

High-Value Provider Networks

Introduction

Evidence over the last decade indicates that by nearly every measure, the United States spends more money on health care than any other nation in the developed world. Economists estimate that national health care spending will grow at an average annual rate of 5.8 percent over the next decade—a full percentage point faster than overall economic growth.¹ And, as our health care spending grows, it crowds out other investment and spending in areas such as deficit reduction, infrastructure, education, and other priorities. Moreover, despite the trillions of dollars we invest in health care each year, we are missing opportunities to improve the value of that investment and continue to waste limited resources at the expense of improved health outcomes.

Health plans and employers have explored and implemented a range of strategies designed to improve efficiency, clinical effectiveness, and value—and have a meaningful impact on bending the current, unsustainable health care cost curve. One such strategy involves the use of high-value provider networks. Over the past several years, health plans and employers have begun to redesign benefits to encourage the utilization of higher-value providers. Relying on data relative to provider performance, health plans and employers can identify providers with a demonstrated ability to deliver quality, efficient health care and offer consumers incentives, such as reduced cost-sharing, to obtain care from those high-value providers.

Health plans' use of high-value networks is also an important way that plans can preserve benefits and keep premiums affordable as changes in the health reform law are implemented. This is particularly the case for the Medicare Advantage (MA) program—which faces major funding challenges as a result of more than \$200 billion in payment cuts, the phase-out of the quality bonus demonstration program and related program financing challenges.

Background Information on Provider Networks

Provider networks have been a mainstay of private health insurance coverage for the past 25 years—providing consumers with access to a broad range of high-



quality hospitals, physicians and other health care providers along with financial incentives for members to obtain care within the plan's provider network. Virtually all private health insurance coverage—including benefits administered by private plans in public programs such as Medicare and Medicaid/CHIP—utilizes provider networks to deliver health care benefits and services. It is estimated that 90% of all hospital and physicians participate in health plan networks.²

The most prevalent option for individuals and families covered under employer-sponsored coverage are preferred provider organization (PPO) plans—covering 57% of covered workers and dependents.³ PPOs provide subscribers with access to both in-network and out-of-network care—with lower cost-sharing requirements and out-of-pocket costs when using care delivered by in-network, preferred providers. Other network-based plans—including Health Maintenance Organizations (HMOs), Exclusive Provider Organizations (EPOs), and Point of Service (POS) plans—cover the remainder of individuals.⁴ Today, less than 1% of employees and families are covered under traditional indemnity products which do not use provider networks.

Provider networks are part of a broad array of tools and strategies used by health plans—including financial incentives for consumers, disease and care management for individuals with chronic conditions, prevention and wellness, and collaborating with providers on payment and delivery reforms—to deliver high-quality and cost-effective care to patients and consumers. By contracting with hospitals and physicians that have met standards set by established accrediting organizations, health plans work to ensure that patients have access to high-quality and effective care. These industry-wide standards, established by independent accrediting organizations such as The Joint Commission (on Accreditation of Healthcare Organizations), are used to evaluate health care

organizations such as hospitals, home health, rehabilitation and other facilities to ensure that these facilities meet state-of-the-art standards including patient safety goals and credentialing standards for practitioners to ensure high quality care for patients.⁵ Consumers benefit when receiving care in-network—because they have peace of mind that the provider meets such standards for the quality of care they deliver—and lower cost-sharing and out-of-pocket costs. Moreover, using network providers protects patients and consumers from excessive costs due to “balanced billing.” That is, consumers benefit from health plans' negotiated payment rates to contracted providers (when satisfying deductible or co-insurance amounts) and, likewise, participating providers are barred from charging any additional costs to subscribers.

2014 Federal Marketplace Plans

Data from the states where the federal government is operating the Exchange (Federally-Facilitated Marketplace, or FFM) show that consumers will have a large number of health plans to select from when making coverage choices for 2014. On average, individuals shopping in the FFM will be able to choose from 53 qualified health plans.⁶ Consumers in many states will also have the option to choose among different plan designs—PPO, HMO, EPO, or POS—selecting the one that best fits their needs. The vast majority of states will offer at least two different plan design types, with half of these states (17) offering three or four plan design choices (Appendix 1). Across all FFMs, the PPO is the most prevalent plan design (40.6% of all plans), followed by HMO (39.8%), EPO (13%) and POS (6.6%).

