



High-Performance Networks: Optimizing Health Insurance Networks to Improve Care

As health care costs in the United States continue to grow, policymakers, insurers, providers, and consumers are exploring new tools and strategies to more efficiently and affordably deliver quality care. One tool that insurers and providers are using to reduce costs for patients is the implementation of high-performance networks (HPNs). HPNs utilize a variety of features and strategies to improve collaboration between insurers and health care providers, with the goal of delivering high-quality and efficient care that can also lead to lower health care costs overall.

Navigating the Ins and Outs of Health Care Networks

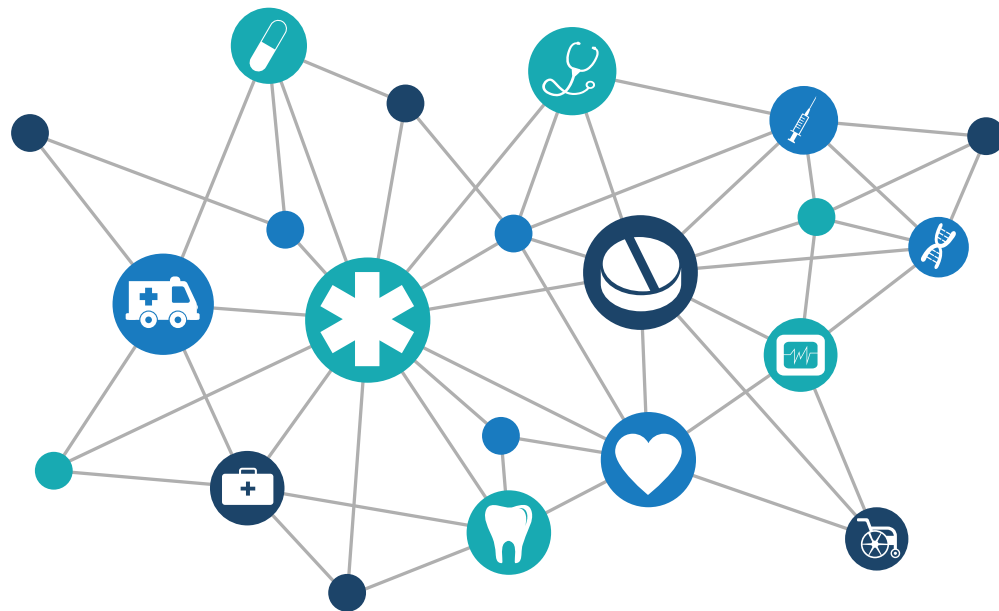
Health care consumers in the U.S. can expect to encounter “in-” and “out-of-” network providers and services as they seek care. These networks are established by health care insurers and providers, including physicians, other health care professionals, hospitals, and diagnostic and laboratory facilities. Insurers benefit from these “in-network” arrangements by gaining greater oversight over health care management, billing, and auditing. Similarly, providers benefit by receiving access to a steady flow of patients, direct payments from insurers, and clearer expectations around claim and reimbursement disputes.

Health care networks have evolved since the first health insurance plans were established in the 1930s, and can vary in scope and design, from “fee-for-service” plans that allow members to choose providers with minimal restrictions, to preferred provider organizations (PPOs) that incentivize members to seek care from providers that agree to dis-

count their services for certain plans. HPNs are sometimes referred to as “narrow networks” because they are typically composed of smaller groups of high-value providers serving a defined patient population.

Several aspects of HPNs distinguish them from other health care networks:

- *Tiered Networks / Select In-Network Providers.* HPNs can use quality and efficiency metrics to categorize providers into two or more tiers. Providers could agree to lower reimbursement rates in exchange for inclusion in the top tier.
- *Primary Care Physician Requirement.* Members of HPNs could be required to select a primary care physician, and to seek primary care before visiting a specialist or hospital.



- *Limited Out-of-Network Benefits.* HPNs could choose to cover out-of-network providers at higher cost-sharing levels, or eliminate coverage for such providers altogether.
- *Access and Adequacy Requirements.* HPNs can include requirements for access to and adequacy of certain providers, based on factors such as geographic proximity and the number of available providers in a certain region.

Achieving High Performance

HPNs are not simply narrower networks, nor do they focus only on reducing health care costs. Instead, HPNs are designed with the aim of delivering efficient, high-quality care and strengthening relationships between insurers, providers, and patients—which can potentially result in lower costs.

HPNs use several strategies to achieve these goals:

- *Taking a wide variety of actions.* HPNs can take steps, such as value-based designs incentivizing good health care practices by providers and patients, in order to improve member health outcomes and reduce unnecessary admissions and readmissions to hospitals. In addition, HPNs can take actions to target specific conditions and to reduce waste and inefficiencies throughout the network.
- *Utilizing expertise throughout the system.* HPNs can maximize the unique strengths of providers and insurers through increased collaboration.
- *Developing infrastructure and economies of scale.* HPNs can improve efficiency through actions such as centralizing analytics or implementing infrastructure to provide support and education to providers as needed.
- *Linking provider reimbursement to network financial results.* Rather than basing provider payments on a fee-for-service system, HPNs can incentivize providers to deliver high-quality, affordable care by linking payments to performance.

HPNs Can Help Health Care Stakeholders Address Growing Costs

As policymakers and health care stakeholders work to address growing health care spending in the United States, the expansion of HPNs may provide a potential solution. The work of establishing an HPN can be complex and challenging, with collaboration and engagement required from all stakeholders of the network. Consequently, HPNs are continuing to evolve and improve over time, and can offer important examples of strategies and tools to incentivize high-quality and efficient care.

Measuring High Performance

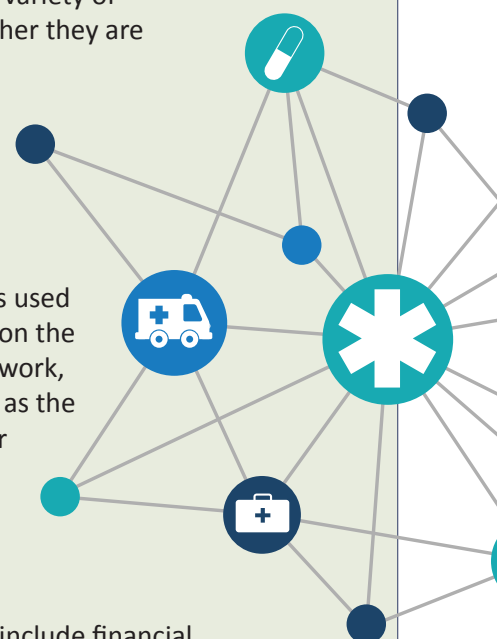
The Centers for Medicare & Medicaid Services (CMS) in 2015 identified a three-part goal for improving health care delivery in the U.S.: better care, smarter spending, and healthier people. HPNs use a variety of measures to determine whether they are meeting these goals.

Quality Measures

Quality measures evaluate health care processes and outcomes, with the goal of providing effective, safe, and timely care. Quality measures used by HPNs will vary depending on the population served by the network, and can include metrics such as the number of well-child visits for young children and hospital readmission rates.

Efficiency Measures

Efficiency measures typically include financial measures evaluating the cost of care. These measures can include loss ratios (the ratio of claims paid to total premiums), monthly costs per member, or costs for each episode of care.



Additional Resources from the American Academy of Actuaries

High-Performance Networks (2018)

http://www.actuary.org/files/publications/HighPerformanceNetworks.IB_.pdf