

High-performance health networks

&

A methodical
approach creates
a right to win

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Executive summary



Narrow networks are becoming more prevalent in healthcare, and with good reason: They help payors reduce costs and increase the quality of care. However, the approach for designing and implementing such networks is still evolving. Many current offerings have fallen short of the expectations of both patients and regulators, leading to increased scrutiny, new regulations, and even lawsuits. Payors can avoid such problems and give themselves a clear competitive advantage by designing high-performing health networks using three criteria:

- *Total cost of care*, which considers costs for an entire healthcare episode from the member's perspective, rather than the traditional approach of looking at per-visit or per-procedure costs
- *Quality of care*, which entails new metrics to assess whether healthcare is safe, effective, patient-centered, timely, efficient, and equitable
- *Consumer preference*, which factors in patients' willingness to pay for choices in primary care providers, specialists, and specific health systems

In addition, payors must be able to design and implement networks in a scalable and repeatable way — and to learn quickly from past experience (including missteps). That requires collaboration among internal functions and management of all external stakeholders: consumers, providers, and regulators.

By applying this three-lens approach and improving the way they implement new networks, payors can capitalize on the promise of such arrangements. They can create provider networks that are so well tuned to the needs of specific patients that consumers and regulators alike view them as high-performance — rather than narrow. In this way, network design can help payors achieve the three-part agenda of improved outcomes, a better patient experience, and reduced costs.

The promise of narrow networks

More and more, payors are turning to narrow and tiered networks to create affordable healthcare products and win in current and emerging segments. Given increasing medical costs, highly variable costs, and wide differences in quality of care among providers, these network designs are a critical tool for payors as they compete for membership and growth. Though U.S. employers and consumers have historically demanded broader access, the landscape is changing. Ongoing healthcare premium increases, cost sharing, rate pressure in government segments, increased transparency in total product prices, and the growth of retail segments are leading to a significant increase in the adoption of narrow network products. The rollout of these products has been aggressive; nearly two-thirds of the current offerings on public exchanges are narrow network products.

Designed and implemented correctly, narrow and tiered network products will play a critical role in improving the way that care is delivered and paid for. Using these network products, payors will steer members toward high-quality and low-cost providers while negotiating better rates. The evidence of cost savings so far is encouraging. Narrow network products for a given payor — adjusted for benefits design, rating area, and product type — can cost as much as 35 percent less than traditional healthcare models. In addition, a recent study published by the National Bureau of Economic Research analyzing the Massachusetts state employees insurance program found a significant decline in both the quantity of services and cost per service.¹ The study also cites an increase in primary care while reducing downstream costs, which is essential to fundamental transformation in healthcare.

That said, these products pose challenges for payors and consumers. Pain points include imperfect and incomplete information, disjointed processes, and inadequate support mechanisms. A recent article on narrow network products provides ample examples of issues related to design and implementation: Consumers must determine whether a given provider is in his or her network, even during a health emergency. “You have to remember to ask every time,” one patient reported. “You have to ask every doctor, and you have to ask for every lab test.”² Worse,

Narrow network products can cost as much as 35 percent less than traditional healthcare models.

the information provided is often inaccurate, as implementation difficulties have led to incorrect provider directory updates.

In other cases, implementation problems have led to widespread confusion among consumers and providers, and — in some cases — a severe backlash. In one case, out-of-network claims jumped from 5 percent to 30 percent after a new network launched. Many individuals in the plan did not fully understand the scope of what they had bought, or they thought their old provider was still in the network, or they went to an emergency care facility included in the payor's broader network but not for that particular product.³ Better design will reduce these problems, as will recognizing and planning for the issues that will inevitably arise (e.g., "Are we ready to answer the angry phone calls we expect from excluded providers?").

Besides such problems for members, design and implementation issues can cause serious damage to payors' reputations and growth prospects, as well as drawn-out lawsuits and unwanted government regulation. Several leading commercial payors in California currently face these issues.

