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WHITE PAPER

Transforming Network Strategy: How Payors Can Drive Long-Term Value

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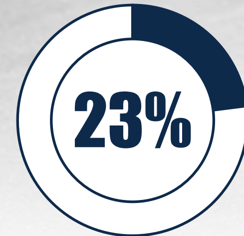
Transforming Network Strategy:

How Payors Can Drive Long-Term Value

Payor organizations have long used network design to offer competitive products to the market - with varying degrees of consumer receptivity to the inherent tradeoffs they posed between network breadth and price. In the 1990s, payors retreated from closed-network managed care products after considerable consumer pushback, swinging the industry back to open access and choice. As long as insurance purchasers could afford the annual premium increases, health plans offering the greatest network options were often the winners, with little differentiation between fully, self-insured, government or individual networks.

In recent years, this premise is again being tested under the banner of value-based care. In both Medicare Advantage (MA) and the individual marketplace, tiered and narrow network products are seeing a resurgence. A 2015 study found only 23% of MA plans included broad hospital networks, defined as greater than 70% or more hospitals in an area.[1] On the 2016 exchange, 48% of products across all metal tiers were narrowed in terms of their hospital networks.[2] Meanwhile on the employer side, tiered networks are more commonplace than narrow networks. A 2015 survey found that among employers offering health benefits, 17% had a high performance or tiered provider network in their largest plan, while only seven percent offered a narrow network plan.[3]

2015



of MA plans included broad hospital networks.

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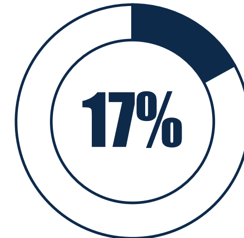

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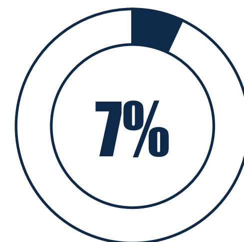
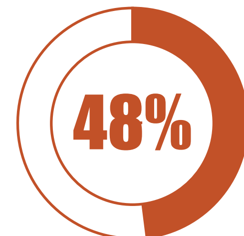


offered a narrow network plan.

2016



of Marketplace products across all metal tiers were narrowed in terms of their hospital networks.

With the current batch of limited network products in the market today, many payors have achieved short-term victories in the cost-containment game. The median premium difference between a narrowed network and a broad network silver plan from the same carrier was 22% in 2016 compared to 16% just two years earlier. The premium differential for the platinum tier was as high as 33% and in the MA space, the average premium for broad plans is almost 50% higher than that of narrow plans.[4]

Given the success of narrow networks to date and the continued imperative to contain the cost of care, we anticipate they will remain in the market and may grow in prevalence under the Trump administration. Significant change is likely ahead for the subsidized Marketplace, where narrow networks have flourished, as the new administration dismantles the Patient Protection and Affordable Care Act (ACA). Yet in the to-be-determined 'replacement' policies we expect the new administration to give the private sector — including payors and employers — significant latitude to pursue approaches to manage cost pressures, with fewer explicit consumer protections than defined in the ACA. The new administration also is likely to support privatization, with MA and Medicaid managed care likely to continue to expand, both of which employ network design to manage costs.

However, there are significant shortcomings with many of the narrow network products currently in the market that, if not resolved, will limit their impact to drive value in the market over the long-term. Challenges remain for consumer decision-making both at the time of purchase and at the point of care, including understanding which providers are in or out of network. Additionally, current determinations of network inclusion/exclusion are highly reliant on unit price rather than drivers of long-term total cost and value such as utilization and quality measures.

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In this paper, we share two significant focal points for payors to address these shortcomings, evolving the design and accessibility of narrow and tiered network products in support of longer-term sustainability. We also describe the opportunities for payors to reinforce the repositioning of network design as a key strategic differentiator, including realignment internally—in how payors are organized—as well as externally—in how payors relate to providers.

