2016 MAKING ISSUES COUNT

HIGH-PERFORMANCE NETWORKS

MOST HEALTH INSURANCE PLANS USE PROVIDER NETWORKS

made up of doctors, hospitals, and other providers that the insurer contracts with to provide health care to its members. Provider networks are structured in a variety of different ways. High-performance networks (HPNs) are designed to deliver high-quality and efficient care; promote stronger relationships between the insurer, provider, and member; and provide a potentially lower-cost health care option. HPNs provide an additional option to consumers seeking to maximize their health care dollar and present both potential benefits and disadvantages to consumers through a variety of distinctive features.

Contractual agreements between health care providers and health insurers are a major driver of the U.S. health care system. Insurers contract with providers to provide members with access to care and to establish relationships with providers regarding the management of medical care, including efforts to improve quality, implement disease and other care management initiatives, and secure legal rights to monitor provider billing practices and perform claims auditing. Providers likewise enter into contracts with insurers to gain access to a consistent flow of patients, to receive direct payment from the insurer rather than patients, and to clarify expectations around disputing claims and reimbursements.

The providers with whom an insurer has contracted collectively form the insurer's network, which members can usually access at an in-network benefit level. Conversely, providers that are not contracted are usually accessed by members on an out-of-network (OON) basis, with reduced or no benefits. Insurers offer incentives through benefit plan designs that reduce the portion of costs the insured is responsible for in order to encourage use of in-network physicians. More recent trends have emphasized the development of HPNs that the insurer anticipates will optimize cost, improve quality, and improve efficiency.

High-performance networks are growing in popularity because consumers are insisting on more for their health care dollar, which leads insurers to provide the highest-quality care at an affordable premium, while rising health care costs and the creation of the exchanges have led insurers to develop more efficient networks. Additionally, new technological

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and data capabilities allow insurers to pinpoint which providers in an area deliver the highest-quality care in the most efficient manner, and enable insurers to develop management programs that can optimize their members' care experience within these networks. This is different from historical attempts to limit provider access based solely on cost. New technologies feature improved measurements of care quality, use evidence-based medical standards and protocols, and enable communication with members and providers.

Aspects of HPN Design

HPN networks feature one or more of the following characteristics:

- **Tiered Networks / Select In-Network Providers:** HPNs may categorize providers into two or more "tiers" based on quality and efficiency metrics. Quality is usually determined through adherence to care standards and evidence-based protocols. Tiered networks supported by plan designs aim to direct members to select providers, strengthen the insurer's relationship with providers, allow for better care management opportunities, and achieve optimized pricing terms. Providers may accept lower reimbursement to be part of a limited group of top-tier physicians, which can result in increased patient flow. The insurer may return savings from these agreements to the consumer through reduced premium costs. Consumers may also see reduced costs in response to care management efforts, achieving fewer complications and faster recovery times. At the same time, consumers using an HPN product may have restricted access to the providers they want to use, which may include restricted access to academic and specialty hospitals with strong reputations. And while HPNs focus primarily on high-quality providers and only secondarily on lower-cost providers, HPNs may exclude some high-quality providers with elevated charge levels from the list of preferred providers when other high-quality but lower-cost providers are available in an area. The use of select providers in top tiers has contributed to the pejorative use of the term "narrow network" to describe HPNs.
- **Primary Care Physicians Requirement:** HPNs may require members to select a primary care physician (PCP) and consult or visit with the PCP prior to seeking specialist care or hospitalization. PCPs can help coordinate care across multiple providers and give guidance to patients regarding recommended care. Consumers also may benefit from a close relationship with a primary physician because they see the same familiar face when they access the health care system. At the same time, consumers who already have a relationship with a physician may need to establish a new relationship with a different provider in response to the HPN's requirements.
- **Limited OON Benefits:** HPNs may rely on plan designs that incent members to access preferred providers instead of OON providers. Members still may be able to access OON providers, usually at higher cost-sharing levels, or the providers may be excluded from the plan altogether. Regardless of the providers' tier status, members usually access emergency care at the preferred tier cost-sharing level. HPNs can be complex and difficult to navigate, and insurers' efforts to assist members through provider directories, plan design summaries, treatment cost estimators, and other tools may not bridge this gap.
- **Access/Adequacy Requirements:** Access (e.g., distance/travel time for members to reach each type of provider) and adequacy (e.g., number of providers) are key considerations in designing or choosing a HPN product. Insurers want to provide networks that meet their members' needs and meet state-specific legal requirements that regulate network design. Similarly, policyholders must evaluate whether the benefits inherent in the restricted panel are an acceptable trade-off relative to potentially more convenient access to a broader group of health care professionals.

Conclusion

HPNs will likely continue to play an important role in the U.S. health care system because of rising health care costs, insistence by consumers for higher-quality health care delivery systems, and increased competition among insurers. For example, recently released 2017 exchange regulation[1] highlight the growth of HPNs by establishing network adequacy thresholds and continuity of care guidelines; a prominent inclusion of a mechanism for network adequacy ratings transparency on the healthcare.gov website is another example of the increase in prevalence of HPNs.

1 "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2017; Final Rule," Department of Health and Human Services.