



High-Value Healthcare Provider Networks

Prepared for and at the request of:
America's Health Insurance Plans

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EXECUTIVE SUMMARY

There is broad agreement among policymakers and experts that health care costs continue to increase at an unsustainable rate and that more must be done to reduce costs and assure an affordable health care system for all Americans. While costs have moderated recently, the U.S. still spends more on health care than any other industrialized country and health care spending continues to take up a larger share of our nation's gross domestic product—which, in turn, crowds out other important priorities and is a major contributor to the nation's budget deficit and national debt.

Health plans have been at the forefront of health-system delivery and payment reforms that hold promise in reducing costs, while also improving efficiency of care delivery and enhancing quality of care and patient outcomes. The implementation of the Patient Protection and Affordable Care Act (ACA)—which has significantly expanded access to coverage and includes a number of targeted changes aimed at improving quality and reducing costs—has brought about increased focus on the range of tools that health plans have used to keep coverage as affordable as possible for consumers. The use of high-value provider networks is one of the tools used by health plans to reduce costs and provide incentives for high-quality and cost-effective care for consumers. By identifying providers that consistently meet quality and safety metrics and are more efficient relative to their peers, health plans have created an important tool that can be used to advance and improve the provision of high-quality care.

This paper primarily focuses on the development of high-value networks in the new marketplaces and how these tools are evolving to meet the healthcare cost and quality challenges ahead. The major findings include:

- **The use of high-value provider networks can help reduce premiums and promote more affordable coverage options for consumers—with premium reductions of 5% to 20% or more when compared with broad network plans.** Many of the products offered on the ACA exchanges achieved more affordable premium rates by offering some form of high-value network. In some cases, insurers were able to negotiate lower payment rates with healthcare providers. In almost all cases, the insurers identified the more efficient, lower-cost providers to include in their networks. Health plans optimized these networks with a broad view toward having high-quality and efficient providers comprise these networks. Through these efforts, insurers are offering health plans at much more affordable prices than would otherwise be the case.
- **High-value networks are developed through a deliberative evolution process considering more than just fee levels.** Efforts by the industry and other stakeholders to offer more affordable coverage to a price sensitive uninsured and employer population has resulted in the use of networks as a tool to improve outcomes and reduce costs. In addition, measurement, analytic, and

technological advances over the past 20 years have provided new tools to help transform traditional networks into high-value networks. High-value networks are usually categorized as those that:

1. Are developed through a deliberative evaluation process that considers not only fee levels, but also other key characteristics of the providers, especially those associated with efficient and quality care protocols
 2. Maintain a cooperative relationship between the health plan and the providers
 3. Provide care in an efficient manner and will consistently deliver desirable outcomes
 4. Are often horizontally and vertically integrated among various provider types and specialties
 5. Coordinate the integration of its capabilities and care protocols with the health plan's benefit design
- **Health plan provider networks—including high-value networks—must comply with state and federal laws and regulatory requirements, including network adequacy standards.** In building a network of providers, a health plan must consider both state and federal law, essential community providers, and accreditation. Having an adequate network is a condition of qualified health plan (QHP) certification. Without it, a QHP cannot be brought to market. When QHPs are certified, they must meet federal and state regulations for network adequacy for commercial populations. Under federal regulations, QHPs are required to have a sufficient number and type of providers that are available without unreasonable delay.
 - **Active cooperation and collaboration—between the health plan and participating providers—is a hallmark of successful high-value networks plans.** A high-value network uses an active strategy to optimize patient care while holding down costs. An active strategy means that health plans and providers work together to understand and improve patient outcomes. Provider engagement and appropriate sharing of timely data help make this active management approach successful.
 - **Performance on quality measures is the key part of the criteria used for provider selection and inclusion in a plan's network.** The primary measure used to select providers for a value network has been some type of quality measure—including consensus quality, patient satisfaction, and health outcome measures developed by NCQA and AHRQ.
 - **Integration of the value network into plan designs is being used to improve the efficiency of care management and quality of care.** A key aspect of the effectiveness of a high-value network is its appropriate integration into the plan design of the products offered by the health plan. Key elements of benefit design include care management provisions and formulary designs that provide the greatest value to the patient—such as through reduced cost-sharing for cost-effective prescription drugs.