Market challenges add additional complexity to network design. They include the following:

- *Provider consolidation:* With providers consolidating across the care continuum, contracts may apply at varying levels (healthcare system, independent practice association, or individual practitioner), making it hard to align them for comparison. In addition, payors must identify and manage professional providers aligned to specific healthcare systems; many provider databases do not clearly capture this information.
- *Advanced network configuration:* The rise of multiple network configurations and negotiated rate structures for various lines of business makes competitive benchmarking of provider rates much more complex. Historical benchmarking services are no longer relevant in helping clients determine their medical cost position.
- *Quality transparency:* Greater transparency regarding the quality of care in managing chronic conditions — along with the provision of preventive care — increases the importance of selecting and managing primary care practices within a broader network of providers.
- *Regulatory complexity:* Finally, payors must address increasingly stringent regulatory requirements for network adequacy — particularly in primary care, behavioral health, and oncology.

Given these challenges, it is understandable that many payors struggle to get the basics right in designing and implementing narrow networks. Our work with payors shows that a cohesive network design approach with more sophisticated provider segmentation — along with more advanced implementation capability — will help payors create high-performance networks and gain a clear edge over their competitors.

Applying three lenses to network design

Specifically, we recommend that payors use a framework of three criteria — or lenses — in designing and implementing narrow networks: the total cost of care, provider quality, and consumer preference (see *Exhibit 1, next page*). Thus far, we do not see any payor refining its selection criteria using all three lenses.

Lens 1: Total cost of care

Currently, most payors design narrow networks using an economic model built around unit cost and discounts (e.g., per visit, per procedure). This model provides adequate inputs for determining which providers to include in a network, but it limits the payor's ability to understand total cost for a given healthcare episode. A more evolved approach to network design is to consider costs for the entire healthcare episode from the member's perspective, which leads to more accurate cost information.

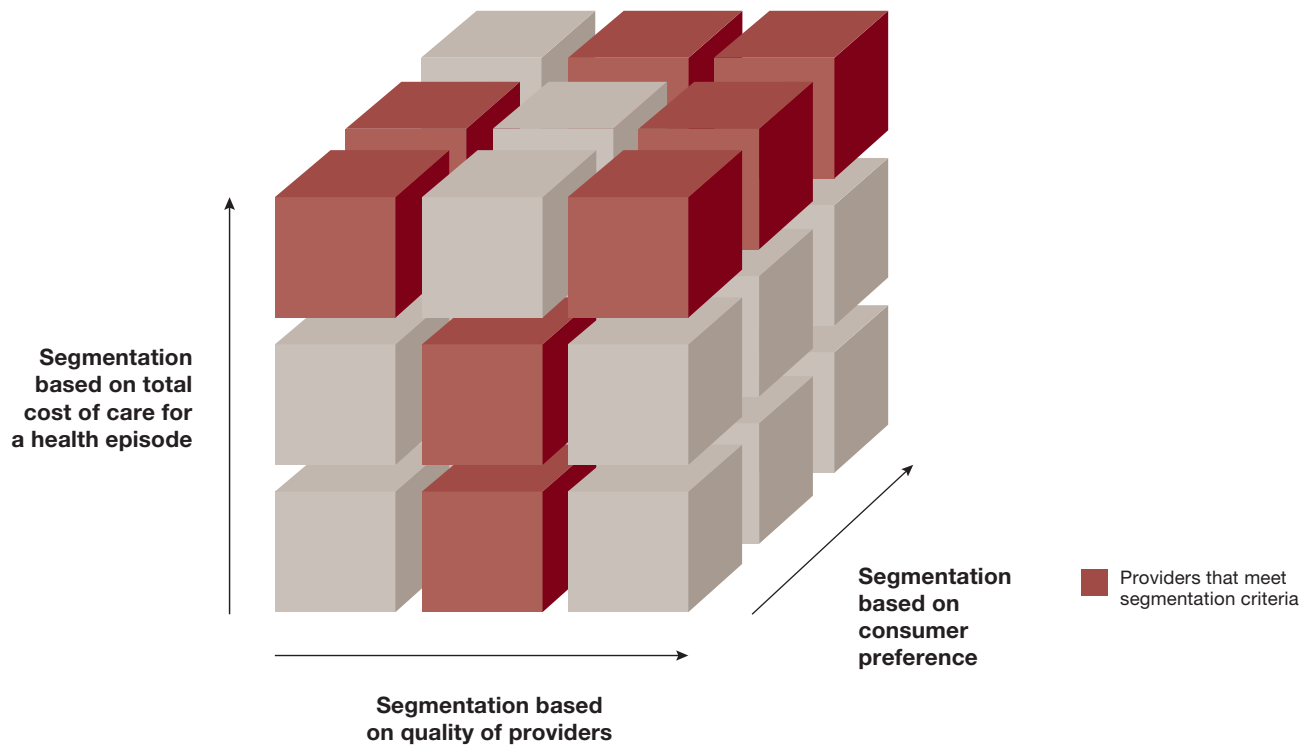
This lens outlines the economic value of a network configuration driven by member utilization profiles and provider cost across multiple services within a given instance of care. It gives payors a comprehensive, granular, highly targeted approach to excluding high-cost, undifferentiated-quality providers and including low-cost, high-quality providers. On a per-patient basis, it allows payors to gauge how efficiently a given provider can manage the care of that individual to achieve the lowest possible cost.

