Maximizing value in high-performance networks

David Knott, Tom Latkovic, David Nuzum, Jessica Ogden, and Shubham Singhal
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Many payors now have experience developing value networks, but they may not yet have optimized their network configuration or approach. Over the long term, payors must be able to maximize the value these networks deliver.

With healthcare costs in America continuing to rise and an increasing number of value-conscious employers and consumers making explicit choices about healthcare coverage, the time is ripe for payors to focus on the development of lower-cost, high-performance provider networks. Although these value networks can take a variety of forms, they all give members access to only a limited number of quality-credentialed providers, in return for lower premiums, lower out-of-pocket costs, or both.

Over the past two years, most major payors have begun creating value networks or have expanded their portfolio of such networks. These efforts were undertaken, in large part, to ensure that payors could offer affordable options to individuals who will be purchasing health insurance on the new state and federal exchanges, especially those with lower income levels. In many cases, however, development of the new networks was accelerated to meet the timelines specified in the Affordable Care Act (ACA), resulting in some cases in network designs that address basic requirements but are not necessarily optimal—they are, in essence, version 1.0 value networks.

Now that this deadline has been met, payors have the opportunity to think more carefully about the optimal design of their value networks and their overall portfolio of networks.

There are a number of reasons for doing this. For example, attitudes toward value networks are changing. Until recently, most employers and individual consumers have chosen broad networks as a way to maximize choice and minimize patient/provider disruptions. However, McKinsey’s market research described in the appendix) has found that when consumers are exposed to a simulated exchange environment and then asked to select their own health benefits, up to 80 percent of them are willing to trade access for a lower premium. (The percentage varied in different simulations, depending on the size of the premium reduction and the specific providers involved.) Even many purchasers in the gold and platinum tiers were willing to make this trade-off.

Furthermore, value networks could play an important role outside the individual exchange market. These networks could, for example, help hold down premiums in the growing (but potentially reimbursement-rate-constrained) Medicare Advantage and managed Medicaid markets. They could also be an attractive option for employers looking to control benefits costs to their employees.

Thus, as payors begin to design their networks for 2015 and beyond, they should ask themselves how they can maximize value in high-performance networks. To address

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this issue effectively, payors must carefully appraise the dynamics of each local market to determine which type (or types) of value network would work best in each region. They must also decide on the approaches they want to use with providers in the near term to hold down premiums. In addition, they must contemplate the types of innovations they are willing to adopt over the longer term to hold down overall healthcare spending and improve care quality.

We believe that, over the next few years, there will be a dramatic increase in the prevalence, profile, and importance of value networks. However, careful stakeholder communication and dialogue will be critical for payors that want to expand their use of these networks. High-performance networks entail a substantial change in the way payors interact with providers, and some providers (especially those not participating in these networks) may react negatively. Furthermore, a range of other stakeholders, including regulators, legislators, advocacy groups, and the general public, will be following the development of these networks closely. Payors that proactively communicate to all stakeholders the benefits a new value network can deliver to the community will likely increase the chances of successful implementation significantly. The message should be clear: value networks help give patients access to more affordable, high-quality care.

Types of value networks

The majority of payors’ networks today, including those considered to be health maintenance organizations, give members broad access, either as an explicit choice or because the penalties for using out-of-network providers are relatively modest (often, less than a 20-percent difference in co-payments). Value networks, in contrast, restrict access either by not covering out-of-network services or by imposing significant cost-sharing differentials (often, co-payment increases of 20 to 50 percent).

The restrictions can be applied to some or all categories of providers, including inpatient and outpatient facilities, primary care physicians, specialists, pharmacies, and ancillary service providers, but not emergency care. Typically, value networks limit a member’s access to at least one major category of provider to between 30 and 70 percent of those in a local market (except for emergency care, where all facilities continue to be covered). However, the providers included in these narrower networks are also quality-credentialed, given the networks’ objective of maximizing value, not just minimizing costs.


Transparent networks are closely related to value networks, but they do not formally limit members’ access to providers. Instead, they use provider performance report cards and/or consumer decision support tools to encourage members to obtain care only from high-performing providers. They often also offer incentives to members, providers, or both to achieve this aim. As more and more data about healthcare quality and costs become available, value networks
For a payor, the first step in creating a strong value network is to understand the dynamics of each local market in which it operates, because healthcare delivery remains a local concern and the healthcare landscape—including reimbursement pressures—varies significantly from region to region. The primary factors that must be understood on
**EXHIBIT 2** Growth in individual market may vary significantly by market