Although these plans may differ in the way they structure their network of providers, all health plans must meet robust standards for network adequacy and access to care. Professional accrediting organizations—such as the National Committee for Quality Assurance (NCQA) and

URAC—require plans to meet standards for access and availability of services and are measured against these standards—including standards for the number and geographic distribution of providers. Plans are evaluated on how they meet network adequacy and access to care benchmarks—such as the ability of members to get regular appointments, urgent care appointments, after hours care, and member services by phone.⁷ NCQA and other organizations are also seeking to improve measures for evaluating plans on their networks and access to care—including focusing on quality of care and related delivery system innovations.

The Emergence of High-Value Networks

The use of high-value provider networks is one component of a larger effort to redesign benefits by creating financial incentives to encourage the utilization of higher-value treatments and services, such as evidence-based preventive care, and lower utilization of unnecessary treatments and services.

Value-based provider networks are currently being designed in two ways:

- (1) The use of tiers of health care providers and facilities based on specified performance metrics, including cost efficiency and measures of quality. Copayments are then reduced for consumers who seek care from those providers and facilities that fall into a higher-performing tier and are increased for those providers and facilities that fall into a lower performing tier.
- (2) The creation of smaller provider networks comprised of selected, high-value providers who have a track record of providing high-quality, cost-efficient care to patients. Some health plans and employers have introduced products featuring these smaller networks of providers who have demonstrated their performance on quality and cost criteria.

State and federal network adequacy laws ensure that consumers have access to a sufficient number and type of physicians and hospitals in health plans' provider networks. These network designs have become part of a larger effort on the part of health plans and employers to help preserve benefits, mitigate the impact of rising costs, and promote quality care, while still providing access to a range of health care professionals and facilities.

A 2011 Mercer survey of employers found that 14 percent of large employers were using small networks of high performers. A 2011 Kaiser/HRET survey of employers similarly found that approximately 20 percent of all firms nationally offer a tiered or high-value network option.

Moreover, a recent study of small employers and their perspectives on health insurance coverage found that small employers were interested in health plans with smaller provider networks if they resulted in lower costs. Specifically, a majority of small employer respondents (57 percent) indicated that they would choose a smaller provider network if it resulted in 5 percent lower premiums and an even greater percentage (82 percent) would choose a smaller network if it resulted in 20 percent lower premiums.⁸

A poll of consumers showed a similar preference, with a majority of respondents (58 percent) preferring “less expensive plans with a limited network of doctors and hospitals” to “more expensive plans with a broader network of doctors and hospitals.”⁹

Strong Quality Criteria

While the use of tiered or smaller networks have raised questions of similarities to the 1990s managed care products, the science of quality measurement has improved significantly since the 1990s and there is now a heavy emphasis on quality as well as efficiency in selecting providers for high-value networks.

Using widely recognized, evidence-based measures of provider performance, such as those endorsed by the National Quality Forum (NQF), health plans and employers can create tiered, or smaller, networks of providers comprised of clinicians and facilities that score well on measures of efficiency and quality. A recent survey of health plans examined performance measures used by private payers and found that the performance measures used in high-value network and tiering programs most often focus on cardiovascular conditions, diabetes, preventive services, and patient safety. Not surprisingly, these areas of focus were consistent across other payment and delivery reform strategies as well, including accountable care organizations, patient-centered medical homes, and pay-for-performance.¹⁰

Evidence Showing the Benefits of High-Value Provider Networks

A growing body of data indicates that high-value networks can help drive consumers to better-performing providers and facilities while helping to reduce spending. For example:

- ▶ One plan's program assesses providers across 21 specialties based on quality of care and cost efficiency, with the best value providers receiving "Premium Two-Star" designation. The program yields an estimated average savings of 14 percent, with savings ranging from 7 to 19 percent depending on physician specialty.¹¹

