Narrow, Tailored, Tiered and High Performance Networks: An Emerging Trend

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Executive Summary
A recent BDC survey of national and regional Health Plans indicates there is a resurgence of narrow, tailored, tiered and high performance networks products in the market with premiums substantially below traditional open access offerings and with a new focus on quality. These new benefits plans are now being embraced by the market after falling into disfavor over the past decade for allegedly sacrificing quality for cost, as benefits managers opted for full service HMOs and open access PPO alternatives. Now with employers and patients seeking greater value for their health care dollars, businesses are showing a new willingness to offer narrow network products which encourage members to use more efficient health care alternatives, either by restricting networks to the most efficient providers and/or by having different copays and coinsurance for providers in different tiers of the network.¹

BDC’s survey indicates these new narrow, tailored or high performance networks will be substantially different from the first generation narrow networks in the 1990s. Instead of focusing almost exclusively on reducing cost, the new network products are being designed to also maximize value and provide sustainable affordability. They are being rebranded in some instances as “accountable care partnerships” and “tailored” or “high performance networks,” and are designed with new payment mechanisms which include performance-based contracts, bundled care / episode payments, shared risks and

¹ Narrow, tailored, tiered and high performance networks are all terms used to describe similar types of benefit plans which have costs substantially lower than traditional open access PPOs or standard HMO offerings. We refer to them as a group for the purposes of this article although there are many different designs of these benefit plans depending on the markets and the requirements of plan sponsors. Current narrow or high performance networks are selected on both quality and cost indicators, not simply price, according to most plan sponsors.
savings, and even capitated budgets with prices at 15% to 25% below standard PPO and HMO rates.

Clinically integrated networks (CINs), which combine well designed market coverage with a care delivery model that can “move the needle” on cost and quality, will provide a strong foundation for these network offerings, as well as equipping providers to participate effectively in the expanding individual market, if and when Health Insurance Exchanges take hold in 2014.

As a result of the narrow network resurgence, the market will continue to shift from traditional open access PPOs to these new “high performance networks” and “accountable care partnerships.” As a result of the accompanying focus on quality in addition to cost, these new health plan offerings may be less about being a “Narrow Network” and more about a care delivery model that provides the highest value and most efficient performance.

**Introduction and Background**

“Narrow” physician networks were initially incorporated in 1990’s managed care offerings as an effort to control spiraling premium costs by restricting patient access to a select group of low cost providers. The narrow network plans grouped physicians into networks primarily based on costs, and/or the efficiency of care provided. From the employer’s point of view, these networks were designed to encourage patients to visit more efficient doctors by restricting the networks they can use to more efficient providers.

While insurers described these narrow network products being selected based on cost and quality factors, cost was the primary determinant used to select providers. Payers typically felt that they needed lower provider rates to create a sufficient pricing advantage to sell the network, although in some instances the cost advantages were gained without fee schedule reductions through more comprehensive and conservative care management techniques.

By agreeing to lower fee scales, participating physicians were rewarded with greater volume from the plans’ membership channeled to their offices. As tightly managed care generally fell out of favor in the late 1990s, this option lost favor as physicians, patients and employers complained about the lack of choice, chafed at inadequate access of care, and complained of burdensome pre-approvals for treatment. While the options remained in the market, they failed to thrive in comparison with open access products, or full service HMOs.² Their reintroduction now is part of a broad effort on the part of private insurers to respond to the incentives and mandates of health reform and to realign their payment strategy with their delivery system strategy to meet the needs of today’s market and future populations.