INTRODUCTION

Although having moderated in recent years, the persistent upward trend in U.S. healthcare spending has prompted policy makers at all levels of the healthcare system—health plans, providers, and governments—to consider adopting policies that can help hold down costs while maintaining high-quality care. These policy interventions, and the outcomes they intend to achieve, are often incorporated into the more broad health system goals known as the “triple aim”: (1) improving the experience of care, (2) improving the health of populations, and (3) reducing the per capita costs of healthcare.¹

The Patient Protection and Affordable Care Act (ACA) was intended, in part, to better align our healthcare system toward achieving these goals. Its passage and implementation have brought increased focus on the range of tools used by policy makers and health plans to do this. One such tool used by health plans is the development of provider networks and structuring benefit designs that encourage the use of providers that consistently meet quality metrics and are more efficient relative to their peers. While the concept of varying network offerings is not new, the ACA’s high level of public attention has sparked discussion among stakeholders and the public about the role of provider networks in the reforming marketplace.

America's Health Insurance Plans (AHIP) requested Milliman to prepare this issue paper for public educational purposes. The paper discusses general characteristics of traditional and high-value networks, and their role and potential effectiveness toward achieving the objectives of the triple aim. It examines the criteria used to create these networks, and how they interact with other facets of a health plan to achieve these goals. Milliman conducted independent research regarding high-value provider networks and interviewed a number of health plans regarding their goals and approaches to establishing high-value networks. The networks discussed are those comprised of healthcare facilities and medical professionals; the paper does not include pharmacy networks as part of the discussion, although use of pharmacy networks is another approach to helping ensure quality and safety while also containing the costs of health care.

The paper primarily focuses on the development of high-value networks in the ACA exchanges, but we recognize that their place in the healthcare system transcends a specific marketplace.

¹ Berwick, D.M, Nolan, T.W., Whittington, J. (2008). The Triple Aim: Care, Health, and Cost. *Health Affairs* 27, no. 3: 759-769; 10.1377/hlthaff.27.3.759.

WHAT IS A “HIGH-VALUE” PROVIDER NETWORK?

In October 2013, health plan products and premium rates that were filed on the various public exchanges created by the ACA were unveiled. The rollout revealed differences in the makeup of the provider networks that were associated with the various products sold both inside and outside of the exchanges. Creating networks—or selecting providers to be included in the health plan based on quality, cost, and effectiveness metrics—was one strategy health plans used to lower costs and offer more affordable coverage options. Medical costs contribute 80 to 85 percent of premium and have two components: 1) the utilization of services and 2) the charges for services. In developing a preferred provider network, health plans negotiate discounted payment rates with providers to better control the charges for services. Healthcare providers are more willing to grant deeper discounts for networks because being one of fewer preferred providers makes it more likely for them to be chosen by an insured member for medical services. Using a defined network of providers will often lead to lower costs of services and thereby lower premium rates simply due to the deeper discounted charges and fees.

Efforts by regulators and the health insurance industry to offer more affordable, high-quality coverage to price-sensitive uninsured and employer populations have resulted in the use of networks as a tool to improve outcomes and reduce costs. In addition, measurement, analytic, and technological advances over the past 20 years have provided new tools to help transform traditional networks into high-value networks.

High-value networks are usually characterized as those that:

High-value networks are developed through a deliberate evaluation process considering quality care protocols as well as fee levels.

- Are developed through a deliberate evaluation process that considers not only fee levels, but also other characteristics of the providers, especially those associated with efficient and quality care protocols.
- Maintain a cooperative relationship between the health plan and the providers. In some cases, the partners agree that the health plan retains all the insurance risk, and the provider assumes the clinical operating risks.
- Provide care in an efficient manner and will consistently deliver desirable outcomes.
- Are often horizontally and vertically integrated among various provider types and specialties.
- Coordinate the integration of its capabilities and care protocols with the health plan's benefit design.

There exists a spectrum of differences among networks currently used by health plans as they approach the right network balance to achieve true high value. The development of a high-value network represents an evolving trend from focusing primarily on affordability to that which can be structured on an

integrated system focused on delivering quality care in an efficient manner, such as an “accountable care organization” (ACO) and perhaps coupled with a “patient-centered medical home” (PCMH). This type of high-value network is specifically geared toward providing personal and comprehensive care to patients in an environment where providers effectively communicate and coordinate with each other regarding best treatment protocols for the patient, resulting in the elimination of wasteful spending.

Minimum requirements for provider networks

In building a network of providers, a health plan must consider both state and federal law, essential community providers (ECPs), and accreditation. Having an adequate network is a condition of qualified health plan (QHP) certification. Without it, a QHP cannot be brought to market.