- ▶ Another plan's tiered provider network uses clinical performance and cost efficiency criteria to assess providers in 12 specialties and enables employers to set the level of incentives to drive employee behavior. The plan reports that its high-value providers are 1 to 8 percent more cost efficient relative to other providers within the network.¹²
- ▶ Recognizing in-network hospitals and selected specialties (general surgery, ob-gyn, cardiology, orthopedics, and gastroenterology) on quality, cost efficiency, and accessibility performance generated savings for one plan of up to 10 percent.¹³
- ▶ A study of a high-value network in California found that use of provider tiers resulted in 20 percent lower health care costs and 20 percent higher quality.¹⁴
- ▶ In California, some of the largest employers—including the state employee program (CALPERS)—have offered a high-value plans option with premium savings of up to 25% over traditional broader network plans.¹⁵
- ▶ Health plans are also incorporating high-value and tiered networks as part of new innovations in care delivery and payment—including adoption of patient-centered medical homes and value-based insurance design. By combining multiple payment and benefit design strategies, these innovations are assuring greater value and efficiency in care delivery while promoting affordable coverage.¹⁶

Additional Advantages of High-Value Networks

Many of the new payment and delivery reform models rely on close collaborations between employers, health plans and provider groups to achieve better health outcomes, such as through accountable care organizations. Selective and/or smaller provider networks can make these

collaborations easier to implement and affect positive change in the patient population.

Additionally, while it may be too early to see quantitative evidence, some have suggested that the increased use of tiered or narrow networks based on performance metrics could have an effect among providers more broadly, motivating providers outside of these networks to improve their performance so that they may be included in such networks in the future.¹⁷

High-value networks can also be an effective way at addressing high provider prices that—according to health policy experts—lie at the heart of the health spending problem in the U.S.¹⁸ By providing financial incentives for consumers to select high-quality and cost-efficient providers, high-value networks and related initiatives can help constrain provider prices through market forces while rewarding efficiency and value.

The Role of High-Value Provider Networks in Preserving Benefits and Affordable Coverage Amidst Sweeping Changes to the Health Insurance Marketplace and Health Care System

The Affordable Care Act (ACA) includes a broad array of insurance market reforms, such as guaranteed issue, community rating, and prohibiting pre-existing condition exclusions. These reforms are intended to work in tandem with the new insurance marketplaces, subsidies, and the individual coverage requirement to expand health insurance coverage. By expanding access to care and broadening coverage, the law adds new benefits and new costs to the health care system.

- ▶ The reform law expands access to insurance and broadens insurance benefits. Anyone can sign up, including those with pre-existing conditions. These new benefits bring new costs.

- ▶ New rules strictly limiting how much premiums can differ among people in the same community will increase premiums for younger and healthier individuals.
- ▶ A new sales tax on health insurance that begins in 2014 will result in higher costs for working families, small businesses, and seniors.

High-value networks are an important tool for health plans in assuring that premiums are affordable while preserving access to comprehensive and important benefits. As a result of the high-value networks that health plans have implemented, premiums in the new marketplaces are lower than they would be without these network changes. According to the U.S. Department of Health and Human Services (HHS), individuals purchasing coverage in the new exchanges will have “significant choice and lower than expected premiums.”¹⁹

The health reform law also includes funding reductions to Medicare Advantage (MA)—the part of Medicare through which private plans provide comprehensive medical coverage to seniors and other Medicare beneficiaries. Over 14 million Americans, or roughly 28 percent of all Medicare beneficiaries, have chosen to enroll in a Medicare Advantage plan because of the better services, higher-quality care and additional benefits these plans provide. Analysis of federal data also shows that Medicare Advantage is an important option for low-income and minority Medicare beneficiaries. Beneficiaries who chose to enroll in Medicare Advantage express high satisfaction with their coverage and benefits.

The ACA imposes \$200 billion in funding cuts on the Medicare Advantage program over a ten-year period. To date, only 10 percent of the cuts originally estimated by the Congressional Budget Office have gone into effect. In addition, not taken fully into account at the time of ACA passage was the impact of the health insurance tax that begins in January. Over the next two years, that tax alone will mean a reduction of

approximately \$500 - \$1,000 per beneficiary per year on top of the Medicare Advantage cuts made in the legislation. Finally, further destabilizing this program is the impact of sequestration cuts and the threat that such cuts will continue into the future. Due to the cumulative impact of these cuts, overall Medicare Advantage funding is failing to keep pace with the growth in health care costs.

