NIHCM FOUNDATION

Expert Voices

In Health Care Policy

TIERED PROVIDER NETWORKS AS A STRATEGY TO IMPROVE HEALTH CARE QUALITY AND EFFICIENCY

Anna D. Sinaiko, PhD, Research Fellow, Department of Health Policy and Management, Harvard School of Public Health

February 2012

Health plans and large self-insured employers have long attempted to direct patients to certain "preferred" providers. These efforts face a renewed sense of urgency given the escalating pressure to contain health care costs and improve efficiency, coupled with mounting evidence that high prices do not necessarily signal high quality.[1] In contrast to the mid-1990s, however, when HMOs directed patients to particular providers by using closed networks, health plans today are increasingly likely to channel patients through value-based network designs.

Value-based, or tiered, provider networks attempt to engage consumers in making informed decisions about their care, while maintaining consumer choice of provider. This benefit design reflects the lessons learned from the managed care backlash against restricted provider choice and has been enabled by improvements in recent years in measuring individual provider performance. In a tiered network, health insurers sort providers into tiers based on cost-efficiency and quality performance measures. Efficiency is typically gauged using case-mix adjusted episode-level costs and utilization, while quality is judged through claims-based process measures, external certification, and, in some cases, use of health information technology. Providers achieving higher efficiency and/or quality scores are placed in the preferred tier, and patients are given a financial incentive to choose these providers. In the case of physicians, this incentive is typically a moderately lower copayment; for hospitals it may be a lower coinsurance rate. In addition to encouraging individual consumers to seek value in their health care choices, tiered networks also hold the potential to improve the value of the health care system overall as lower-performing providers work to enhance the quality or efficiency of their care in order to improve their ranking, either to recover lost market share or simply for its own sake.

DEVELOPMENTS OVER THE PAST DECADE

Tiered provider networks in their current incarnation were first introduced in the mid-2000s. In many cases, such as in Boston and Seattle, the impetus came from large employers; in other cases, the initiative started with a major commercial health plan. Although some of the tiered networks in use today include primary care physicians, most focus on specialist physicians or hospitals, on the theory that patients are more likely to substitute among these types of providers than among primary care providers. For example, Aetna's Aexcel tiered network ranks physicians in twelve specialties while the Blue Cross Blue Shield of Massachusetts Hospital Choice Cost-Share program tiers hospitals as either high-value or high-cost.

Today, most major commercial health insurers offer a tiered network product, and 20 percent of employers include a tiered provider network in their health plan with the largest enrollment.[2] Tiered provider networks have also caught the attention of state-level policy makers hoping to harness competitive forces to improve quality and efficiency. Massachusetts, for example, now requires insurers that cover more than 5,000 lives in the individual and small group market to offer at least one tiered network option costing at least 12 percent less than their most comparable non-tiered option. Minnesota is examining quality and cost measures to develop provider peer groups for its hospitals and physician clinics and will require health plans and employers to use this information to develop products that encourage value-seeking choices by health care consumers.

As use of tiered provider networks has expanded, they also have encountered substantial resistance from providers, especially physicians who question the reliability of the profiling methods. Particular concerns relate to how patient visits are attributed to specific physicians, the minimum sample size required to assess performance, and differential tier assignments when multiple payers use different classification methods. Physician suspicion around the accuracy of profiling measures, lack of transparency in health plans' measurement methodologies, and the public nature of physician tier-rankings have resulted in several prominent legal challenges. Most notably, the New York Attorney General's inquiry into tiering practices of the major commercial providers in that state resulted in establishment of standards to assure accuracy and transparency in tiering programs.[3] Litigation is still ongoing in other cases.

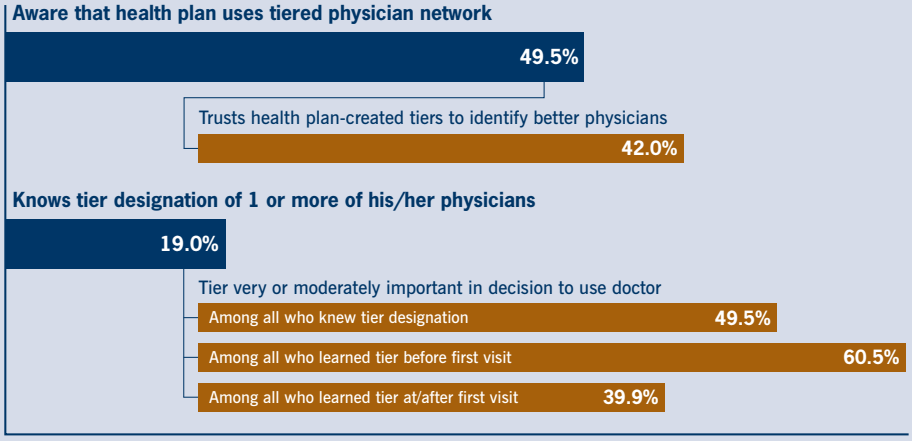
EVIDENCE ON BEHAVIORAL RESPONSE

While evidence suggests that hospitals increase their quality improvement activities in response to public reporting of provider performance data,[4] there are no formal studies of how providers respond specifically to tiered networks and little empirical work on consumers' behavioral responses. One study of a tiered network for hospitals found evidence that some consumers switched to preferred hospitals when the price differential between preferred and non-preferred tiers was large (~$400).[5]