When QHPs are certified, they must meet federal and state regulations for network adequacy for commercial populations. Under federal regulations, QHPs are required to have a sufficient number and type of providers to ensure that all services are available without unreasonable delay.² This includes providers that treat substance abuse and mental health conditions. This also includes having a “sufficient number and geographic distribution” of essential community providers (ECPs) to ensure reasonable and timely access to them.³ Beginning in 2015, the ACA also requires QHPs to only include hospitals and other providers that meet certain patient safety and quality standards, as determined by the Centers for Medicare and Medicaid Services (CMS). It also calls for rewarding quality through market-based incentives.⁴

ACA regulations require that at least 30 percent of ECPs be in a health plan’s network (up from 20 percent for 2014 exchange plans). It is not clear that all of these ECPs would actually meet the rigorous quality standards required by some health plans for their high-value provider networks, but legislation mandates that they must be included, with the possibility of some exceptions. If the minimum percentage continues to increase each year, it may ultimately adversely affect the value and quality of the provider network.

Currently, QHPs are deemed to have a “sufficient” network as part of overall accreditation review by the National Committee for Quality Assurance (NCQA), Utilization Review Accreditation Committee (URAC), or AAAHC (Accreditation Association for Ambulatory Healthcare).

² 45 CFR 156.230: Code of Federal Regulation; Department of Health and Human Services; Health Insurance Issuer Standards under the Affordable Care Act, including Standards related to Exchanges; Qualified Health Plan Minimum Certification Standards; Network Adequacy Standards.

³ 45 CFR 156.235: Code of Federal Regulation; Department of Health and Human Services; Health Insurance Issuer Standards under the Affordable Care Act, including Standards related to Exchanges; Qualified Health Plan Minimum Certification Standards; Essential Community Providers.

⁴ ACA §1311. Affordable Choices of Health Benefit Plans. Subsections (g) and (h).

High-value networks: A cooperative relationship between the health plan and the provider

A key feature of high-value networks is the presence of administrative mechanisms that aid them in achieving the objectives described above. A high-value network uses an active strategy to optimize patient care while holding down costs. An active strategy means that health plans and providers work together, on a formal or informal basis, to understand and improve patient outcomes. Provider engagement and appropriate sharing of timely data help make this active management successful.

Providers are often motivated to participate due to market pressures faced by their own organizations. The transformation of Medicare and Medicaid programs, the trend toward physician employment (leading to horizontal and vertical integration), and the competition brought on by low-cost network exchange plans have brought the need for providers to transform their organizations in fundamental ways.⁵ The payor mix is no longer sustainable to shift revenue, and health systems are facing pressure from all of their payors to reduce the total cost of care, maintain quality, and coordinate care.

However, health systems cannot do this well without the appropriate data. Health system data does not contain information and costs that occur outside the system, including leakage to other facilities, prescription drugs dispensed outside the health system, and some specialist and provider visits. Claims data, to which the health plan has access, does contain this type of information, enabling a user to follow a patient's complete care record to identify use of services.

On the flip side, health plans want to include the appropriate providers in their networks to attract customers. These providers are the ones that are achieving good patient outcomes and high quality. Health plans cannot understand quality outcomes without the appropriate data. Claims data does not include racial information, socioeconomic status, income, nonreimbursable benefits, or clinical information outside of diagnosis and procedure codes. Claims data also lacks relevant clinical data (e.g., lab scores, blood pressure, disease severity) and nonreimbursable services (e.g., education, training). Some of this information can be gleaned from the electronic health record (EHR), although linking this data back to claims data may be a challenge. Appropriate information sharing between the health plan and the provider can help optimize the quality care of the patient in a more efficient and less costly manner.

⁵ McKinsey & Company: Sutaria, S. (May 2013). "Transforming Provider Performance in Post Reform Era." *Post Reform Health System: Meeting the Challenges Ahead*. <http://healthcare.mckinsey.com/post-reform-health-system-meeting-challenges-ahead>

HOW DO HIGH-VALUE NETWORKS IMPACT PREMIUM RATES?

The use of high-value networks within a health plan typically results in reductions in premium rates compared to rates of plans using broader provider networks. Our discussions with health plans for the purpose of this paper and other research we performed indicated that premium rate reductions range from 5 to 20 percent or more when compared to rates for health plans using broad provider networks. However, we note that actual claims experience for some of the health plans we interviewed tended to produce a smaller reduction in actual claims costs than reflected in pricing, although still a meaningful reduction. In the Milliman report “Comprehensive Assessment of ACA Factors That Will Affect Individual Market Premiums in 2014”⁶, we estimated that the introduction of high-value networks coupled with plan design and managed care features would enable health plans to lower premium rates up to 10 percent. Actual 2014 premium rates for many plans appear to have been set even lower than that estimate, although it is difficult to distinguish how much reduction is attributable to the introduction of a high-value network versus market competition and anticipated selection. One health plan that we interviewed stated that it was able to secure discounts from some providers of up to 30 percent over and above the discounts it was already getting. Other health plans we interviewed lowered premiums 10 to 15 percent due to the use of a high-value network. A McKinsey report indicated that products with broad hospital networks had higher premiums than narrow network products, “with a median premium increase of 26 percent between broad and narrower networks of the same carrier, product type (e.g., HMO, PPO), metal tier, and rating area.”⁷ This is equivalent to narrow network plans being priced about 21% lower than broad network plans.

