

Will Virtual Pediatric Subspecialist Networks “Disrupt” Existing Narrow Networks?

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Health plans try to maintain profit margins and limit rising premiums as escalating drug prices, expensive new technologies, and higher physician and hospital expenditures increase health care costs. Rural areas have the additional issue of adverse risk because young, healthier people often move to live in urban areas, leaving an older, sicker population in these communities. Health plan cost-containment strategies include having a narrow network that excludes primary care, specialty, and pediatric subspecialty physicians whose practice patterns and/or high payment rates result in higher costs. When a health plan’s physician network is restricted (narrow), the plan has more leverage to negotiate favorable payments because a high proportion of the patients in a participating physician’s practice are enrolled in the plan. Having a network that has fewer specialists and pediatric subspecialists may also discourage the enrollment of children and adults with chronic and complex conditions when they recognize that their physician does not participate in the plan. When a plan has fewer sick enrollees, it can have lower premium costs, which also encourages enrollment of lower cost healthy people. Even when sicker people enroll, health plans with narrow networks can shift costs to the enrollees by “forcing” them to go to out-of-network providers with higher copayments to get needed care.

What do we know about the adequacy of the pediatric subspecialty network?

This question is addressed in the article by Wong et al¹ in this issue of *Pediatrics* entitled “Pediatric and Adult Physician Networks in Affordable Care Act Marketplace Plans,” and the findings are disturbing. The study analyzed the physician networks for 1836 individual marketplace plans in the silver cost category in 2014. The networks were classified by using the proportion of physicians in the geographic rating area that participated in the network according to adult specialty and pediatric subspecialty. For all specialties/subspecialties, a larger proportion of pediatric networks (43.8%) had no available subspecialists in the area compared with adult networks (10.4%) ($P < .001$). This finding is not surprising given the lower number of pediatric subspecialists compared with adult specialists for all disciplines. When the network included <10% of the available physicians in the area, the network was called “limited.” For every specialty but psychiatry, a higher proportion of pediatric (39.3%) compared with adult (27.3%) ($P < .001$) networks were limited. In addition, for all specialties/subspecialties, the proportions of narrow networks (meaning no specialty or subspecialty physicians were available) were considerably greater for pediatric (65.9%) compared with adult (34.9%) ($P < .001$) networks.

Why is there such a large discrepancy between pediatric and adult specialty networks? The smaller numbers of

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Opinions expressed in these commentaries are those of the author and not necessarily those of the American Academy of Pediatrics or its Committees.

DOI: 10.1542/peds.2016-3975

Accepted for publication Jan 13, 2017

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PEDIATRICS (ISSN Numbers: Print, 0031-4005; Online, 1098-4275).

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FINANCIAL DISCLOSURE: The author has indicated he has no financial relationships relevant to this article to disclose.

FUNDING: No external funding.

POTENTIAL CONFLICT OF INTEREST: The author has indicated he has no potential conflicts of interest to disclose.

COMPANION PAPER: A companion to this article can be found online at www.pediatrics.org/cgi/doi/10.1542/peds.2016-3117.

To cite: Berman S. Will Virtual Pediatric Subspecialist Networks “Disrupt” Existing Narrow Networks?. *Pediatrics*. 2017;139(4):e20163975

pediatric subspecialists compared with adult specialists is a factor for narrow networks. The presence of none or only 1 or 2 pediatric subspecialists working in an area results in having more limited networks. Health plans are also reluctant to contract with children's hospitals or university academic centers because of their higher costs. There are multiple reasons for this reluctance: (1) children's hospital/academic center cost differential, which may be associated with higher patient acuity levels; (2) a need to subsidize programs such as child abuse and developmental/behavioral pediatrics; and (3) the cost shift associated with caring for a disproportionate patient population with public or no insurance. In addition, there are costs related to student and resident education and training activities. Health plans may also be encouraged by large for-profit hospital entities to avoid contracting with children's hospitals and academic centers to obtain more favorable rates for their adult care.

What can be done to strengthen pediatric physician networks, especially in non-metropolitan regions? Given the uncertainty of the Patient Protection and Affordable Care Act, increased effective regulatory activity is unlikely. However, evolving technologies are likely to change the way pediatric subspecialty care is delivered in nonurban regions. During the next decade, virtual pediatric subspecialty networks will "disrupt" current concepts of network adequacy. Telemedicine subspecialty consultations are already rapidly expanding in non-metropolitan areas. Virtual radiology reading rooms are increasing their market share, especially among private practice specialists and smaller hospitals. Entrepreneurs are developing sensitive and specific computer algorithms to read ultrasounds, echocardiograms, and computed tomography scans. Cell phone-based technologies and implantable chips will monitor vital signs, have ultrasound capability, and obtain many laboratory values.

Once established and functioning, virtual pediatric subspecialty networks will compete across traditional geographic boundaries. Entrepreneurs are likely to create virtual networks and then contract with or sell them to health plans. These virtual networks will challenge the existing traditional networks of academic pediatric subspecialists but may fragment care, especially when hospitalization is necessary. Academic centers and children's hospitals will need to develop and market their own virtual networks to compete in this challenging environment. If done right, pediatric virtual networks will become a "disruptive innovation" that will make pediatric subspecialty care more available to children in nonurban areas.

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Pediatrics 2017;139;

DOI: 10.1542/peds.2016-3975 originally published online March 1, 2017;

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Pediatrics 2017;139;

DOI: 10.1542/peds.2016-3975 originally published online March 1, 2017;

The online version of this article, along with updated information and services, is located on the World Wide Web at:

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