



Tiered and High-Performance Networks

What are tiered and high-performance networks?

Narrow networks comprise a subset of the providers in a carrier's broadest network, and are selected for their pre-existing lower costs, or because the carrier can negotiate deeper discounts in exchange for greater patient volume. Within the category of narrow networks are high-performance networks, for which the carrier selects providers based on care quality and efficiency as well as cost. High-performance networks purport to deliver superior care outcomes at a lower price point. In a high-performance network plan, consumers generally face high cost-sharing and the risk of balance billing—in some cases forgoing insurance coverage—if they receive non-emergent care from a provider outside of the network. Some carriers require that purchasers offer high-performance networks exclusively, replacing the broader network. Others allow purchasers to offer the high-performance network alongside a broader network option, allowing consumers the choice of whether to enroll.

Tiered networks are created by breaking the network's providers into discrete groupings, based on their historic cost and quality performance. Providers that deliver higher-value care (high quality at low cost) are placed the highest tier, while those who are higher cost or lower quality are relegated to lower tiers. Generally, tiered networks are accompanied by benefit incentives, designed to reduce the out-of-pocket cost to patients when they seek care from the highest tier. A key advantage of the tiered network design is that it allows consumers to make decisions regarding the trade-off between choice of provider and cost of care. However, tiered networks will only work well when consumers are able to freely choose providers based on tier.¹ Additionally, consumers must have sufficient incentive (large enough savings or a severe enough penalty) to seek high-value care. Finally, providers must be aware and willing to take the network structure into account when making referrals and coordinating patient care.

Both tiered and high-performance networks are designed to reduce health care costs without sacrificing quality. The trade-offs can be summarized as follows: high-performance networks offer more predictable cost of care savings and quality outcomes because they enable steeper discounts and reduce consumer choice, and, tiered networks preserve consumer choice and reduce the risk of steep member penalties. However, their ability to reduce costs hinges on how well the purchaser and plan members optimize benefit incentives, and how much prices differ among providers within the market.²

¹ Suzanne Delbanco, Roslyn Murray, Robert Berenson, and Divvy Upadhyay "Benefit Designs: How They Work," The Urban Institute (April 2016) https://www.catalyze.org/wp-content/uploads/2017/04/2016-Benefit-Designs_How-They-Work.pdf.

² Simon F. Haeder, David L. Weimer, and Dana B. Mukamel "California Hospital Networks Are Narrower In Marketplace Than In Commercial Plans, But Access And Quality Are Similar," Health Affairs (May 2015), <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2014.1406.at.745-747>.



How common are tiered and high-performance networks?

High-performance networks are popular on the individual market, due to the lower cost for both health plans and consumers. For 2019, 72% of the plans offered on HealthCare.gov had high-performance networks.³ However, these plans have not been as popular among employers offering health benefits. According to Kaiser Family Foundation's 2019 Employer Health Benefits Survey, 92% of employers say that their plan with the largest enrollment has a "very broad" or "somewhat broad" network, while only 7% say it is "somewhat narrow." Additionally, only 14% of larger firms (50+ employees) that offered health benefits included a tiered provider network in their health plan with the largest enrollment. These findings may not capture situations in which employers are offering such plans but the enrollment in them is not the largest. When asked how much cost savings the firm would need to realize to shift any of their health plans to narrower networks, 39% of employers say that they would never reduce network size for cost savings, and 25% say that they would need to realize savings of more than 30%.⁴ A survey of mostly larger employers conducted in 2019 by Willis Towers Watson found that 20% plan to offer high-performance networks in 2020, and 52% are considering it for 2021.⁵

Do tiered and high-performance networks improve the quality & affordability of care?

Tiered and high-performance networks are designed to reduce spending while continuing to provide patients with a high quality of care. Small, localized studies suggest that several of these aims may materialize when a high-performance or tiered network program is implemented in a new population, but more studies are needed.

In 2010, the Commonwealth of Massachusetts Group Insurance Commission (GIC) introduced high-performance network plans for its members. Researchers from the National Bureau of Economic Research found that GIC enrollees who switched to the new plans spent about 36% less, which reduced the GIC's total spending by 4.2%. Further, the number of primary care visits increased, as did primary care spending (28% increase), but this was more than offset by fewer visits to and lower expenditures on specialists (45% reduction). The results also show that the distance enrollees traveled for primary care visits decreased by 0.65 miles, while the distance they traveled to see a specialist rose, but not significantly.⁶

In a more recent study, researchers examined data from a large payer in the southeastern U.S., which offered plans in the state marketplace. In 2014, the payer introduced high-performance network plans, alongside broad network plans. Results show that consumers enrolled in high-performance network products had lower mean outpatient out-of-pocket expenditures and 10% lower premiums than individuals in the broad network plan.⁷ Another group of researchers focused specifically on the small group market—companies with approximately 2-50 employees. They concluded that 96% of the savings from the high-performance network was attributable to the selection of lower-cost providers in the high-performance network, who also may order fewer tests or refer less frequently to specialists or prescribe fewer drugs.⁸

³ Shelby Livingston, "Most ACA exchange plans feature a narrow network," Modern Healthcare (December 2018).