Premium rate reductions for high-value provider network plans range from 5 to 20 percent or more

The amount of premium reduction is dependent on several characteristics of the provider network:

- Health plans choosing participating providers that historically have had lower allowed charges for their patients.
- Participating providers agreeing to deeper discounted rates to be part of the ACA marketplaces.
- Utilization management or clinical operating protocols resulting in lower utilization and lower costs (although these types of savings often take some time to develop).
 - Anticipated shift in sites for treatment (e.g., hospital to ambulatory care center; outpatient facility to physician office)

⁶ Milliman: O’Connor, J. (April 2013); Comprehensive Assessment of ACA Factors that will Affect Individual Market Premiums in 2014. Client report prepared for America’s Health Insurance Plans (AHIP). <http://www.ahip.org/MillimanReportACA2013>

⁷ McKinsey & Company; McKinsey U.S Center for Health System Reform: Coe, E. et. al. (December 2013); “Hospital networks: Configurations on the exchanges and their impact on premiums”. <http://healthcare.mckinsey.com/hospital-networks-configurations-exchanges-and-their-impact-premiums>

- Changes in treatment protocols to more effective and efficient approaches
- Increased communication, coordination, and data sharing between the health plan and the providers
- Anticipated reduction in utilization of medical services due to the typical characteristics of people attracted to such a network plan.
- The anticipated increase in utilization of non-network providers for emergency and other types of covered care due to having fewer network facilities available.

WHAT REIMBURSEMENT STRUCTURES ARE USED FOR HIGH-VALUE NETWORKS?

Our research has shown that there is no unique reimbursement structure (or arrangement) being used with high-value networks. In some cases, health plans and providers establish capitation with risk- and/or profit-sharing arrangements, but many plans use traditional discounted fee-for-service arrangements. For these fee-for-service arrangements, the health plan has relied on the fact that the providers chosen for network participation deliver care efficiently and at reasonable fees and are unlikely to change their healthcare protocols for a less efficient manner. These plans have not found it necessary to incentivize these providers to provide even less costly care. In most cases, part of the reimbursement arrangement is contingent on the provider meeting mutually agreed upon quality targets.

Other health plans have entered into various reimbursement arrangements with their participating providers. Besides capitation with risk- and/or profit-sharing pools, they include bundled services payments, case rates, targeted episodic payments integrated with facility and professional services, diagnosis-related groups (DRGs), and per diems for hospitals. Many providers are open to engaging in risk arrangements with insurers, but on a limited basis, at least until they become fully aware of the risks they have accepted. Some providers are apprehensive about risk arrangements due to prior unfavorable experiences with these types of programs. There is evidence that the provider community in general views the transition from volume-based to value-based reimbursement as inevitable. From the provider's perspective, increasing their risk exposure now, on a limited basis, may be beneficial. The individual exchanges provide ample opportunity for such limited exposure because they typically comprise a small percentage of each provider's patient panel.

There is a renewed emphasis on integrated care among all levels and types of providers. Although ACOs and medical homes are the current terms of art, the basic concepts are not new. The prospects for success are considerably better now than in the past because of the technological improvements in systems that will allow for faster and more efficient communication and data-sharing among the various providers involved in a patient's care and the health plan. Technological advancements have also improved the ability for health systems and health insurers to more quickly and comprehensively identify

those areas in which they are more efficient and produce better quality outcomes versus those areas that need further attention for improvement.

As noted above, reimbursement for most high-value networks is contingent on achieving quality targets. For ACOs, for example, bonuses might be paid in increments based on achievement of certain quality targets. Also, some health plans will only increase fee-for-service payments by an inflation rate and will pay an additional bonus for quality targets. In some cases, quality targets will be similar to those seen in the Medicare Advantage Star program or the Medicare Shared Savings Program. In other cases, health plans may opt for a more comprehensive portfolio of quality targets. Whatever approach is taken, there is usually a balance between choosing targets that truly indicate quality and targets that are not administratively difficult to measure, but are statistically significant.

CRITERIA FOR PROVIDER SELECTION

A health plan considers several criteria when selecting a provider for a high-value network. Foremost, the network must comply with applicable state and federal laws, and thus meet applicable access and adequacy standards. Cost and brand name are also considerations.

The primary measures used to select providers for a value network are nationally recognized quality measures.