The challenge is that providers are needed in the mix to get at the real cost, yet they, too, often have partial information. (A physician can manage a patient's chronic conditions well, and a hospital can manage the usage of specialists well, but these are only pieces of the puzzle.) Furthermore, as members jump from provider to provider, payors quickly lose the ability to track and predict costs. And as providers move in and out of networks, the challenges mount. In many such cases, physicians continue to refer patients to specialists and ancillary providers — on the basis of long-standing, trusted

The current model limits the payor's ability to understand total cost for a healthcare episode.

Exhibit 1

Three lenses to segment providers and design high-performance health networks



Source: Strategy& analysis

in-network relationships — without realizing those providers are now out-of-network, leading to expensive bills and frustrations all around.

For this reason, payors are taking an intermediary step toward a total cost approach by holding providers accountable for an “episode of care.” An episode includes all professional and facility services as well as treatments related to a particular episode, such as a heart surgery or hip/knee replacement, including post-discharge and readmission. Episode grouping tools are currently being piloted to design networks, particularly in the Medicare space, and they are increasingly applicable to nongovernment network design as well (see *Exhibit 2, next page*).

Exhibit 2

Framework for assessing appropriate cost metrics by provider type and line of business

	Unit costs	Episodic cost of care	Per capita spend
Facility/institution	↑ Medicare relativity ↔ Medicare base rate ↔ Summary of commercial costs per Current Procedural Terminology (CPT)	↑ Risk-adjusted, episode-based facility allowed amount ↓ Episode-based facility allowed amount	<i>Less valuable criteria for high-performance network readiness evaluation</i>
Primary care physicians (PCPs)	↑ Medicare relativity ↔ Allowed amounts per relative value unit ↔ Summary of commercial costs per CPT	↑ Risk-adjusted episode-based professional allowed amount ↓ Episode-based professional allowed amount	↑ Risk-adjusted average cost per member, per month
Specialists	Same metrics as for PCPs	↑ Risk-adjusted, episode-based total allowed amount ↓ Episode-based total allowed amount	<i>Less valuable criteria for high-performance network readiness evaluation</i>
↑ Value increases ↔ Value stays the same ↓ Value decreases			
<div> <div></div> All business lines <div></div> Commercial/Medicaid business <div></div> Medicare business </div>			

Source: Health Care Cost Institute; CMS; Strategy& research

The end-to-end view also helps payors better understand referral patterns and create high-performance virtual mini-networks that can ensure sufficient access and appropriate referrals, and reduce the very expensive out-of-network leakage that threatens the fundamental value proposition of narrow networks. (*Exhibit 3, next page*, shows our proprietary analysis for tracking referrals among providers, factoring in elements such as the quality and cost of care.) Eventually high-performing networks and products designed around them should become a key component of value-based care, along with care bundles and ultimately population health.