<https://www.modernhealthcare.com/article/20181204/NEWS/181209976/most-aca-exchange-plans-feature-a-narrow-network>

⁴ Kaiser Family Foundation, "Employer Health Benefits 2019 Annual Survey," <http://files.kff.org/attachment/Summary-of-Findings-Employer-Health-Benefits-2019>

⁵ Willis Towers Watson, "Employer Best Practices 2019 Annual Survey," <https://www.willistowerswatson.com/en-US/News/2019/10/with-health-care-costs-projected-to-rise-another-5-in-2020-employers-look-to-new-strategies>

⁶ Jonathan Gruber and Robin McKnight "Controlling Health Care Costs Through Limited Network Insurance Plans: Evidence from Massachusetts State Employees," National Bureau of Economic Research Working Paper 20462 (September 2014) <http://www.nber.org/papers/w20462.pdf> at 4, 21, 23-24.

⁷ Emily Gillen, et al. "The Effect of Narrow Network Plans on Out-of-Pocket Cost," American Journal of Managed Care (September 19, 2017) <https://www.ajmc.com/journals/issue/2017/2017-vol23-n9/the-effect-of-narrow-network-plans-on-out-of-pocket-cost> at 540-545, 542-543.

⁸ Alicia Atwood and Anthony Lo Sasso "The Effect of Narrow Provider Networks on Health Care Use," Journal of Health Economics (2016) at 92-93.



In instances where tiered networks have been implemented, patients have saved money while being less likely to receive health care from the worst performing tier of providers. In 2009, prior to the introduction of its high-performance network, the GIC included a 3-tier network for enrollees in its health plans. Approximately 20% of physicians were in the top or preferred tier, 65% of providers were in the middle tier, and the remaining 15% of providers were in the worst-performing tier. Researchers from Harvard University found that physicians in the worst-performing tier earned lower market shares of new patient visits. Specifically, relative to middle-tiered physicians, physicians in the worst-performing tier experienced a 12% loss in market share. Further, patients saved an average of \$60 in copays if they saw a top-tiered physician and \$30 in copays if they saw a middle-tiered physician, assuming an average of three visits per year.⁹

Similarly, Harvard researchers examined the Blue Cross Blue Shield of Massachusetts' (BCBSMA) three-tiered hospital network, finding that tiered network members were more likely to receive care from preferred and middle-tier hospitals than non-preferred hospitals. In addition, they noted that if all members were in a tiered network plan there would be a 7.6 percentage point shift from non-preferred hospitals to middle and preferred.¹⁰ Another study by Harvard researchers, evaluated the impact of BCBSMA's tiered network plans on total health care spending, as well as spending on inpatient care, outpatient care and outpatient radiology. They found that the tiered network was associated with \$43.36 lower total adjusted medical spending per member per quarter—about a 5% decrease in spending.¹¹

What are the limitations of tiered and high-performance network designs?

Despite these promising results, why are some employers still reluctant to implement tiered and high-performance network arrangements? When employers were asked to identify the biggest obstacle adopting a narrower network plan or plans, 28% cite employee considerations, such as disruption of provider relationships or employee.⁴ Patients may be reluctant to partake in high-performance network plans, even with cost savings, if they face the possibility of losing access to their preferred provider.

According to an analysis of the Covered California participants, average consumers were willing to pay approximately \$46 a month in post-subsidy premiums for a broader network, compared to a high-performance one.¹² A 2018 analysis examined consumer choice between one broad network and four high-performance networks of varying sizes from a single health insurer serving the upper Midwest. The results found that consumers are willing to pay between \$84-\$275 more per month to have a network that includes their current primary care provider and up to \$115 more per month to keep their specialist physicians. Employees with a complex health status are willing to pay more for continuity of care than healthier employees. However, if their preferred providers are within the network, consumers generally do not show aversion to being in a narrower network plan.¹³

⁹ Anna Sinaiko and Meredith Rosenthal "The Impact of Tiered Physician Networks on Patient Choice," Health Services Research (August 2014) <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4239853/> at 1350-51, 1355-56.

¹⁰ Matthew Frank, John Hsu, Mary Beth Landrum, and Michael Chernenow "The Impact of a Tiered Network on Hospital Choice," Health Services Research (October 2015) <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4600365/> at 1628, 1639, 1641-42.

¹¹ They also observed that enrollment in a tiered network plan was associated with savings in the outpatient setting and outpatient radiology; spending on inpatient care also decreased but was not statistically significant when controlling for the health risk of enrollees.