Our research has shown that the primary measure used by many health plans to select providers has been some type of quality measure. Fee levels are typically considered after a subset of providers has been selected using quality criteria.

Network access and adequacy

As discussed earlier, health plans must meet state and federal requirements for access and adequacy, but also must consider the competitive landscape of their service areas. In addition to the rules for ECPs discussed earlier, state rules for network adequacy vary based on plan type (e.g., PPOs and HMOs). In general, though, most health plans evaluate the sufficiency of their networks to meet the needs of the population using two standards:

- Access. Presented in distance or time, access is a way of measuring the distance between provider offices and member locations. Access standards are typically expressed in terms of a percentage and a miles standard (e.g., 90% of patients have access to two primary care providers within 10 miles). There are variations on this theme including an X-mile radius, an X-mile driving distance, and an X-minute driving time. Our research suggests that the radius measure is the most common, but

that use of driving distance is increasing because of the ready availability of software for calculating true driving distances.

- Adequacy. Presented in ratios of providers per member or members per provider, adequacy is a way of measuring whether a network has enough providers to meet the needs of the population. They are typically expressed for primary care and selected specialties. For example, PPO adequacy ratios for the State of Illinois are:
 - Primary care:⁸
 - Primary care physician (PCP): 1 physician per 1,000 members
 - Specialty Care:
 - Cardiology: 1 per 10,000
 - Gastroenterology: 1 per 10,000
 - General surgery: 1 per 5,000
 - Neurology: 1 per 20,000
 - Obstetrics and gynecology (OB/GYN): 1 per 2,500
 - Oncology: 1 per 15,000
 - Ophthalmology: 1 per 10,000
 - Urology: 1 per 10,000

Some organizations have started using “appointment availability” as a third standard for evaluating their provider networks. These standards typically involve measuring the number of appointments available for a routine appointment within a given time period (e.g., on average, the provider should be able to offer three appointment slots within seven days of the patient’s request). Health plans measure performance against this standard through outbound telephone calls to a sample of providers, by surveying members, and by researching member complaints.

In developing their high-value networks, health plans must consider the implications of removing certain providers from their networks. Especially in rural areas or markets where the providers are concentrated in a few affiliations, removing a single provider from the network (especially a hospital or health system, or a particular specialist) can have a major impact on whether the network meets access and adequacy standards. Often, this results in plans modeling access and adequacy in an iterative process to try to determine an adequate or sufficient number of providers and their locations necessary to meet access and adequacy standards. This can result in situations where a health plan will prioritize Provider B instead of Provider A, even though Provider A may be superior when measured against the plan’s criteria

⁸ The PPO Requirements checklist can be accessed at:
http://insurance.illinois.gov/LAH_HMO_IS3_Checklists/documents/NETWORKadequacydocument.pdf.

for high-value network participation, because Provider B helps the health plan meet required access/adequacy standards.

Health plan provider network and benefit designs continue to evolve and change over time. Going forward, any changes in the federal or state regulatory framework should work to encourage innovations in this area. This includes new advancements in technology and related elements that support electronic communication such as e-visits and videoconferencing, telemedicine, and team-based coordinated care. In many cases, physical access to providers can be supplemented with the use of technology to support communication with providers outside of traditional office visits. Moreover, virtual consultations and clinical advice hotlines are additional tools and strategies to expand a service area and access to care.

Cost levels

Cost levels, of course, are a key consideration for the formulation of high-value networks. It should be noted that a low-cost provider may not necessarily be equated with one that grants deep discounts from its normal fees to the health plan. Some higher fee providers may operate more efficiently, resulting in lower overall costs. For example, a hospital may more effectively avoid emergency rooms by making much less costly urgent care centers readily available, thus driving down the overall costs for emergency/urgent care. Furthermore, a high-cost tertiary facility may have sicker and more complicated patients transferred to it and thus have higher costs, but still may be operating efficiently, resulting in lower costs than typical for such a patient risk mix. An insurer will need to take risk adjusters and the severity and mix of a population into consideration when evaluating a healthcare provider's efficiency. Of course, if the health plan can secure deeper discounts from these more efficient providers that they have identified as also being high-quality providers, all the more value is brought to those who purchase the plan.

Quality measures

Some of the quality measures considered by health plans include the following:

- Episode Treatment Groups[®] (ETG) total case analyses: ETGs are a widely used illness classification methodology introduced by Ingenix (now Optum) in the 1990s. One of their uses is as an analytic unit for measuring and comparing healthcare providers based on the cost of treating patient episodes. ETGs are designed to be clinically homogeneous, which means each member's illness and severity are medically consistent with others belonging to the same ETG. Clinical homogeneity allows for more valid comparisons across providers. Illness and severity can account for differences in the expected resources required to treat an episode of care, which is why it is important for them to be

taken out of the equation. The ETG severity information allows the health plan to adjust for differences in case mix between providers, resulting in a more valid comparison.