Lens 2: Quality of care

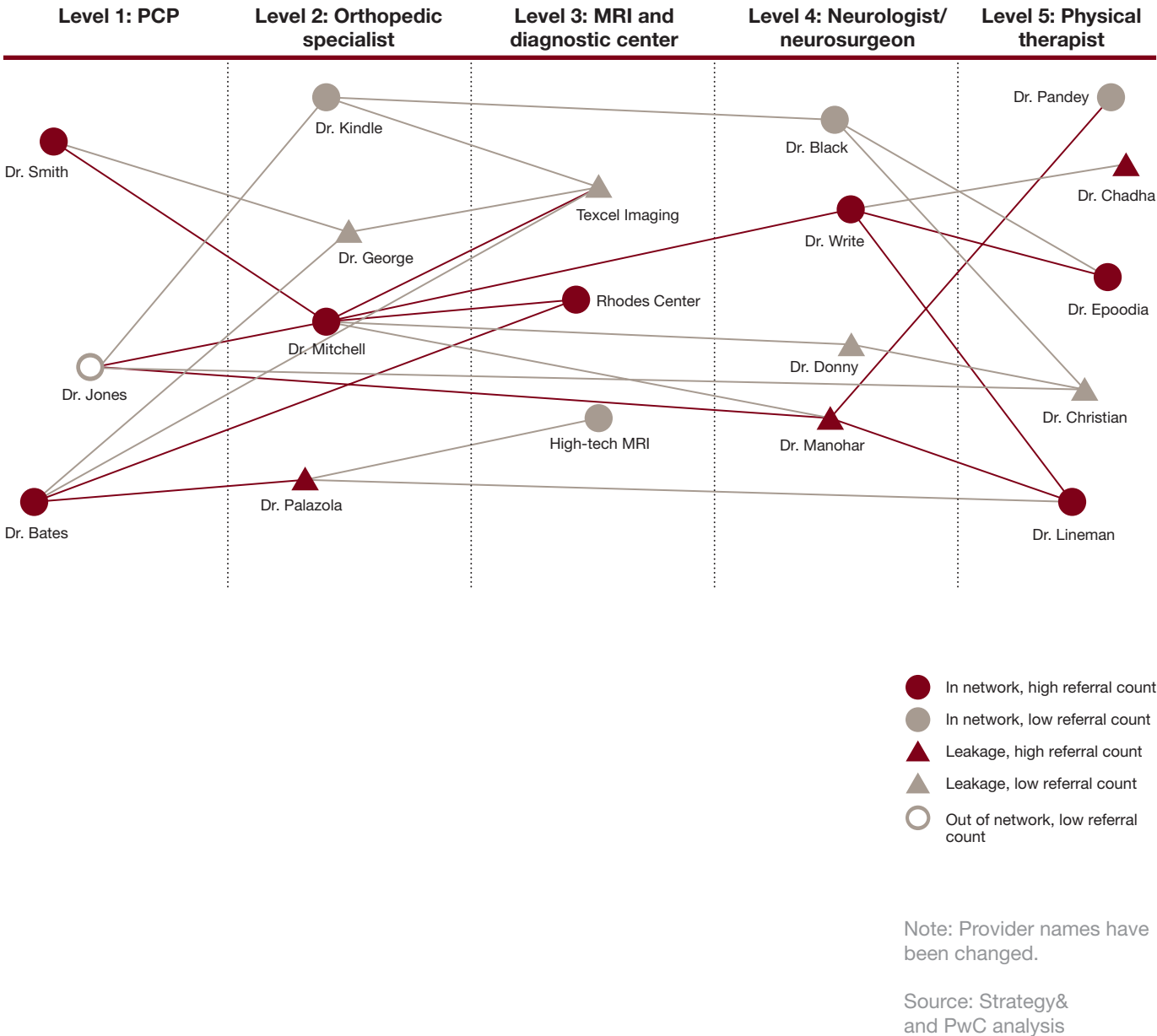
Quality healthcare is defined by the Institute of Medicine as care that is “safe, effective, patient-centered, timely, efficient, and equitable.” In reality, however, current metrics to gauge quality against these six criteria fall short. The metrics tend to be process-driven (for example, measuring whether a hospital sufficiently planned a patient’s discharge, or how often it followed recommended procedures). Moreover, current metrics typically don’t grade providers or reward high performers with greater patient volume. And current measurement systems do not consolidate quality and performance information for individual patients to review and apply. As a result, today’s quality assessment systems rank very few providers as being statistically above or below national norms.

