to settle all claims on a reimbursement basis but this would be a retrograde step as direct billing is faster and far more convenient for all. The real solution would be for regulators to provide a standard contract that would be the default contract. To avoid hundreds of thousands of bilateral contracts between every provider and every TPA (or insurer) this standard "contract" would have to be enshrined in legislation. This legislation could still allow for bilateral amendments to its terms.

Thought 3 - How can this be achieved?

There are two necessary requirements, both of which will require regulatory change and support:

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Firstly, the development and introduction of a scientific, outcome-based, risk-adjusted provider grading system. This would have to be far more detailed than just a “star rating”.

Secondly, the development of a standard contract between payers and providers enshrined in and referenceable in law. All interactions between payers and providers would be governed by this “statutory” contract, obviating the need for hundreds of thousands of bilateral contracts unless two parties wish to agree separate amendments where allowable under the law.

Thought 4 - The telehealth dividend

Reform of the network system could be combined with a greater focus on “gatekeeping” as a cost containment exercise by using telehealth consultation organisations.

Thought 5 - What would this achieve?

Firstly, it would provide transparency in the quality of healthcare providers and negate the myth that “price equates to quality”.

Secondly, it would allow insured members to access any provider on the basis of quality of outcomes (subject to the premium which they pay) rather than being restricted to a list that may not be geographically or otherwise convenient.

Thirdly, it would go some way to reducing the oligopolistic tendencies of the current network system.

Fourthly, it will remove the focus of individuals to want the “best” providers in their network based upon the “price equates to quality” myth and to remove the tendency for employers to restrict access based upon the price of provider services.

Fifthly, it would provide the comfort of standard payer-provider contracts but with as much flexibility as regulators wish to allow (Saudi Arabia already has a standard payer-provider contract).

Sixthly, it will allow insurers to design contracts that meet the needs of insured members’ and employers’ financial resources which are based upon quality of outcomes rather than the quality of the curtains!

--- *Robin Ali*

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