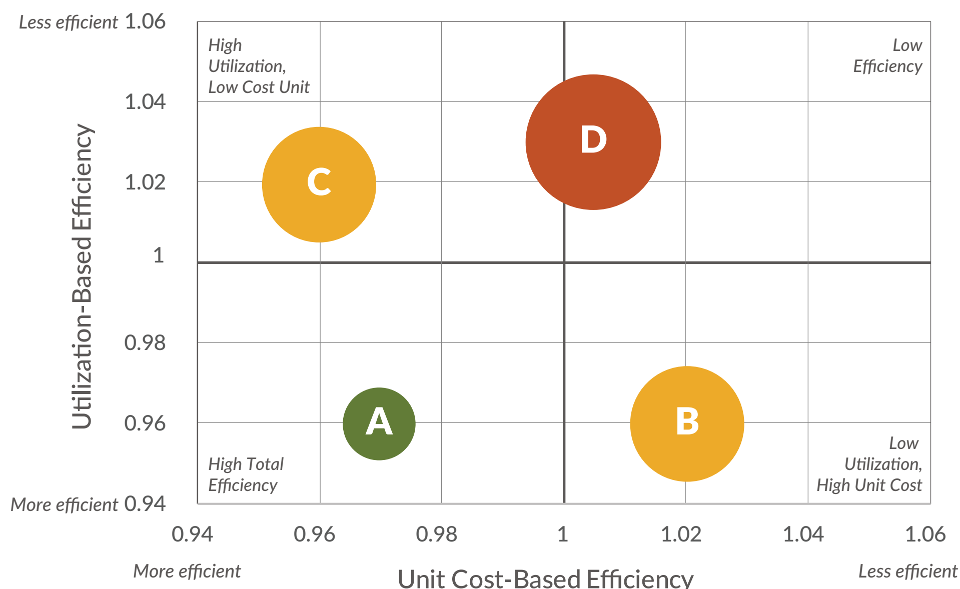
Focus Area 1: Taking a Holistic Approach to Network Design

Payors have limited means with which to directly and substantively impact premium costs in an ever-increasing price sensitive marketplace. While recognizing the complicated nature of reducing the total cost of care, where **P**rice x **Q**uantity = **T**otal **C**ost, payors have been able to achieve premium price reductions over traditional networks by gravitating to a network of providers with the most aggressive reimbursement rates for a narrow network product, or requiring unit cost concessions as a means of entry and participation. Focusing on the "P" in the equation allows payors to create relatively "quick wins" in the race to more competitive positions. However, this approach fails to address other levers that impact the "Q" side and eventually the total cost of care, namely outcomes and utilization. When narrow or tiered networks are created using total cost of care metrics rather than unit cost, a superior network design, composition and longevity can be achieved. Taken a step further, when these networks are paired with value-based reimbursement models, the economics align around the broader view of managing the health and spend of a population.

Payors are increasingly considering the total cost and efficiency of care rather than simply the fee-for-service rates a provider system may have in its contracts. Yet this is easier said than done. As payors are implementing new models for tiering providers, there is considerable pushback on the validity of the methodologies used to calculate providers' respective "value." Moreover, having reliable and complete data by which to measure provider efficiency can be complicated at times. For example, using episodes to evaluate a provider requires clear beginning and ending points as well as a definition of diagnoses and procedure codes excluded from the episode. Some payors have found their analytic tools do not capture the full scope of influenced costs, limiting their view of provider costs and performance. Payors must be able to evaluate performance in a more comprehensive way to better inform network design and with transparency in their calculations. As payors' understanding of performance progresses, so too can network design that is reflective of comprehensive performance versus low unit cost.

A useful framework for evaluating provider performance is Relative Total Cost Efficiency based on two key metrics: **Utilization-Based Efficiency** and **Unit Cost-Based Efficiency**. Relative Total Cost Efficiency assesses what portion of total cost is driven by utilization versus by unit cost. In the example below, provider A is the most efficient and provider D is the least efficient. From a network design perspective, it is clear that the payor would prefer provider A over D. However, a payor only considering unit cost may choose provider D over B, despite D's lower overall value. Meanwhile, providers B and C have the same total cost (as represented by the size of the circle), so determining which provider to include in the network is much more nuanced. Should the payor include both? If the payor were to include only one, which one would make more sense?