² We would note that Kaiser-Permanente, even though it is not generally described as such, is perhaps the largest and most successful “Narrow Network” product with approximately 9 million members and is achieving high marks for cost efficiency and patient satisfaction.
Currently, approximately 20% of all firms nationally offer a high performance network option -- up from 16% in 2010 and 15% in 2007.\(^3\) Approximately 17% of the workers in small firms (3-199 workers) and 10% of all workers nationally were enrolled in these types of plans in 2011.\(^4\)

However, the narrow network products which will be offered in the market in the next decade will be substantially different than in the past. The products will include a new set of performance management tools including data transparency, P4P, and care coordination instead of medical necessity review -- in addition to aggressive out of network benefit control. Depending on provider readiness, payers will focus eventually on accountable care risk sharing agreements, generally beginning with the HMO patient base, but expanding to PPO populations once the infrastructure and IT technology permits. Unlike the earlier narrow networks which were selected based on profiling of individual physicians or groups, the new narrow network products are being negotiated with large organized groups of providers—hospitals and physicians—at a senior executive level.

Rebranded as “Accountable Care Partnerships” in some markets, or as “Tailored” or “High Performance Network” products in others, the narrow networks will offer price points substantially below Open Access PPOs, and at a discount to HMOs, with aggressive penalties for out-of-network care. The success of these new networks will depend on the effectiveness of design to achieve both lower unit costs, as well as better care management, to attract and hold healthier lower-risk members who are willing to make the trade-off of open access for more affordable premium prices. Frequently building on existing narrow or tailored networks, the new products are being developed with a market or sub-market focus in specific geographic areas depending on the needs or demands of employers who believe their employees, particularly individuals and young families, are willing to make the tradeoff between open access and more reasonably priced care.

There is likely to be significant variability in how the narrow networks evolve: most national players will have a state-by-state strategy, and individual state Blue’s plan approaches will vary widely. There will not be one modular benefit design that can be plugged in everywhere: narrow networks and risk sharing plans will be tailored to provide value depending on individual market requirements.

**Survey Findings**
A recent BDC Advisors survey of senior health care executives in eight major health plans, accounting for more than a third of the national insurance market, indicated a renewed interest in narrow network products as part of their portfolio in selected geographies. The renewed interest is in response to the stimulus of the PPACA, with

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\(^3\) Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2011, Exhibit 14.3

\(^4\) Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2011, Exhibit 14.5
plans adopting accountable care partnerships as the key element in a “high performance” product portfolio focusing on brokering a marriage between effective payer activity and effective provider activity. In addition to using structured telephone interviews, BDC reviewed presentations on health plan delivery system reform from 15 different organizations, which focused on collaborative approaches to the market between payers and providers. We found a number of common themes:

- **Health plans are preparing for a new influx of demand.** Despite the uncertainties caused by the Supreme Court challenge of the ACA, almost all large insurers are already preparing plans to address a substantial increase in demand if Health Insurance Exchanges go into operation in 2014. While some HP Executives have reservations about entering the market given the lack of specificity of what the government will require in new benefit plans, most agree “market will be just too big to ignore,” assuming the individual mandate is upheld. As noted previously, the interest among employers in plans with a high performance network option has grown substantially in the past five years, and a number of Blues plans interviewed report that the individual market is their fastest growing business segment—even though it is the most time consuming to market. Some plan executives theorized the market may be approaching a tipping point in the acceptance of high performance / narrow network products as employer premiums are continuing to rise faster than health care inflation as a whole.\(^5\)

- **Narrow, tailored, tiered and “high performance” provider networks are staging resurgence.** After falling out of favor in the past decade as employee benefits managers emphasized open access plans over more restricted, lower cost benefits options, the percentage of employers offering a high performance or tiered network option nationally increased from 16% in 2010 to 20% in 2011. The change was most dramatic in the West where employer health plans, including a high performance option, more than doubled between 2007 and 2011 from 13% to 33%, with most of the increase coming in the last year. The growth of high performance networks in the Northeast was more modest, increasing from 15% in 2007 to 19% in 2011 with all of the increase coming in the last year. The percentage of employers offering these options in the Midwest or South either declined or remained the same.\(^6\)

- **Tiered benefit structures and high deductible options will become more prevalent.** The enactment of the PPACA has actually driven up employer benefit costs in the short term, but has also encouraged private sector innovation. All major insurers are mining their claims data and beginning to link payments to

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\(^5\) Coupled with the impact of HIE’s to cover the uninsured, the aging of the baby boom generation will increase Medicare eligibility to 80 million by 2030, double that in 2000. Enrollment in Medicare Advantage has risen from 11.7 million in 2011 to 12.8 million in 2012.