Other evidence that consumers respond to price incentives when making health care choices comes from our experience with prescription drugs, where tiered cost sharing featuring lower copayments for more cost-effective drugs has been used for many years. Studies show that consumers respond to the differential cost sharing in part by switching to drugs in the preferred tiers and reducing demand for non-preferred drugs.[6]

However, the importance of trust between patient and physician suggests that copayment differences will be less effective for influencing choice of providers than they are for drugs. Research has shown that consumers are more likely to speak with friends, family or a physician when selecting a provider than they are to use published quality reports.[7] My own work on consumer experience in health plans with tiered physician networks in Massachusetts found relatively low awareness and use of the network design among plan enrollees and low rates of trust in their health plan as a source of information for identifying "better" physicians. The networks had the greatest potential to influence decisions when a patient was selecting a physician to see for the first time (Figure 1).[8] Experimental work with this same population suggests that the office visit copayment differences will have to exceed the $10-$25 differentials commonly found in the market in order to counteract recommendations for lower-rated physicians from friends, family and physicians.[9]

Figure 1. Consumer Awareness, Trust and Use of Tiered Networks



Results from a survey of Massachusetts state employees enrolled in health plans with a tiered physician network. For more information, see Sinaiko and Rosenthal (2010).

FUTURE DIRECTIONS

Market trends suggest that tiered provider networks are likely to be an important part of ongoing efforts to encourage better value and contain health care cost growth. Educating consumers about their available choices and the financial consequences of those choices is essential, and efforts to provide this information at the time it is most salient to patients' decisions will be key to achieving desired levels of consumer engagement. Resolving remaining methodological challenges associated with profiling and achieving provider buy-in will also affect the long-term success of these initiatives.

Going forward, we are likely to see further evolution in how tiered provider networks are used. One variant of the concept that has already appeared is the use of reference pricing in combination with an identified network of providers willing to render targeted services at or below the pre-determined price. For example, in collaboration with CalPERS, Anthem Blue Cross in California last year launched a program whereby it agreed to pay up to $30,000 for a single hip or knee replacement and identified 47 hospitals willing to provide those services for that price. Patients using the identified hospitals face only their required deductible and other cost sharing, but those opting to use a more expensive facility must also pay all allowed charges above $30,000. To the extent that health plans see only muted consumer responses to the relatively modest copayment differences commonly used today, we may start to see more employers and health plans move in the direction of a reference pricing model, especially for these types of "big ticket" items.

Tiered provider networks also offer an opportunity to enhance the likelihood that Accountable Care Organizations (ACOs) will achieve their potential to improve efficiency by building patient loyalty to a specific set of providers, although several issues related to patient assignment to ACOs and structuring incentives so as to encourage use within a higher-value ACO need to be resolved.[10]

Both as an independent policy lever and a complement to provider-focused reforms that aim to control costs, tiered provider networks are likely to play an increasingly important role in the U.S. private insurance market. Further research is needed to fine-tune the underlying approach to differentiating providers, the cost-sharing structure, and the consumer decision support needed to maximize the impact on costs and quality of care while minimizing adverse effects.

1 Office of Attorney General, Massachusetts. "Examination of Health Care Cost Trends and Cost Drivers." Report for Annual Public Hearing, March 16, 2010.

2 Kaiser Family Foundation/Health Research and Educational Trust. Employer Health Benefits Annual Survey. 2011.

3 Office of the New York State Attorney General Andrew Cuomo, "Attorney General Cuomo Announces Agreement with CIGNA Creating a New National Model for Doctor Ranking Programs." Oct 29, 2007.

4 Fung CH, Lim YW, Mattke S, Damberg C, Shekelle PG. "Systematic Review: The Evidence That Publishing Patient Care Performance Data Improves Quality of Care." *Annals of Internal Medicine* 148(2):111-23, 2008.

5 Scanlon DP, Lindrooth RC, Christianson JB. "Steering Patients to Safer Hospitals? The Effect of a Tiered Hospital Network on Hospital Admissions." *Health Services Research*, 43(5p2):1849-68, 2008.

6 Goldman DP, Joyce GF, Zheng Y. "Prescription Drug Cost Sharing: Associations with Medication and Medical Utilization and Spending and Health." *Journal of the American Medical Association*, 298(1):61-9, 2007.

7 Kaiser Family Foundation/Agency for Healthcare Research and Quality. "National Survey on Americans as Health Care Consumers: An Update on the Role of Quality Information." 2000.

8 Sinaiko AD, Rosenthal MB. "Early Evidence of Consumer Experience with a Tiered Provider Network." *American Journal of Managed Care*, 6(2):123-30, 2010.

9 Sinaiko AD. "How Do Quality Information and Cost Affect Patient Choice of Provider in a Tiered Network Setting? Results from a Survey." *Health Services Research*, 46(2):437-56, 2011.

10 Sinaiko AD, Rosenthal MB. "Patients' Role in Accountable Care Organizations." *The New England Journal of Medicine*, 363(27):2583-5, 2010.