Figure 1: Unit Cost-Based Efficiencies and Utilization-Based Efficiencies



DEFINITIONS:
Utilization-Based Efficiency: Relative cost efficiency as influenced by utilization only, where unit cost is held constant.
Unit Cost-Based Efficiency: Relative cost efficiency as influenced by unit cost only, where utilization is held constant.
Note: Size of bubble represents total cost

An argument could be made that provider C is preferred in the short-term because it immediately provides lower unit costs, and over time could offer new incentives to lower utilization. On the other hand, provider B is more efficient on a utilization basis, which could be attractive and beneficial long-term. However, in spite of an option to lower unit cost payment levels, provider B's current utilization efficiency may represent less opportunity to manage future costs. A clear understanding of a provider's position in unit cost-based and utilization-based efficiencies is required to design and structure the most cost-conscious network. Providers gravitating to the lower left quadrant offer demonstrably more value to a high performing network.

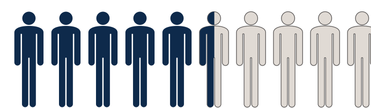
Quality-related value drivers should also inform network design. In the MA segment, many payors tie network design to performance by incorporating Stars Ratings and other quality metrics with unit cost and risk adjustment scores. In other lines of business, payors are using HEDIS, Quality Rating System (QRS) scores or other metrics to understand provider quality, and in some cases harnessing this information to begin to inform network creation. However, further work is required to continue to enhance these metrics – both in terms of the measurement methodologies themselves, as well as how these metrics align to the strategic objectives and value proposition of specific products.

Plans should continue to evolve how network design considers and accounts for the needs of the population being covered, taking into account clinical risk, geography, access – both location and care modalities – and consumer experience. For example, a plan may determine through its analytics approach that a population has a high prevalence of diabetics in a specific geography, suggesting a need for a larger complement of primary care physicians and endocrinologists than required in its region overall. Since controlling diabetes utilization would be of strategic importance, assessing providers' ability to control LDL levels, blood pressure rates, smoking and HBA1C levels would all be important criteria for network development.

A network designed around a more holistic view of cost, quality and member profile can offer longer-term value than a network only narrowed around price. The challenge for payors is to continue to evolve the methodologies by which this conceptual objective can be translated into specific decisions of who is in and who is out of a given network, or a given network tier.

Focus Area 2: Supporting Consumer Decision Making and Experience

Once it is determined who is in or out of the network, the next consideration is how such information gets communicated to consumers. Theoretically, if consumers purchase a narrow network product, then they must be inherently comfortable with the tradeoffs between access and price. But as consumers shop for coverage, they do not always have access to full information or a complete understanding of what they are choosing. A recent study of MA products found that while information was available to meet threshold CMS requirements, the network directories available were limited, increasing beneficiary burden and data errors, making it very challenging for consumers to fully understand the implications of selecting a narrow network product.[5] In one survey, 44% of individuals purchasing coverage on the Exchange for the first time did not know the network configuration for their plan; 19% of those that also purchased plans the prior year did not know their plan's network configuration.[6]



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Even after the plan is purchased, payors may change who is in network, leaving beneficiaries uncertain of coverage. When an individual does access care, he or she may be surprised. Another common point of confusion is balanced billing for out-of-network services, such as anesthesiology, at in-network facilities. In a study of emergency care in Texas, three large insurers reported that between 41% and 68% of dollars billed for emergency physician care at in-network hospitals were submitted by out-of-network emergency physicians. Provider directory analysis suggested that for these same insurers, between 21% and 45% of in-network hospitals had no in-network emergency physicians.[7]

> We expect continued regulatory pressure and leading payors to stay ahead of emerging requirements.