\(^6\) Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2011, Exhibit 14.2
outcomes. Most big insurers now publish all-in prices for hundreds of services provided by physicians and hospitals, which may finally give patients the necessary transparency and incentives to make informed choices about where they seek care. Tiered benefit structures, with graduated cost-sharing will steer patients to lower-priced networks. High deductible plans with health savings options are gradually gaining acceptance. Nationally, the percentage of covered workers enrolled in high deductible plans with savings options increased from 4% in 2006 to 17% in 2011.\(^7\)

- **To be attractive, narrow, tailored, tiered and high performance networks will need a 20%-25% price advantage over PPO and HMO products.** Interviews with six major national and regional payers indicate that new high performance network products with aggressive management of deductibles and primary-care physician lock-ins will likely be priced at a 20% to 25% discount to open access PPOs, and a slightly less discount to standard HMOs. Health Net, the California-based health plan, for example, recently announced SmartCare, an expanded tailored network in Southern California offering expanded benefits and flexible benefit choices selling for 25% below their full state-wide HMO network.

The experience of Blue Cross Blue Shield of Illinois, however, which offers a narrow network PPO product at a 15% discount to their standard open access plan was that most employers were not willing to switch from the Open Access Plan for that amount.

Blue Cross, however, reports that it is having success in the individual market with the narrow network plan now because individual purchasers are willing to make the marginal trade-off for a 15% difference. Industry sources indicate that tiered products that encourage use of in-network providers can generate up to a 4% reduction in health care costs, narrow networks another 5-8%, and “gated primary care lock-ins” and specialty referrals a 4% to 15% cost reduction.\(^8\)

- **Clinically integrated networks (CINs) will provide the foundation upon which many new narrow network products will be built.** A majority of payers and providers are now recognizing the importance of clinically integrated networks to any effort to manage the care of defined patient populations. Payers have endorsed collaborations to bring new models of care delivery and payment reform to create improvements in quality and the affordability of care. United Health Group, for example, announced in February 2012 that it would launch 8-10 accountable care partnerships with networks or groups of physicians in 2012. Blue Shield of California recently selected 18 California hospitals, health systems, clinics and physician groups to receive $20 million in grants to help

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\(^7\) Kaiser/HRET Survey of Employer-Sponsored Benefits, 2011, Exhibit 8.4

\(^8\) "Gated-primary care lock-in"=assigned primary care physician controlling specialty referrals.
develop the infrastructure to allow them to participate more effectively in accountable care organizations.

- **Narrow, tailored, tiered and high performance networks will be at the core of the individual market if and when it emerges.** “We made a big decision that we are going to be successful in the Exchanges if they ever come,” said one regional Blue Cross executive. “In our state, we are probably going to have fairly narrow networks with an assigned gatekeeper primary care physician, contracting with federally qualified health plans where we already have a relationship, one or two multi-specialty clinics where we have a medical home program, a few affiliated hospitals.” This Blues product will be designed for exchanges, individual, and small group markets, but could be offered more broadly depending on demand. The company has spent the entire year getting value-based care models in place for a roll out next year.

- **Open Access PPOs will lose share as new narrow networks take hold.** The core of the commercial insurance business for the past 30 years has been the open access PPO and a fee-for-service volume based payment system. Most observers agree that fee-for-service must be replaced by a new value based payment system which includes a combination of payment reform—performance based contracts, bundled payments, shared savings / risks, and capitation—and delivery system reform including Patient Centered Medical Homes, CINS and ACOs.

