Opinion

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Are EPOs the New Narrow Networks?

A *New York Times* headline referred to H, M, and O as "scarlet letters."[1] This is because health maintenance organizations got a bad reputation in the 1990s, when patients rebelled against the lack of choice and critics accused HMOs of skimping on care. More recently, companies have been curbing their costs by shifting them to patients, through higher deductibles and copays. But as the market has exhausted patients' ability to absorb more costs, an emerging strategy for employers is to offer an exclusive provider organization (EPO) option.

How does this newer option compare with an HMO or a PPO (preferred provider organization)? Like an HMO, an EPO defines an exclusive network of providers and doesn't cover most out-of-network care. However, unlike an HMO, an EPO doesn't use a primary care physician as a gatekeeper for services. In addition, both EPOs and PPOs pay physicians on a fee-for-service basis; they limit patients' choice of providers—but not patient utilization of care.

Why aren't patients complaining about the lack of choice? Patients are more willing to accept narrowed networks in 2016 than they were in 1996 because they are now motivated to manage out-of-pocket expenses. And the emerging EPOs aren't small networks of physicians but, rather, are huge health systems that offer lots of choice. For example, Advocate Health Care, the largest integrated health system in Illinois, teamed up with Blue Cross Blue Shield to create an EPO that provides (or limits) access to Advocate's 12 hospitals and 6,300 physicians.

Digital health insurers are developing EPO products as well. In Colorado, the newly formed Bright Health is gearing up to provide coverage in 2017, partnering with the state's largest integrated health system, Centura Health. This will give patients access to (and limit them to) Centura's 17 hospitals and 6,000 physicians.

One advantage of a large health system is that it is often one of the largest employers in the region and can give its employees insurance options through its own system. Advocate Health Care enrolled a large group of its own employees in their new EPO. Amazingly, health costs in the EPO group increased by only 1.6%—compared with a 12% increase in the company's PPO group.

Beyond limiting choices, EPOs save money by managing contracts with their own providers. Noted health economist Paul B. Ginsburg, an Academy public trustee, said that "to the degree that EPO providers have lower fees or, in the more sophisticated versions, have lower spending per episode of care, the purchasers can achieve savings in premiums."

EPOs are likely to grow quickly in the next few years. The health systems are leveraging their size, their internal sources of insured lives (their own employees), their integrated EHRs, and their increasingly strong relationship with their own physicians. They are also partnering with insurance companies. Employers and patients will be drawn to the lower-cost option. What are the implications for ophthalmologists?

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Many ophthalmology practices function independently of any single health system and hope to provide services for multiple health organizations. As EPOs grow, the ophthalmology practice risks losing access to those patients. Paul Ginsburg sees little upside for ophthalmology, saying, "from the perspective of ophthalmologists in the aggregate, it is hard to find a positive. EPOs steer patients away from some toward others who are less costly. It also increases payer leverage to negotiate lower rates with ophthalmologists." However, through innovation and ingenuity, ophthalmologists usually manage to adapt to new systems and continue to provide efficient, cost-effective, and superb care. Dr. Ginsburg alludes to our resourcefulness when he says, "The only winners are those physicians who wind up with more patients and have the capacity to treat them."

1 www.nytimes.com/2016/02/29/business/trying-to-revive-hmos-but-without-those-scarlet-letters.html?_r=0.