Consumer advocates are pursuing regulatory changes that offer better protections, in some cases supported by provider organizations who have been left out of networks. Federal and state lawmakers are instituting changes to improve consumer information and access. During the 2017 open enrollment period, CMS began to pilot a network rating and labeling system for plans sold on healthcare.gov, beginning in four states (Maine, Ohio, Tennessee and Texas). Additionally, continuity of care adjustments will require that even if a plan drops a provider, patients in "active" treatment (e.g., women in the second or third trimester of pregnancy) can continue to see that provider for 90 days. At the state level, at least 28 states have defined requirements for network adequacy, such as standards for coverage or requirements for how plans share information about networks.[8] Many of these are not nearly as prescriptive as requirements for MA, while others are seeking to solve surprise medical bills.[9] We expect continued regulatory pressure and leading payors to stay ahead of emerging requirements.

The tools currently available do not meet consumer demand for real-time, accurate data. Consumers who can afford to may begin voting with their feet by making different coverage selections. Limiting choice on a cost basis — particularly if these limits are not well understood by consumers — is unlikely to build long-term affinity with consumers or product marketability. As the market moves away from open access PPO arrangements and/or creates more complex benefit structures, making tools available to consumers for identifying the right provider at the right time will be a major factor in customer satisfaction and retention. Consumers should be able to readily navigate toward high-value providers, and to understand, if they are in restricted network products, the individual financial consequences for where they receive care.

More sophisticated, performance-based network design will allow for better matching between network and consumer need. We expect that tiering and other mechanisms such as reference pricing or price-transparency on shoppable commodity services may surpass narrow networks as more consumer-friendly levers to contain costs. Rather than simply a one-time decision regarding access at the time of purchase, consumers will be able to determine when and how to trade off choice based on actual need. Communication and information systems to support the activation of the consumer as a price-sensitive decision maker are also very important. So too will be the role that the provider plays in the decision-making process.

Imperatives for Payors: Internal and External Realignment

As payors move network design from a "Price" lever to one that also focuses on "Quantity", and develop products and tools to respond to consumer needs, there are many factors to consider. Internally, payors may explore realignment of network development from a pure contracting function to one that is deeply integrated with clinical and quality goals and line of business requirements. Externally, payors and providers may seek to realign the way in which they relate to and work with each other.

Internal Operations and Culture

Within payor organizations, network design traditionally sits primarily with contracting and has limited integration with quality or other clinical activities. For example, in many organizations, Chief Financial Officers and Chief Operating Officers manage contracts and unit costs, while Chief Medical Officers manage utilization and outcomes. Such organizational silos can create incongruity in network approach, goals, outcomes and performance metrics and management.

Internal realignment should advance traditional contracting and network functions to more fully integrate with clinical and quality functions. Such endeavors may indicate changes in organizational structure at the executive level. Drawing new lines or boxes will not address misalignment without significant functional integration, collaboration and a broad cultural shift in thinking. The role of the network within the payor organization and the product itself must mature beyond a cost lever to one that considers true performance optimization. Payors that bring a clinical lens to network development will be better positioned to create narrow network products reflective of true market value, inclusive of quality outcomes and experience.

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Supporting more productive relationships with providers in the development and management of networks may necessitate new models for operational integration while taking into account the specific needs of each line of business (LoB). For example, successfully managing MA or individual market lives requires integration with providers to manage Stars, QRS and Risk Optimization, while self-insured LoB lives gravitate to corporate health and wellness, HRAs and traditional quality programs. It has not been uncommon for payors to utilize multiple management and analytic tools and/or ask providers to do so, for instance, using one tool to measure clinical quality, another to assess a MA program and another for a commercial ACO program. Similarly, various pockets of the payor organization may be signaling competing priorities to providers. Payors should recognize and design their provider activities in ways that support LoB variations but also create administrative transparency and simplicity for providers.