Given the overwhelming market demand to shift from the traditional fee-for-service model to value-based care, payors can take the lead — in conjunction with providers — in creating a system to measure and apply provider quality in the way they design networks and reimburse providers. We recommend that payors start small, with a few metrics to address each of the six components specified by the Institute of Medicine, and design a composite quality metric index that grades providers, along the lines of the star ratings issued by the Centers for Medicare and Medicaid Services (CMS). The specific metrics, category weights, and other criteria will need to reflect payor objectives, product type, and local market issues and conditions.

Another alternative is to adopt a subset of metrics from the CMS’s Total Performance Score, ideally those that are outcome-driven and suited for a differential grading system (instead of the binary yes/no classification). There is also an opportunity for payors to incorporate lessons learned from past efforts. For example, publishing report cards with the mortality rates for cardiac surgeons in the state of New York has had the undesired result of surgeons refusing to accept complicated cases. Finally, payors will need to take a long-term view and a continuous improvement approach to developing and

Payors can take the lead in creating a system to measure and apply provider quality.

Exhibit 3
 A proprietary Strategy&/PwC tool maps current referral patterns



implementing a quality system, given the inherent complexities involved. (*Exhibit 4, next page*, shows a means of grading providers by quality, risk, and cost, which we built for a client through our proprietary tool and database.)

Lens 3: Consumer preference

The third lens for high-performance network design — consumer preference — is perhaps the most novel. Given the dominance of the employer-sponsored insurance market in the past, payors didn't have to take consumer preferences into account. Cumbersome regulatory processes and long product development cycles were two of the many reasons they found it difficult to truly put members first.

With the shifts to retail markets, payors are improving their consumer capabilities. As a result, they are beginning to gather direct consumer input on product and network preferences. Consumer data opens the door for demand analytic techniques (such as conjoint analysis) to better understand consumers' willingness to pay for choices in primary care providers, specialists, and specific health systems, along with the alignment of those preferences around consumer health status and demographic factors.

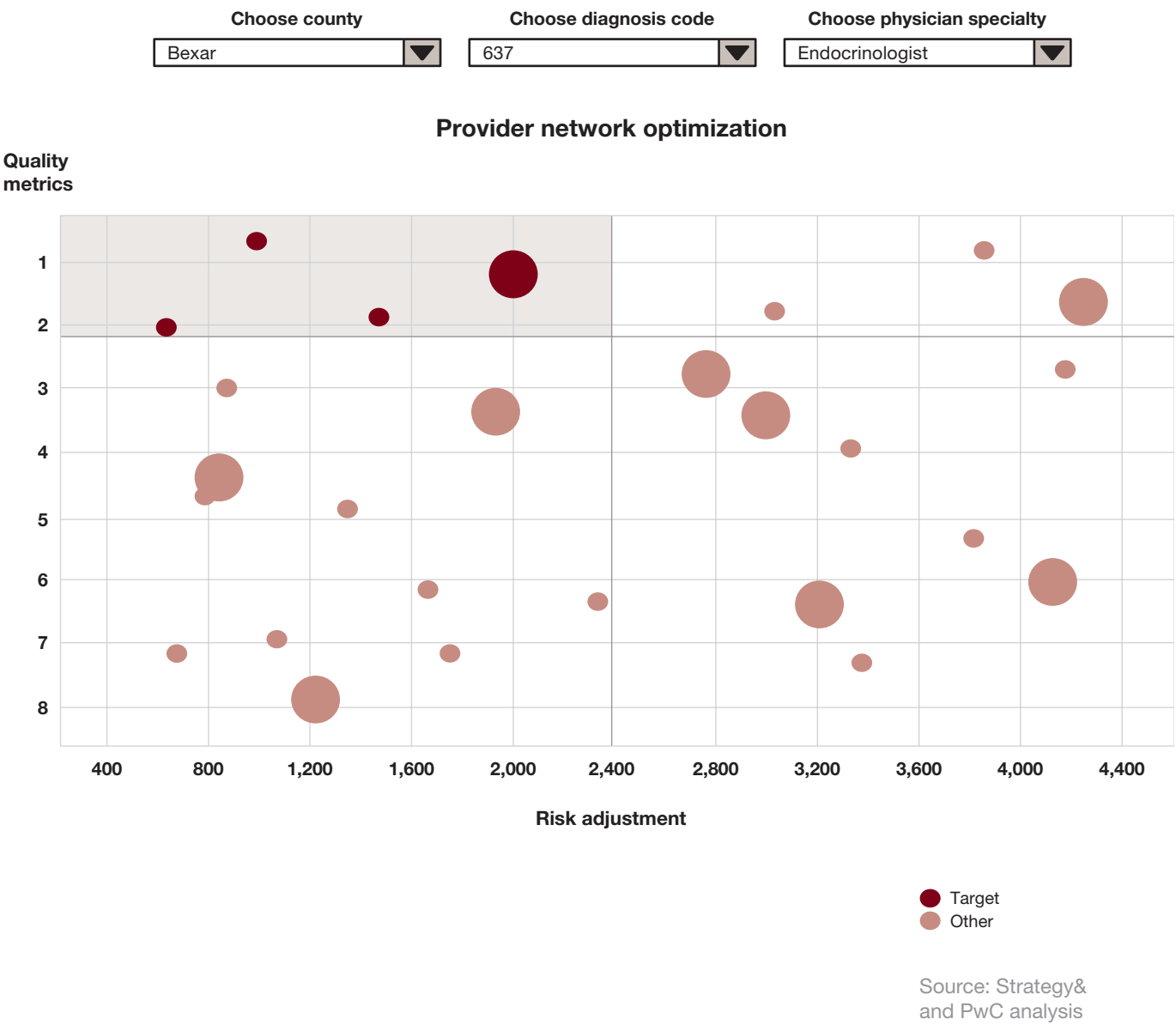
Segments with different needs will make quite different choices regarding the premium they are willing to pay for a product, as payors are now discovering. A very narrow and low-cost network is likely to appeal to price-sensitive “young invincible” consumers with few health issues. By contrast, a less price-sensitive segment with greater health needs will value access to at least one premier health system and exceptional service (*see Exhibit 5, page 14*). Both are valid options for a high-performance network.

