Network Design:
Trends in Tiered and Narrow Insurance Networks

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The U.S. healthcare system is undergoing major transformation. Payers and providers across the country are moving away from uncoordinated, volume-driven care. Instead, they are moving toward implementing new payment models and network designs that are altering care delivery, with a heightened focus on population health and paying for value.

Horizon Blue Cross Blue Shield of New Jersey recently announced the launch of the OMNIA Health Alliance as well as new tiered health plan offerings. This tiered provider network with clinical data sharing capabilities and value-based payment characteristics will be offered state-wide in the individual, small group, large group fully-insured, and self-insured markets. In making this decision, Horizon joins Aetna, AmeriHealth, and Health Republic in offering a tiered network in New Jersey's commercial health insurance market.[1]

Horizon asked Avalere to examine the prevalence of tiered and narrow insurance network products in U.S. health insurance markets. Specifically, this brief examines the available data on their prevalence, evidence of their effectiveness in improving care while holding down costs, factors driving their growth, potential challenges associated with these networks, and their possible roles in the increasingly value-driven U.S. healthcare ecosystem.

TIERED AND NARROW NETWORKS ARE RELATED BUT DISTINCT DESIGNS. HOWEVER, BOTH MODELS CAN BE CREATED BASED ON PROVIDER PERFORMANCE.

"Narrow," "tiered," "performance," and "high-value" are all terms used to describe insurance networks. They are often used interchangeably. However, many times they are indeed distinct.

Narrow Networks

As defined in the Kaiser Family Foundation/Health Research & Educational Trust 2015 Employer Health Benefits Survey:

> "[N]arrow networks are plans that limit the number of providers who can participate in order to reduce costs. Typically narrow network plans include fewer providers than a typical HMO network."[2] Narrow network plans often offer consumers low monthly premiums,[3] though consumers can be exposed to significant out-of-pocket costs if they seek or need care outside of the prescribed network.[4]

Tiered Networks

Tiered networks are less restrictive than narrow networks. Much like the tiering of prescription drugs on a formulary, tiered provider networks offer consumers financial incentives to seek care with preferred providers. Yet, under this construct, consumers maintain access to, and insurers maintain contracts with, non-preferred providers. AcademyHealth recently described tiered networks as:

> "[A] variation of narrow networks," that "offer consumers a broader array of choices and more flexibility. Consumers are subject to different levels of cost-sharing such that consumers who choose providers in 'high-value' tiers pay less...The tiered network strategy takes advantage of recent advances in the use of data to develop profiles of provider groups or individual providers."[5]

These networks encourage patients to visit preferred providers by having different cost-sharing requirements based on the provider's tier. Like narrow networks, tiered network plans can offer consumers low monthly premiums, and often lower cost-sharing and deductible levels for using preferred providers. Consumers enrolled in tiered network plans can also be exposed to significantly higher out-of-pocket costs if they seek or require care in non-preferred tiers or outside of the prescribed network.[6]

Role of Provider Performance

In the case of both tiered and narrow networks, a provider's past performance may drive their inclusion in a preferred tier. For example, plans may identify preferred providers by evaluating one or a combination of clinical, efficiency, cost, and quality factors.

EVIDENCE INDICATES THESE NETWORKS ARE BECOMING MORE PREVALENT.

Comprehensive enrollment data for tiered and narrow network plans across the commercial insurance market is not available. However, data does reveal that these network designs are highly prevalent in the exchange markets, and that the concept is gaining traction among employers.