Open access benefits plans will decrease as cost inflation, new influx of demand, growing primary care shortage, and changes in the commercial market lead to new offerings with tailored CIN / accountable care networks combined with various types of payment reform. “The business will be rebooked,” said one health plan executive. “You can count on it.”

"The strength of the narrow network," he continued “is both in better management and better unit costs. To use the narrow network solely for low unit cost doesn’t really seal the deal, but if you can combine the low unit cost with better care management, it makes a very attractive proposition.”

- **New network products will require effective payer / provider collaboration.** With the market again showing a willingness to accept narrow network products, effective new offerings will require collaboration between organized groups of physicians, hospital systems, and payers at a system level—as opposed to focusing on an amalgamation of independent providers through individual contracts. The new agreements will begin driving existing blocks of HMO business to new agreements such as the partnership between Blue Shield of California’s ACO partnership with Hill Physicians and Catholic Health Care West (now “Dignity”) to serve 40,000 CALpers members in the Sacramento regional
market. Blue Shield’s goal in its Sacramento region ACO has been to hold partnership costs for 2010 flat, which they have accomplished. Health Net of California’s new expanded tailored network product, SmartCare, is built around an accountable care alliance with a number of leading Southern California Medical Groups. United Healthcare, Aetna, Cigna, and WellPoint have developed similar collaborative strategies which will make use of new narrow and high performance network products in accountable care types of partnerships.

- **Narrow, tiered and high performing network contracts are becoming more complex over time, with new P4P outcomes measurements, and trends to tougher to earn, but richer incentive pools.** Value-based contracts are at the core of most new narrow or high performance network contracts with performance-based payments for quality, shared savings for efficiency, and capitation for risk sharing. Most narrow network contracts include improved P4P metrics that can amount to 10% to 15% of provider compensation. Blue Cross Blue Shield of Illinois reports that its HMO agreement with 75 different risk bearing IPAs and multi-specialty medical groups, largely in the Chicago metropolitan area, has approximately 20% of the funding for HMO patients based on quality metrics. A major challenge for CINs participating in narrow network offerings will be to gain sufficient cost and quality transparency to reconcile their actual performance to their reported performance, and hence, have some meaningful control over payment levels.

- **Positive ROI for accountable care partnerships not yet realized.** Payer provider partnerships using accountable care agreements are showing positive results in driving down costs faster than unmanaged networks – but efforts dealing with broader patient populations have yet to demonstrate a positive overall ROI for the investments made to date according to Blue Cross Blue Shield of Illinois, and some of these efforts have been in place for over two years now. A major issue appears to be figuring out how to control the flow of inpatient admissions to higher cost hospitals, both in- and out-of-network. In some ACO type of experiments, the percentage of hospitalization going to out of network facilities has actually increased and remains substantially more than 50% of total admissions.

**Conclusion**
The resurgence of narrow and high performance networks, in combination with tiered benefit plans and payment reform, is reshaping the commercial insurance market which provides coverage for 150 million Americans. As a result of these innovative new plans, the commercial market is beginning to rebook its existing commercial business into new narrow / high performance networks, or accountable care programs requiring primary care physician alignment, structured benefit design to incent consumers to make cost-
effective choices, and higher deductibles and co-insurance for out of network care. In return, the new options offer substantially improved value in terms of pricing, better care management, and an improved patient care experience.

The development of successful narrow high performing network products will require new collaboration between payers and providers matching the best skills of both to develop an effective partnership. The development of clinically integrated networks (CINs) will provide the best foundation for the new narrow and high performance network products combining well designed market coverage with care delivery models that can “move the needle” on quality and costs. While all the financial results are not in, particularly for comprehensive accountable care programs, there is growing consumer acceptance of the various new network options and benefit plans.

It is not too far a leap to predict that in future, if current trends continue, we are going to have a market where we have high deductible open access plans for those who can afford them, and tightly managed competing narrow networks for most of us and not much in between.

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