- NCQA's Healthcare Effectiveness Data and Information Set (HEDIS) and Relative Resource Use (RRU) measures: NCQA has been a leader in healthcare quality assessment. Through its various programs, including HEDIS, RRU, and its Health Plan Accreditation (HPA) program, it has become a standard for quality across the industry. The range of evaluative programs offered by NCQA is broad, including five physician recognition programs.
- Agency for Healthcare Research and Quality (AHRQ): AHRQ Quality Indicators (QI) use hospital inpatient administrative data. The current AHRQ QI™ modules include indicators related to prevention (ambulatory care sensitive conditions), inpatient care (mortality for select procedures and conditions; procedures subject to overuse, underuse, and misuse; and procedures with some evidence that a higher use is associated with lower mortality), patient safety (complications and adverse events following surgeries, procedures, and childbirth), and pediatric care (problems that pediatric patients experience as a result of exposure to the healthcare system).
- Medicare Advantage and Part D Star Ratings: The ratings consist of over 50 measures based on information and data collected from several sources: HEDIS, Consumer Assessment of Healthcare Providers and Systems (CAHPS), information collected by CMS, Health Outcomes Survey (HOS), and CMS's Independent Review Entity (IRE). These measures rate Medicare Advantage and Part D plans according to five domains: staying healthy via preventive services such as screenings and vaccines; managing chronic conditions; ratings of plan responsiveness and care; complaints, appeals, and voluntary disenrollment; and telephone customer service. Data to support these star ratings come from surveys, empirical observation, administrative (claims) data, and medical records. Based on criteria provided in technical specifications outlined by CMS, rates and scores are calculated and stars are awarded on a contract level. CMS star ratings are published annually and are available for viewing by all Medicare members prior to open enrollment. Because health plans that sponsor Medicare Advantage and Part D and providers offering Medicare Advantage and Part D services are already tracking these measures, it offers some efficiency for health plans developing provider networks for their non-Medicare business.
- Integrated Healthcare Association (IHA) and Pay for Performance (P4P) measures: IHA programs and their P4P measures are used by some health plans to help configure high-value provider networks.
- Analyses of referral patterns: This includes an analysis of the hospitals to which a physician may refer patients, as well as ancillary services ordered by the physician. These analyses can include referral patterns to specialists, ambulatory surgical centers versus hospital outpatient centers versus physician office care, types and sites of labs used for pathology screenings and blood tests, and sites used for radiological services.

- Prescription drug prescribing patterns: Measurement of prescribing percentages when generic alternatives are available. This could also include an analysis of brand name drug choices or even generic choices where there are multiple options for treating the condition (e.g., starting with lower-cost drugs to see if they are effective before prescribing higher-cost options).

Not all of these quality measures and resources are used by every high-value provider network health plan, and the sophistication of the analyses varies among plans. However, the use of any one of these measures is a step in the direction of better quality and improved value in a health plan. It is likely that improvements in technology and the development of more sophisticated analysis techniques will lead to improvements in the provider selection process going forward.

Regardless of how the provider network is reimbursed (FFS, cap, risk arrangement, etc.), the network must be sufficient to support the clinical needs of the population. The type of risk arrangements may influence the way that providers practice, which likely has an impact on the way that networks should be optimally designed.

Brand names

Additionally, there are certain providers that are important for inclusion in the health plan's provider network, even if they are not the lowest-cost or even the most efficient provider. This may include the area's children's hospital or a top tertiary or teaching hospital. However, there are examples of some prominent hospitals and healthcare systems being excluded from networks used by exchange plans due to their being assessed as not meeting the value criteria set by the health plans where a sufficient number of hospitals are included to meet members' needs.

INTEGRATION OF A HIGH-VALUE NETWORK INTO PLAN DESIGNS

A key aspect of the effectiveness of a high-value network is its appropriate integration into the plan design of the products offered by the health plan. The benefit design needs to support the efficacy of the care management being implemented by high-value network providers.

The benefit design needs to support the efficacy of the care management being implemented by the high-value network

Patients no longer locked into a PCP, but PCPs are still important

Effective care management may necessitate that the benefit contract requires use of a primary care network system or other mechanism to better assure that the patient (insured member) receives care within the network. Using a provider outside of the network could result in a breakdown of the

communication and coordination among the various providers involved and the health plan, which are often essential to attaining high-quality, efficient, and effective care.