There are several keys to successful design that satisfies consumers while maximizing value. First, payors should provide a reasonable number of products tailored to varying needs of different customer segments, based on the overarching strategy for the line of business. The second key is to align internally on the overall economics and the number of consumers being targeted (e.g., a very profitable small segment or a less profitable large segment). Without this organizational alignment, no amount of analysis will result in a successful product.

Agreement on the target segments for a line of business across a payor's functional groups will inform trade-offs on price, network adequacy (distance to providers and time to appointment), membership, communication plans, and more. All of these trade-offs are part of the product and network strategy required to attain a differentiated

With the shifts to retail markets, payors are improving their consumer capabilities.

Exhibit 4
A means of grading providers by quality, risk, and cost, which Strategy& built for a client



Provider network optimization

Quality metrics

1

2

3

4

5

6

7

8

400

800

1,200

1,600

2,000

2,400

2,800

3,200

3,600

4,000

4,400

Risk adjustment

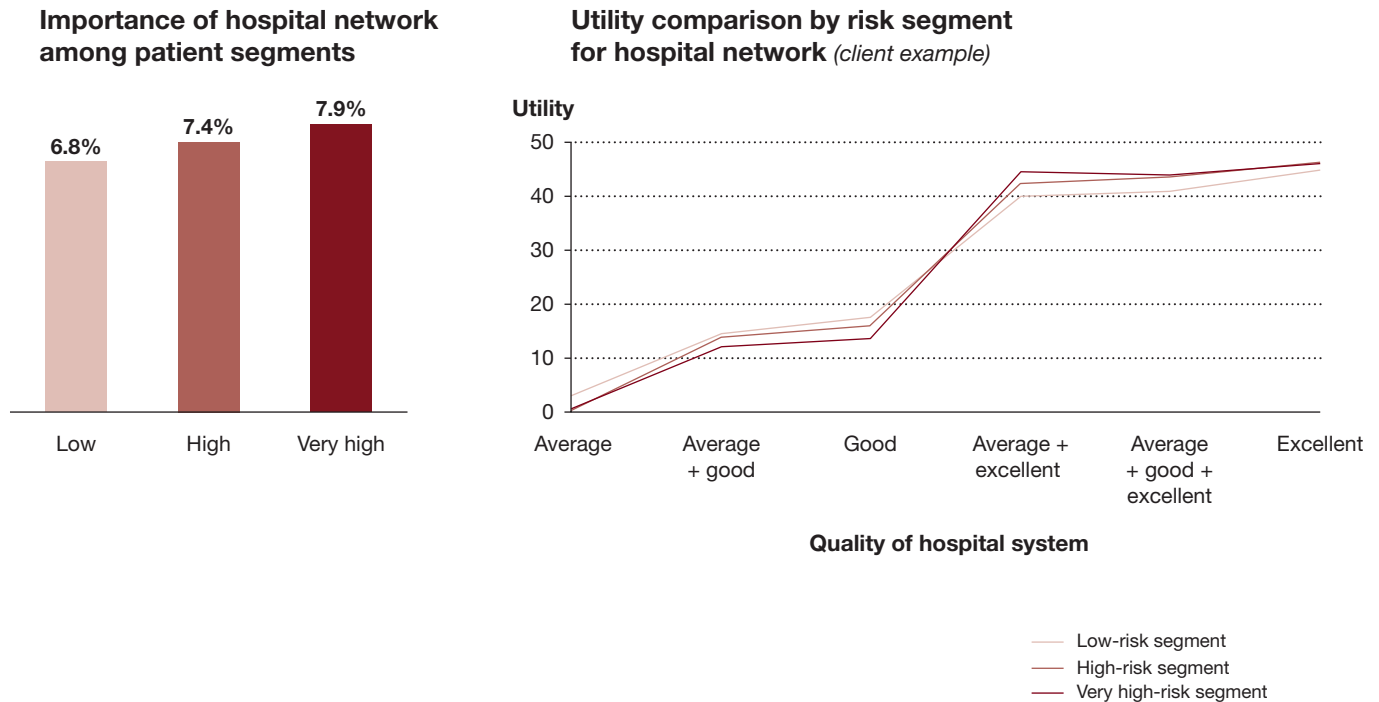
Target

Other

Source: Strategy&
and PwC analysis

Exhibit 5

Some consumer segments greatly value access to at least one premier health system



competitive position with sustainable economics. (Payors can also learn from the product management capabilities of industries like automotive and consumer products as they launch new product campaigns.)

By following these design guidelines, payors can move past the increasingly outdated notion of narrow networks as only a way to cut premiums — and toward the goal of designing high-performance networks based on consumer preference (see *Exhibit 6, next page*). Indeed, some products that offer higher service and quality levels are likely to be more expensive than current products. Even more important, payors need to embrace the bigger picture. Their networks are “live,” and designing them is not a one-time exercise. In time, we will see many variations of networks to suit the needs of different subsegments.

Exhibit 6