Employer Market

Recent data on 2015 employer plan designs reveals that 17 percent of employers are offering high-performance, tiered networks in their largest plan by enrollment.[7] The prevalence of these networks increases for the largest employer groups offering health benefits—24 percent of employers with more than 200 employees offer tiered, high-performance networks in 2015.[8] In the Northeast region, the percentage of employers offering a tiered, high-performance network has increased from 15 percent in 2007 to 27 percent in 2014.[9]

Employer embrace of narrow networks has been more muted. In 2015, approximately 7 percent of surveyed employers offering health benefits offered a narrow network plan, which is consistent with 2014 trends.[10]

ACA Exchange Market

In the individual market, where insurers are under intense pressure to keep premiums low, narrow networks represent a significant portion of the plans offered in the exchanges. A recent Avalere study of the 2015 exchange market finds that the average provider networks for plans offered on the health insurance exchanges created by the Affordable Care Act (ACA) include 34 percent fewer providers than the average commercial plan offered outside the exchange.[11] Another recent study examining 2015 exchange plan networks characterized nearly 50 percent of exchange plans as "narrow" or "tiered."[12]

NATIONAL AND REGIONAL HEALTH INSURERS OFFER TIERED AND NARROW NETWORKS, WHILE INCREASINGLY ENGAGING WITH PROVIDERS TO IMPROVE CARE QUALITY AND LOWER TOTAL COST OF CARE.

Prominent insurance executives speak frequently about the importance of tiered networks and alternative payment models to their business, and their commitment to them over the coming years.

During Aetna's first quarter 2015 earnings call, CEO Mark Bertolini asserted:

> "[V]alue-based contracting now represents approximately 30 percent of Aetna's medical spend with a goal to achieve 75 percent by the end of the decade…We have over 760,000 members in what we call our high-performance networks."[13]

UnitedHealthcare CEO Stephen Hemsley frequently expresses his company's commitment to these models. In speaking about the clinical successes of the UnitedHealth Premium physician designation program,[14] which can be organized into a tiered network for employer customers, Hemsley said:

> "[T]he modern health system is being shaped around aligned incentives, supported by transparent information and consistently high-quality clinical services. These changes are helping our nation in turn to achieve optimal evidence-based utilization and cost…We remain focused on executing a deliberate quality and cost agenda because improving healthcare quality and affordability is core to delivering value."[15]

Payer Leadership in Implementing Innovative Network Design

Payers such as Aetna, Anthem, Blue Shield of California, Cigna, Harvard Pilgrim, Health Net, Highmark Health, Humana, Cambia Health Solutions, and UnitedHealthcare, among others, offer tiered and narrow networks in markets across the country.[16] Some insurers are also working in tandem with providers and health systems to offer co-branded or private label health plans with tiered or narrow networks. These payer-provider relationships can involve sophisticated data sharing and alternative payment arrangements. Examples include Innovation Health serving the Washington, DC, area (a partnership between Inova and Aetna), and Community Advantage Plan serving New Jersey (a partnership between AmeriHealth and Cooper University Health Care).[17]

Alternative Payment Models Bolster Innovative Network Designs

Alternative care delivery and payment models give payers and providers reason to collaborate, and are acting as change agents to drive better care and lower costs. These concepts do not inherently tie directly to a tiered or narrow network, but can be offered successfully within such network structures. Payers such as Aetna, Blue Cross Blue Shield of Michigan, CareFirst, Horizon, and Universal American have embraced the accountable care and patient-centered medical home models of care,[18] and are working collaboratively with providers to improve patient care, quality, and outcomes.

One highly studied model that has produced meaningful results and sustained success is the Blue Cross Blue Shield of Massachusetts (BCBSMA) Alternative Quality Contract (AQC). The voluntary AQC consists of a population-based global budget with two-sided risk and performance incentives linked to quality metrics. The contract includes about 90 percent of the BCBSMA network, but has, to date, been limited to the insurer's HMO members. Similar performance-based contracts that include PPO members will launch in January 2016. The most recent evaluation of the AQC found that participating provider groups achieved a 10 percent savings on medical spending by the fourth year, as well as significant improvements in quality and health outcomes, particularly on measures tied to payment.[19] While the AQC has not been used as a design feature in BCBSMA's tiered products, other payers could implement similar models in tiered or narrow networks.