While consumers traditionally value their freedom of provider choice, it might be observed that many, if not most, patients choose to follow the referrals of their primary care physicians (PCPs) when seeking specialists to see for treatment. As such, a provider network contract that strongly incentivizes PCPs to recommend and actively communicate with qualified specialists within the network can result in less need for strict gatekeeper systems. In an HMO plan, the fact that services of providers outside the preferred network are not covered by the health plan may be enough of an incentive to negate the need for such a system. Similarly, PPOs and point of service (POS) plans need to be sure that their out-of-network benefits and cost-sharing provisions reasonably direct the insured member to get care within the network. However, this leverage diminishes as the network increases in size. As such, a high-value network without an effective care coordination system may become less effective as it gets larger. Of course, in order to offer high value, the network must assure that an adequate number of specialists, PCPs, and healthcare facilities participate. High-value networks may also consider appointing a primary care coordinator that is more clinically relevant than a PCP. For high-cost patients with chronic and complex diseases, a multi-specialty clinic or a specialist might be the more appropriate physician to coordinate care, rather than a PCP. For example, perhaps an endocrinologist, rather than a PCP, should be a diabetic patient's care coordinator.

Care management provisions

The policy contract needs to support the care protocols used by the high-value network. These types of care management provisions include such requirements as pre-certification to better assure the use of appropriate services or types of providers, concurrent review activities, and discharge planning. Skilled nursing coverage and home care coverage are important benefits to better assure the continuation of care in less costly settings and reduce the frequency of readmissions. Requiring use of approved lab and radiology services from high value providers may also produce better outcomes. Policy contract reimbursement may incentivize use of designated centers of excellence (e.g., for organ transplants or cancer care), which can reinforce the assurance of high value care. There are other health plan contract provisions that can similarly support high-value network success, such as psychosocial services or training on certain equipment. These need to be identified and coordinated with the provider contract arrangements made with the networks.

Pharmacy formulary and benefit provisions

Ideally, drug formulary and benefit provisions related to the formulary are part of a high-value network plan, and the participating physicians are aware of the drug formulary to which their patients are subject. With this knowledge, physicians can then prescribe the drug that will provide the greatest value to the patient and to the health plan. Use of drugs that will provide a greater likelihood of effectiveness and less overall expense should be the goal of a high-value network and health plan. This may be achieved through effective contracting terms with pharmacy benefit managers (PBMs) and appropriate education of participating physicians. Benefit and cost-sharing provisions related to mail order versus retail prescription drug purchases can reign in prescription drug costs, with the prescribing physician's appropriate understanding of the benefit provisions of the health plan. The coordination between the physician and the formulary can be achieved more easily through a high-value provider network than through a broad, uncoordinated network.

CARE MANAGEMENT PROGRAM CONSIDERATIONS RELATED TO HIGH-VALUE NETWORKS

As noted above, an effective high-value network plan usually consists of a cooperative relationship between the health plan and the providers. In some cases, the parties agree that the health plan retains all the insurance risk, and the provider will assume the clinical operating risks. Providers can achieve care management in multiple ways:

An effective high-value network plan consists of a cooperative relationship between the health plan and the providers

- Inpatient care management is used to prevent or reduce payment for medically unnecessary hospital utilization. It typically consists of hospital admission and concurrent stay reviews to identify and avoid or not pay for medically unnecessary inpatient admissions or days.
- Outpatient care management consists of performing pre-certification on certain high-cost outpatient procedures and other services subject to overutilization or performed by non-network providers. The goal is to redirect services from non-network providers to network providers (leakage control) and also to reduce medically unnecessary services.
- Case management consists of coordination and management activities aimed at reducing emergency room (ER) visits for “frequent flyer” members, the appropriate post-discharge follow-up with patients aimed at reducing readmissions, coordination of care for members with complex problems, and the monitoring of care for patients with high-cost conditions such as transplants, traumatic brain injuries, or neonates.
- PCP management consists of:
 - E-visits

- E-consults
- Urgent care clinics
- Appropriate use of physician assistants, registered nurses, and certified nursing assistants
- Provider incentives
- Hospitalist program
- PCP referral management
- PCP fee increase

E-visits reduce PCP office visits, and e-consults reduce specialist referrals and consultations. Urgent care clinics reduce ER visits by shifting care to lower-cost settings. A provider incentive program is expected to reduce specialist visits by encouraging PCPs to expand their scopes of practice. Hospitalists can help eliminate medically unnecessary inpatient admissions and days. A PCP referral management program helps PCPs refer patients to lower-cost providers. Finally, a PCP fee increase is typically used to attract and retain PCPs.