Evolution of network design to achieve greater value

Network design element	Traditional design approach	Emerging design approach
In-scope provider types	<ul style="list-style-type: none">– Focused primarily on acute inpatient facilities– Evaluate professional providers from an adequacy perspective	<ul style="list-style-type: none">– Focus expanded beyond hospitals to ambulatory care centers and specialists, and in some cases to equipment suppliers and pharmacies
Provider costs	<ul style="list-style-type: none">– Providers included or excluded based on unit cost	<ul style="list-style-type: none">– Segment providers based on episodic costs and the potential for greater efficiencies in utilization, as well as on unit cost and out-of-network spending
Provider quality	<ul style="list-style-type: none">– Limited consideration around quality	<ul style="list-style-type: none">– Segment providers based on performance/ quality and outcomes metrics– Include provider input in designing scorecards to measure quality
Consumer experience and preference	<ul style="list-style-type: none">– Consumer preference assumed rather than tested in a quantitative way	<ul style="list-style-type: none">– Test consumer preference and willingness-to-pay trade-offs via surveys with conjoint analysis– Leverage consumer preference to design the network around targeted risk profiles
Strategic considerations	<ul style="list-style-type: none">– Network design considered independently of other collaboration initiatives	<ul style="list-style-type: none">– Network design factors in long-term partnerships on value-based care– Higher levels of strategic collaboration with sales and marketing

Source: Strategy& analysis

Recognizing and addressing implementation gaps

Clothing juggernauts can bring new styles to market soon after consumers see them on TV. Automotive and consumer product companies have extensive capabilities to manage new product campaigns. Payor capabilities for rolling out new products are not yet nearly as robust. Yet in the new healthcare economy, payors must be able to design and implement networks in a scalable and repeatable way — and to learn quickly from missteps. That requires collaboration among the payor functions and management of external stakeholders (including consumers and providers).