EVIDENCE DEMONSTRATING THE COST-EFFECTIVENESS OF TIERED AND NARROW NETWORKS IS PROMISING. HOWEVER, MORE RESEARCH IS NEEDED ON HOW THIS APPROACH MAY IMPACT QUALITY AND IMPROVE CLINICAL OUTCOMES.

The existing research focused on tiered and narrow network design is most compelling when considering the demonstrated premium and total cost of care savings to plan sponsors and enrollees.[20]

Tiered and narrow networks can drive premium reductions of 5 percent to 20 percent or more when compared to broad, open access plans.[21] One particularly prominent study examined the impact of tiered networks offered to Massachusetts state employees. The study concludes that employees who switched to a tiered network plan spent 36 percent less on medical care. Reductions in spending were attributable to less utilization of hospitals and specialty care; spending increased for primary care.[22] Another compelling case study involves a Taft-Hartley plan that experienced significant reductions in medical trend after the plan evaluated its physicians on cost, efficiency, and select quality metrics, removed 50 physicians from its network, and instituted a performance bonus for the remaining 1,750 in-network physicians meeting efficiency and quality standards.[23]

While the results of these studies are promising, there is a need for further publicly available research to more fully measure the impact of narrow and tiered networks on quality and clinical outcomes.

MARKET AND REGULATORY FORCES ARE DRIVING DEVELOPMENT OF NEW NETWORK DESIGNS.

Many factors are influencing the development of tiered and narrow networks.

Cost Growth

After several years of modest upticks, health spending growth is expected to average 5.8 percent annually through 2024.[24] At the same time, healthcare spending and premiums are projected to continue growing faster than workers' wages.[25] As a result, provider networks are developed with cost growth in mind.

General Market Forces

In addition, forces inherent in local insurance markets also drive the creation of new network designs. Specifically, other variables driving the development of tiered and narrow networks include:

- Variation in provider quality, pricing, and healthcare spending within local markets, driving insurers to leverage this variation to craft networks of the highest quality, most efficient providers[26]
- Provider and insurer concentration in local markets, which impacts an insurer's ability to offer and provider willingness to participate in tiered or narrow networks
- Brand strength of providers and/or insurers in local markets, which influences contract negotiation dynamics between insurers and providers
- Local market activity in the Medicare and Medicaid programs (Medicare Advantage, Accountable Care Organizations, Medicaid expansion), which can influence an insurer or provider to embrace alternative payment models or narrow network constructs across segments
- Consumer preferences that include a demonstrated willingness to accept smaller networks for lower premiums[27]

Affordable Care Act

Multiple reforms stemming from the ACA are accelerating the trend of tiered and narrow networks. Insurers must abide by market requirements, such as medical loss ratio rules, community rating, guaranteed issue, premium rate review, and benefit standards, while designing products to remain competitive in an increasingly cost-transparent environment. Network design and composition remains one of the most effective tools available to insurers to build competitive products. Meanwhile, for employers seeking to avoid paying the Cadillac tax on high-cost health plans beginning in 2018, tiered and narrow networks are one possible benefit design change that could help to avoid triggering the tax.

Medicare's Move Toward Value-Based Care

As payers move to market and implement new network designs, providers are also increasingly adapting to a system that rewards value over volume. Indeed, the drive to value-based payment potentially accelerates the rate at which providers may be interested in participating in narrow or tiered network designs. For providers, the focus on quality improvements and paying for value stemming from the ACA was accelerated with the Department of Health and Human Services (HHS) announcement to tie

30 percent of Medicare fee-for-service payments to alternative payment models by 2016, and 50 percent by 2018. In making the announcement, HHS Secretary Sylvia Burwell explained that:

> "[O]ur goal here is to move away from the old way of doing things, which amounted to, 'the more you do, the more you get paid' by linking nearly all payment to quality and value in some way to see that we are spending smarter."[28]

Tiered networks can be a tool that helps to align incentives between payers and providers to further enhance the chances for success in paying for quality and value.