The Benefits of External Payor-Provider Relationships

Compared to the historical, often adversarial relationship between payors and providers, the evolving environment of accountability has heralded new prospects for collaboration.[10] Unfortunately, the current approach to restricted network design risks eroding any semblance of cooperation. Providers may perceive network restrictions as a lose-lose situation - offer price concessions or be excluded from the network. Some providers left out of these networks are pushing back, in some cases pursuing regulatory pathways to inclusion. Others are proactively introducing provider-led and provider-defined restricted network options to the market. Even for providers who are in-network on narrow network products, there are questions as to whether the gains in access to lives has been worth the requisite discount, including concerns about how a discount on one product impacts the negotiating position across a provider's broader payor portfolio. And all providers (both in- and out-of-network) are often left with the burden of helping consumers understand what is or is not covered.

As long as payors remain the sole arbiter of restricted network product development, providers are likely to perceive the threat of exclusion as a negotiation instrument used to secure price concessions; which may feel adversarial even to those providers that are in-network. Payors who approach narrow network development in partnership with providers have an opportunity to define new models for shared value creation, to the benefit of both parties and the construction of a superior product.

Approaching providers in a more collaborative fashion means moving away from contract-based discussion and negotiation to a more dynamic model that fosters ongoing conversation. Some payors have found trading strategic plans and objectives with select providers can lay the groundwork for partnership development. Establishing a set of guiding principles around the partnership also helps both parties understand how they can collaborate more successfully. In concert, payors should seek to simplify operational requirements and make information more transparent for providers. This could include: offering new ways to strengthen provider network performance through the transparent exchange of information and simplified use of platforms and management oversight; operating lines of business in a more consistent way so providers are not forced to follow different, often competing requirements; and using collaborative partnership to co-develop quality and other performance-based initiatives.

Payors who involve providers in the development of consumer access, experience and quality targets should see improved provider engagement in performance management activities. Those providers who have helped define what they believe is important to measure are more likely to take ownership for achieving such goals – rather than perceiving measurement as an additional burden that may or may not be consistent with their views on patient care. Similarly, because providers offer great insight into natural care patterns that reflect both patient and doctor preferences, engaging them more closely in network development will lead to the creation of better, more attractive networks. In these scenarios, narrow networks do not have to be positioned as a trade-off of access for price, but rather as an opportunity for members to access a provider network that is more integrated and has better coordination of care for greater health outcomes and experiences.

Those providers that have helped define what they believe is important to measure are more likely to take ownership for achieving such goals.

Ultimately, payors are seeking superior, lasting relationships with their customers by offering affordable prices, high quality of care and a differentiated experience – a goal that is shared by most providers. We believe those payors who include providers in the design of the next generation of networks (and corresponding products surrounding those networks) will be positioned to identify and execute against opportunities to achieve this common goal. Over time, payors can more collaboratively work with their providers on additional opportunities for improvement including quality metric reporting, technology, deployment of clinical programs and more.

Such a reorientation can reframe reimbursement philosophy from a zero-sum game to a shared opportunity to deliver meaningful results. Narrowing and tiering networks may remain an effective - albeit blunt - tool to achieve short-term price targets. However, those payors who can mature their network design into a precise value-creation instrument will differentiate for the long-term.

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[2]Including 18% ultra-narrow (<30% of hospitals in the area), 25% narrow (30-70% of hospitals in the area) and 6% tiered. Source: "Hospital networks: "Evolution of the configurations on the 2015 exchanges." McKinsey & Company. April 2015.

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About The Chartis Group

The Chartis Group (Chartis) is a national advisory services firm dedicated to the healthcare industry. Chartis provides strategic and economic planning, value-based care, advanced performance, and informatics and technology consulting services and decision support tools to the country's leading healthcare providers. Chartis has been privileged to work with over two-thirds of the academic medical centers on the U.S. News and World Report "Honor Roll of Best Hospitals," seven of the 10 largest integrated health systems, four of the five largest not-for-profit health systems, nine of the top 10 children's hospitals, emerging and leading accountable care organizations, hundreds of community-based health systems, and leading organizations in healthcare services. The firm is comprised of uniquely experienced senior healthcare professionals and consultants who apply a distinctive knowledge of healthcare economics, markets, clinical models and technology to help clients achieve unequaled results. Chartis has offices in Boston, Chicago, Minneapolis, Needham, New York, Portland and San Francisco. For more information, visit www.chartis.com.

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