Although health plans and providers may historically have had disease management programs and care coordination, providers probably will have a higher patient compliance rate, which is due to a more established relationship with the patient. Information exchange between the two entities will make care management more successful because of the different data that the health plans and providers can share with one another. Collaboration by the health plan and provider will give a more complete picture of a patient's interaction with the healthcare system as well as of their clinical needs. This is much more achievable through a high-value network than through a broad network plan.

MARKET COMPETITION POSTURING USING HIGH-VALUE NETWORKS

The health insurance industry has responded to the challenge of achieving the goals of quality, affordable healthcare available to all simultaneously through the product choices it has made available to consumers. While ACA rules have made sure that products are available to everyone on a guaranteed issue basis, it is the health insurance industry that is working hard to meet the other goals.

The health insurance industry has responded to the challenges of offering quality, affordable healthcare through the product choices it offers

The ACA included comprehensive changes to the insurance market. While facilitating private market competition based on health plan efficiency, many of these changes resulted in higher premium rates (prior to tax credits) for many people than those for substantially similar products sold prior to 2014. Many of these new products achieved more affordable premium rates by offering some form of a high-value network. In some cases, insurers were able to negotiate lower payment rates with healthcare providers, who want to protect their current market shares and attract new patients from the newly insured ranks. In

almost all cases, the insurers identified more efficient, lower-cost healthcare providers to include in their networks. As discussed throughout this paper, the insurers optimized these networks with a view toward having high-quality but efficient providers comprise these networks. Through these efforts, insurers are offering health plans at much more affordable prices than would otherwise have been the case.

At the same time, the health insurers continue to offer their traditional plans with broader networks in addition to the high-value networks in order to provide a wider choice for consumers. Consumers pay more for a wider choice of network providers, but a high-value network plan may meet the needs of many consumers.

The Kaiser Family Foundation (KFF) recently conducted a consumer survey regarding preferences between broad versus narrow network health plans relative to their willingness to pay more for broad network plans.⁹ The results of the survey indicated that 23 percent would opt for a narrow network to save money, even if it meant needing to switch doctors and hospitals. Another 11 percent would consider a narrow network plan if it would mean substantially lower premiums (25 percent in the survey), while another 12 percent would opt for a narrow network plan if the network included their doctors and preferred hospitals. That implies that 46 percent (23%+11%+12%) of the market would consider making the trade-off between a broad choice of providers and cost. It is possible that even more individuals could be attracted to high-value network plans if they better understood the structure and benefits of network plans. A similar survey found that 58 percent of those surveyed would prefer less expensive plans with a limited network of doctors and hospitals over more expensive plans with a broader network of providers.¹⁰

The KFF researchers found that the percentages favoring a more restrictive network plan were even higher among the currently uninsured. This may be because affordability is the prime reason for their uninsured status, as well as the likelihood that they may not have currently established relationships with a doctor and hospital.

SUMMARY

In summary, the introduction of high-value networks has helped the U.S. healthcare system get closer to attaining its long elusive goals of universal access, universal affordability, high-quality healthcare, and consumer choice. While it is essential that a health plan be able to finance high-quality care for each of its members, the size and makeup of the plan's provider network needs to be viewed in terms of its ability

⁹ Kaiser Family Foundation. Kaiser Health Tracking Poll: February 2014. Retrieved May 19, 2014, from <http://kff.org/health-reform/poll-finding/kaiser-health-tracking-poll-february-2014/>.

¹⁰ Morning Consult. Topline Results: September 2013 National Healthcare Tracking Poll. Retrieved May 19, 2014, from <http://www.themorningconsult.com/topline-results-september-2013-tracking-poll/>.

to deliver such care under the contract provisions of the health insurance policy. It is possible that a high-value network can achieve this better than some broader network plans.

STATEMENT OF ACTUARIAL OPINION

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in actuarial communications. Juliet Spector and Jim O'Connor are consulting actuaries for Milliman, Inc. and are members of the American Academy of Actuaries. They each meet the qualification standards of the American Academy of Actuaries to render the analysis contained herein.

LIMITATIONS AND RELIANCE

This analysis was prepared on behalf of AHIP to provide information on high-value provider networks, as well as to stimulate discussion about the advantages that high-value provider networks bring to our healthcare system. The paper has not discussed "narrow" networks that do not foster high value, including quality, as their key focus. The analysis is not intended for other purposes.

The paper is based on information and data from various sources, which Milliman has not audited. In preparation for writing this paper, we interviewed a number of health plans regarding their approaches to establishing high-value provider networks and reviewed various published reports on provider networks and health plans. To the extent that any of the information gleaned from these interviews and reports was incorrect or misunderstood by us, the information presented in this paper could be affected. We have also not reviewed every ACA rule and those of the individual exchanges regarding QHP criteria for a plan's provider network.

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