ACCESS TO CARE, TRANSPARENCY, ALIGNMENT OF REQUIREMENTS IN THESE NETWORK DESIGNS, AND UNCOMPENSATED CARE EXPOSURE FOR OUT-OF-NETWORK PROVIDERS, DEMAND ATTENTION OF PLANS AND PROVIDERS.

Patient Access

Patient access to care in tiered and narrow networks requires the careful attention of insurers and providers to safeguard against care disruptions. While, as noted above, tiered and narrow networks can reduce costs and may improve quality, too narrow of a network can potentially reduce or delay access, or lead to significant out-of-pocket costs for consumers. Ensuring access to care in tiered and narrow networks is particularly important for those patients with significant health needs. The Urban Institute notes the challenge of balancing affordability in health plans with access to quality care, "If the network overly limits choice of provider, excluding those with specialized expertise in treating particular conditions, it could not only compromise the quality of care but also expose policyholders to unanticipated and potentially crippling financial liabilities."[29]

Moreover, after reports surfaced that 2014 exchange plans were excluding cancer centers from their networks,[30] the federal government and some states stepped up network reviews for cancer centers in 2015 exchange plans. A recent Avalere survey conducted jointly with the National Comprehensive Cancer Network found that while the majority of cancer center respondents are included in more than or the same number of exchange plan networks as in 2014, half of centers report that individual exchange plans in their state have tiered provider networks with differential enrollee cost-sharing at each tier. Most of the responding centers report that they fall in the higher tiers only.[31]

Further, action to regulate network adequacy at the state level may surface in the coming months following the release of the National Association of Insurance Commissioners (NAIC) revision of the Managed Care Network Access and Adequacy Model Act. The latest Model Act draft addresses tiered networks, encouraging state insurance regulators to examine them closely for sufficiency purposes.[32]

Transparency

Payers and exchanges—both private and public—will need to focus on providing more consumer decision support tools showing enrollees which doctors, hospitals, and prescriptions drugs are covered, as surveys demonstrate patients would welcome additional transparency tools and resources to navigate their health insurance selections.[33] Indeed, a survey conducted by the National Health Council in partnership with Lake Research Partners found that more than one-third (36 percent) of patients thought it was difficult to find a list of providers when shopping on ACA exchanges.[34] And while some consumers may understand the type of network in which they enroll, many do not. In a recent McKinsey & Company survey, 26 percent of exchange enrollees were unaware of what type of network they had selected.[35] This lack of understanding can prove particularly problematic when and if an enrollee seeks care at an out-of-network or non-preferred provider. This is likely one reason why a recent survey of insurance CEOs found 65 percent worry that narrow networks will reduce patient satisfaction.[36]

Lack of Alignment Between Measures and Models

While tiered and narrow networks and innovative payment arrangements are expected to be an important part of the future U.S. healthcare system, the vast array of reporting requirements, quality measures, and different approaches from different payers is burdensome for providers. Payers need to be flexible and work closely with providers to help them navigate this evolution.

Patient Costs Associated with Out-of-Network Care

In addition, there is a concern that providers will see an increase in bad debt from patients seeking out-of-network or non-preferred care. Given that out-of-network spending does not count toward an enrollee's federal maximum out-of-pocket limit, the bad debt concern is most acute for providers who are out-of-network.

CONCLUSION

Innovation in network design offers opportunities for payers, providers, employers, and patients. Nevertheless, how network design is implemented is likely core to the long-term success of the approach. Indeed, closed network products of the 1990s gave way to open access plans in the early 2000s.[37] In this post-ACA era, network composition is once again playing a central role in health benefit design and health policy debate. This time around, the goals of enhancing clinical quality and improving the patient experience, while lowering the total cost of care, are increasingly at the forefront of these discussions. Initial research on these benefit designs suggests promise in reducing costs; however, additional experimentation and publicly available research is needed to demonstrate clinical impacts and quality improvements of these networks.

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