Payors must carefully manage the sales and marketing of product/network configurations to ensure that consumers understand what they are buying. In addition, payors must help consumers understand their benefits and network access on an ongoing basis, particularly for emergency medical situations (e.g., differences in the out-of-pocket costs for in-network and out-of-network providers, along with authorization requirements).

Payors also must manage provider reactions to network design decisions. Providers that are excluded from one network may be included in another, requiring that payors maintain a productive working relationship. (And providers excluded from all networks may generate public relations challenges.)

Building a coherent network design and implementation capability

Creating high-performance networks is no trivial exercise. The call to action is urgent if payors want to differentiate themselves in their target markets and win customer loyalty.

As a payor executive, you need to plan how you will accomplish the following:

1. Understand what customers want, and incorporate feedback from prior products.
2. Redefine cost and quality over time to develop an end-to-end comprehensive view of efficiency and value.
3. Apply analytics to redesign the network, sizing the savings to inform trade-offs between various network options.
4. Prepare stakeholders (including regulators, providers, employers, employees, and consumers), and plan for implementation. Understand which providers have performed the best — and worst — in the past, and use that information to negotiate contracts for the future (typically one-third of the network is up for renewal every year).
5. Create a detailed change management campaign to assess pain points and deal with them proactively. Develop and disseminate consumer tools to easily identify in-network providers.
6. Learn while doing, and pilot in a few markets if necessary. Adopt product life-cycle management best practices from other industries (such as consumer goods and automotive).

The next-generation opportunity

In summary, payors — given their potential to access detailed cost, quality, and outcome information across patient populations, in different settings, and over time — are best positioned to determine the reasonableness of total and line-item costs, quality, value, and overall performance for facilities and physicians. For example, payors can drill down and look for organizations that take advantage of the care setting to optimize revenue (e.g., by pushing observation cases to inpatient visits or physician procedures to outpatient settings). Taking such an approach for the conditions and care bundles that are most prevalent or expensive will address the problem at its core.

Payors can create near-term market advantage by applying the three-lens framework to network design and striving for better coordination and alignment internally. These steps are necessary — but not sufficient for a sustainable differentiating advantage. Having a high-performing network in a fee-for-service chassis is challenging due to lack of provider incentives to make it happen.

In the near future, these capabilities will have become table stakes for payors. To stand out at that point, payors will need comprehensive healthcare programs designed to “hold patients’ hands” and help them navigate through the care landscape. Those programs, replete with easy-to-use consumer-facing tools, will be particularly important during transition periods between products. Otherwise, provider, regulatory, and consumer backlash against these products will continue.

In the future, payors have the opportunity to build provider networks that are thoughtfully conceived and implemented, as described in this report. These future networks will be so well tuned to what consumers need that consumers truly view them as high-performance rather than narrow, and regulators will see these networks as actively furthering the triple-aim agenda of improved outcomes, a better patient experience, and reduced costs. This is an exciting next-generation opportunity for high-performance networks.

Payors will need comprehensive programs designed to “hold patients’ hands.”

Endnotes

¹ Jonathan Gruber and Robin McKnight, “Controlling Health Care Costs through Limited Network Insurance Plans: Evidence from Massachusetts State Employees,” National Bureau of Economic Research, Sep. 2014.

² Robert Pear, “To Prevent Surprise Bills, New Health Law Rules Could Widen Insurer Networks,” *New York Times*, July 19, 2014.

³ Kevin Drum, “Narrow Networks Are Going to Bite a Lot of Obamacare Customers,” *Mother Jones*, Mar. 26, 2014.

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