Anna Sinaiko, Mary Beth Landrum, Michael Chernenow "Enrollment In A Health Plan With A Tiered Provider Network Decreased Medical Spending By 5%," Health Affairs (May 2017). <https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2016.1087?journalCode=hlthaff> at 870, 873-74.

¹² Drake, Coleman. "What Are Consumers Willing to Pay for a Broad Network Health Plan?: Evidence from Covered California." Journal of Health Economics 65 (May 1, 2019): 63–77. <https://doi.org/10.1016/j.jhealeco.2018.12.003>.

¹³ Higuera, Lucas, Caroline S. Carlin, and Bryan Dowd. "Narrow Provider Networks and Willingness to Pay for Continuity of Care and Network Breadth." Journal of Health Economics 60 (July 1, 2018): 90–97. <https://doi.org/10.1016/j.jhealeco.2018.06.006>.



Similarly, plans must make an effort to create continuity for their enrollees by managing their network. A study of Medicaid managed care plans between 2010 and 2015 found that physician turnover was 3 percentage points higher in plans with high-performance networks after one year, and 20 percentage points higher after five years, compared to turnover in plans with non-high-performance networks.¹⁴

Network adequacy becomes an issue in non-urban areas. Of employers who say they face challenges implementing a narrower or tiered network, 14% cite concerns about access or convenience for employees, 9% say that they are in a rural area and/or there was a lack of providers, and 11% say that their employees are spread out over a large area.⁴ These challenges have already presented on the individual market, and are not limited to extremely rural areas. For example, in Louisiana an analysis of silver ACA high-performance plans found that 43% (3 out of 7) of all silver plans in the state are neurosurgeon deficient in at least 4 large parishes (population of over 100,000).¹⁵

What is next?

One quickly growing type of network that includes a quality component is accountable care organization (ACO)-based health plans. ACOs are groups of physicians and hospitals that share financial and medical responsibility for providing coordinated care, with financial incentives to provide high quality care and to limit avoidable, unnecessary spending.¹⁶ Commercial payers design ACO products to steer patients to the ACO to ensure that the patients, for whom the ACO coordinates and manages care, receive their care from ACO providers. Such products help employers by providing an alternative health benefit plan to offer to employees who want lower premiums and are comfortable not having access to an entire provider network, but instead to a curated subset.

Some employers and other health care purchasers are contracting directly with ACOs as well and finding that enrollment by plan members has surpassed their expectations. In one CPR case study, Qualcomm Incorporated, a semiconductor telecommunications equipment company based in San Diego, chose to offer its employees in the San Diego area an ACO plan with Scripps Health, which is de facto a limited network. In 2017, the first year the plan was offered, enrollment was at 44%, exceeding Qualcomm's goal of 35%. The next year, enrollment increased to 49%.¹⁷ General Motors implemented an ACO through a direct contract with Henry Ford Health System (by definition a narrow network) in Detroit in 2018. In the first year, 12% of GM employees had access to these care networks, and 4% of employees enrolled. By 2020, 85% are projected to have access, with a projected enrollment of 16%.¹⁸ Strong enrollment may be due to more favorable costs to the plan member, but also to an emphasis on creating a better patient experience, including enhanced access to care and support for navigating care, among other added features. Given the positive results from these early adapters, this approach may grow in popularity among health care purchasers in the future.

¹⁴ Ndumele, Chima D., Becky Staiger, Joseph S. Ross, and Mark J. Schlesinger. "Network Optimization And The Continuity Of Physicians In Medicaid Managed Care." *Health Affairs* 37, no. 6 (June 1, 2018): 929–35. <https://doi.org/10.1377/hlthaff.2017.1410>.

¹⁵ Dossani, Rimal H., Piyush Kalakoti, Anil Nanda, Bharat Guthikonda, and Luis M. Tumialán. "Is Access to Outpatient Neurosurgery Affected by Narrow Insurance Networks? Results From Statewide Analysis of Marketplace Plans in Louisiana." *Neurosurgery* 84, no. 1 (January 1, 2019): 50–59. <https://doi.org/10.1093/neuros/nyx632>.

¹⁶ Robert Berenson, Suzanne Delbanco, Roslyn Murray, and Divvy Upadhyay "Accountable Care Organizations—Integrated Delivery Systems," (April 2016) https://www.urban.org/sites/default/files/03_accountable_care_organizations.pdf.

¹⁷ Catalyst for Payment Reform, "Leveraging Market Dynamics In Health Care Innovation: Qualcomm Incorporated," https://www.catalyze.org/wp-content/uploads/woocomerce_uploads/2019/03/Market-dynamics_Qualcomm_CaseStudy_Published.pdf

¹⁸ Catalyst for Payment Reform, "Match Made: An Employer's Approach to Direct Contracting," <https://www.catalyze.org/product/general-motors-direct-contract/>