These cuts are a direct threat to the choices and benefits of Medicare Advantage enrollees. While many beneficiaries are already seeing fewer choices and higher premiums as a result of these cuts, the impact is likely to be greatly exacerbated as even larger cuts are phased in over the next few years and the Quality Bonus Demonstration Project comes to an end. Establishing high-value provider networks is one way health plans can help preserve benefits and mitigate the cost impact on beneficiaries as these changes take effect.

Further Opportunities for High-Value Provider Networks

Currently, Medicare Advantage plans are not permitted to vary copayments within their provider networks, making them unable to differentiate higher-value providers from lower-value providers. Yet, efforts are underway to use provider performance data to calculate hospital and physician payment modifiers within the traditional Medicare fee-for-service program. Similar provider performance data could be used to promote value-based choices by beneficiaries in Medicare Advantage plans if such plans were allowed to tier providers based on value and offer beneficiaries cost-sharing incentives to act on this information.

As the use of high-value networks continues to grow in the private sector, similar strategies to promote value should be explored for use within public programs so that consumers enrolled in all types of health insurance products have the information necessary and opportunity to make decisions based on value.

FFM Health Plan Options – By State ²⁰				
Alaska	PPO			
	30			
Alabama	PPO			
	13			
Arkansas	PPO	POS		
	29	24		
Arizona	PPO	HMO		
	101	71		
Delaware	PPO	HMO	EPO	
	4	5	12	
Florida	PPO	HMO	EPO	POS
	27	125	53	36
Georgia	PPO	HMO	POS	
	1	57	5	
Iowa	PPO	HMO	EPO	POS
	28	10	8	42
Illinois	PPO	HMO	POS	
	69	12	6	
Indiana	HMO	POS		
	53	1		
Kansas	PPO	POS		
	53	12		
Louisiana	PPO	HMO	POS	
	26	10	26	
Maine	PPO	HMO	POS	
	7	12	12	
Michigan	PPO	HMO		
	25	44		
Missouri	PPO			
	48			
Mississippi	PPO	HMO		
	11	18		
Montana	PPO	POS		
	25	4		
North Carolina	PPO	HMO	POS	
	26	8	22	
North Dakota	PPO	HMO		
	29	4		
Nebraska	PPO	HMO	POS	
	26	15	16	
New Hampshire	HMO			
	11			
New Jersey	HMO	EPO	POS	
	2	31	3	
Ohio	PPO	HMO		
	89	55		
Oklahoma	PPO	HMO	POS	
	36	21	3	
Pennsylvania	PPO	HMO	POS	
	70	49	16	
South Carolina	HMO	EPO	POS	
	8	27	17	
South Dakota	PPO	HMO		
	12	23		
Tennessee	PPO	EPO		
	66	8		
Texas	PPO	HMO	EPO	
	30	65	6	
Utah	PPO	HMO	POS	
	4	87	5	

FFM Health Plan Options – By State ²⁰				
Virginia	PPO	HMO	POS	
	28	52	26	
Wisconsin	PPO	HMO	EPO	POS
	29	112	12	32
West Virginia	PPO			
	13			
Wyoming	PPO	HMO		
	5	13		
TOTAL FFM	PPO	HMO	EPO	POS
	960	942	157	308

1 “National Health Expenditure Projections, 2012-22: Slow Growth Until Coverage Expands and Economy Improves,” *Health Affairs*, September 2013, available online at <http://content.healthaffairs.org/content/early/2013/09/13/hlthaff.2013.0721.full.pdf+html>.

2 The Value of Provider Networks and the Role of Out-of-Network Charges in Rising Health Care Costs—A Survey of Charges Billed by Out-of-Network Physicians. America's Health Insurance Plans; August 2009.

3 Employer Health Benefits 2013 Annual Survey. Kaiser Family Foundation. <http://kaiserfamilyfoundation.files.wordpress.com/2013/08/8465-employer-health-benefits-20132.pdf>.

4 HHS offers the following description of different plan types (available at: <https://www.healthcare.gov/what-are-the-different-types-of-health-insurance/>):

“Health Maintenance Organizations (HMOs) and Exclusive Provider Organizations (EPOs): HMOs and EPOs may limit coverage to providers inside their networks. A network is a list of doctors, hospitals, and other health care providers that provide medical care to members of a specific health plan. If you use a doctor or facility that isn't in the HMO's network, you may have to pay the full cost of the services provided. HMO members usually have a primary care doctor and must get referrals to see specialists. This is generally not true for EPOs.”

“Preferred Provider Organizations (PPOs) and Point-of-Service plans (POS): These insurance plans give you a choice of getting care within or outside of a provider network. With PPO or POS plans, you may use out-of-network providers and facilities, but you'll have to pay more than if you use in-network ones. If you have a PPO plan, you can visit any doctor without a referral. If you have a POS plan, you can visit any in-network provider without a referral, but you'll need one to visit a provider out-of-network.”

5 http://www.jointcommission.org/assets/1/18/Physicians_and_The_Joint_Commission.pdf

6 “Health Insurance Marketplace Premiums for 2014.” Department of Health and Human Services (HHS), Assistant Secretary for Planning and Evaluation (ASPE) Issue Brief. September 2013. Available at: http://aspe.hhs.gov/health/reports/2013/marketplacepremiums/ib_marketplace_premiums.cfm

7 NCQA—Network Adequacy and Exchanges White Paper. 2013.

8 J. Gabel, “Small Employer Perspectives on the Affordable Care Act's Premiums, SHOP Exchanges, and Self-Insurance,” *Health Affairs* 32, no. 11 (2013): 2032-2039, available online at <http://content.healthaffairs.org/content/32/11/2032.full.html>.

9 The Morning Consult, National Healthcare Tracking Poll: August 2013, available online at <http://themorningconsult.com/tracking-poll-topline-results-august-2013>.

10 A. Higgins, “Provider Performance Measures in Private and Public Programs: Achieving Meaningful Alignment with Flexibility to Innovate,” *Health Affairs* 32, no. 8 (2013): 1453-1461, available online at <http://content.healthaffairs.org/content/32/8/1453.full.html>.

11 UnitedHealthcare Insurance Company, UnitedHealth Premium Designation Program: FAQ for Employers (2011), available online at <http://broker.uhc.com/assets/100-7939%20Premium%20Employer%20FAZ%20Singles.pdf>.

12 Institute of Medicine, *U.S. Roundtable on Evidence-Based Medicine* (Washington: National Academies Press, 2010).

13 BlueCross BlueShield of North Carolina, *New BCBSNC Products Offer Cost Savings for Individuals and Employers* (Chapel Hill, NC: BlueCross BlueShield of North Carolina, December 12, 2012).

14 R. Steinbrook, “The Cost of Admission – Tiered Copayments for Hospital Use,” *New England Journal of Medicine* 350, no.25 (2004): 2,539-2,542, available online at <http://www.ncbi.nlm.nih.gov/pubmed/15201407>.

15 Duke Helfand, “A shift toward smaller health networks,” *Los Angeles Times*; April 3, 2011.

16 Joseph Burns, “Narrow Networks Found to Yield Substantial Savings,” *Managed Care*; February 2012.

17 H. Meyer, “Return of the Narrow Network,” *Managed Healthcare Executive*, July 1, 2012, available online at <http://managedhealthcareexecutive.modernmedicine.com/managed-healthcare-executive/news/return-narrow-network>.

18 Chapin White et al. “High and Varying Prices for Privately Insured Patients Underscore Hospital Market Power.” *Center for Studying Health System Change*; September 2013.

19 ASPE Issue Brief. Health Insurance Marketplace Premiums for 2014. September 25, 2013. http://aspe.hhs.gov/health/reports/2013/marketplacepremiums/ib_premiumslandscape.pdf.

20 Counts are based on the number of unique “Plan Marketing Name” entries, by state and product type, on HHS's QHP Individual Medical Landscape File. Available at: <https://data.healthcare.gov/dataset/QHP-Individual-Medical-Landscape/ba45-xusy>. While these numbers represent the total number of plan offerings in a state, they may not represent the actual number of plans available to a specific individual since not all plans are offered in all geographic rating areas within a state. Similarly, catastrophic plans are included in these totals, although enrollment in these plans is restricted to those under 30 or those who meet certain income requirements.



America's Health Insurance Plans
601 Pennsylvania Ave., NW
South Building Suite 500
Washington, DC 20004

202.778.3200 · www.ahip.org

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