<table>
<thead>
<tr>
<th>US population by coverage type</th>
<th>Increase in share of individual coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Millions of members, 2010 and 2019</td>
<td>Percentage points, 2010–2019</td>
</tr>
<tr>
<td>Individual</td>
<td>Medicaid</td>
</tr>
<tr>
<td>304</td>
<td>24</td>
</tr>
<tr>
<td>45</td>
<td>60</td>
</tr>
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<td>44</td>
<td>57</td>
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<tr>
<td>153</td>
<td>156</td>
</tr>
<tr>
<td>47</td>
<td>32</td>
</tr>
<tr>
<td>2010</td>
<td>2019 Scenarios</td>
</tr>
</tbody>
</table>

1Approximately 75% of future enrollment in the individual market nationally is likely to be through the exchanges (25% off the exchanges).
2Scenario 1: lower employer opt-out, weaker consumer uptake; scenario 2: lower opt-out, stronger uptake; scenario 3: higher opt-out, stronger uptake.
Source: MPACT version 5.0; McKinsey analysis

At a market-by-market level are the characteristics of the consumer population, the provider landscape, and the regulatory and legislative environment.

**Characteristics of the consumer population**

The payor must be able to estimate how quickly, in each market, the population of consumers with control over their health plan selection will increase and how price-sensitive those consumers are likely to be. Initially, a significant portion of the demand for value networks will come from consumers in the individual market. However, some regions may see much stronger growth in that market than others (Exhibit 2). Among the factors that appear to be driving this variability are the current number of uninsured people in each region, income distribution levels, state regulations affecting individual insurance premiums, and the current industry and employment mix.
However, the number of individuals who will be choosing their own healthcare coverage is likely to grow significantly in other markets as well. For example, population aging makes it highly probable that the number of people with Medicare Advantage plans will increase substantially in many regions. The managed Medicaid market is also poised for significant expansion. Furthermore, many people who retain employer-sponsored coverage may find themselves selecting their own health insurance products if their companies shift to defined-contribution benefit plans and private exchange models. Even some employers that opt not to make this shift may come to view value networks as an attractive way to hold down benefit costs.

Value networks can succeed, however, only if consumers are willing to accept them. As discussed earlier, we found that up to 80 percent of participants in simulated exchanges appeared willing to accept restrictions in their plan design in return for lower premiums. However, the participants’ willingness to accept restrictions was strongly influenced by a number of factors, including the size of the discount offered, the types of insurance coverage they currently have, and the providers included in each network. For example, when we ran repeated simulations in one state, we discovered that the proportion of participants who said they would either change insurance plans or pay extra to go out of network if their insurer removed their hospital from the network varied widely (Exhibit 3).

EXHIBIT 3  Consumers place varying levels of importance on whether certain hospitals are included in their network (disguised state example)

Importance that a specific hospital or health system\(^1\) is within a plan’s network (%)

<table>
<thead>
<tr>
<th>Provider</th>
<th>Unimportant</th>
<th>Important</th>
<th>Essential</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>54</td>
<td>46</td>
<td>41</td>
</tr>
<tr>
<td>2</td>
<td>45</td>
<td>49</td>
<td>44</td>
</tr>
<tr>
<td>3</td>
<td>39</td>
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<tr>
<td>4</td>
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<td>5</td>
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<td>71</td>
<td>71</td>
</tr>
<tr>
<td>6</td>
<td>11</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

\(^1\)May or may not be the “preferred hospital” to which a participant was affiliated.

Source: McKinsey Consumer Exchange Simulation 2012-2013 (state-level data)
Hospitals that have a highly respected brand within their community may inspire more consumer loyalty than other facilities. Thus, the extent to which pricing outweighs consumer loyalty could differ from health system to health system and locality to locality, as well as by product tier within a given locality.

**Provider landscape**

The payor must also have a deep understanding of the providers within each market. Obtaining standard market-composition information (e.g., who the players are, what relationships exist among them, and how much market share each has) is only the first step. The payor must also develop detailed insights into the level of consolidation among local hospitals, the extent of physician ownership of those hospitals (since such ownership influences referral patterns), and each hospital’s capacity utilization. Ideally, the payor should also develop detailed insights into the relative total-cost-of-care performance of each provider (and the level of disparity in that performance within each market). This information will enable the payor to determine whether the market composition can support the creation of a value network (and if so, what type) and also to estimate how much of a discount the providers must offer to retain patients or capture additional volume.

For example, a rural health system with no major competitors would be difficult to exclude from a value network, especially if smaller, nearby hospitals have capacity restrictions. Such a health system is also not likely to offer a payor significant discounts. Similarly, a health system with unique clinical offerings (e.g., the only facility in a region that can provide advanced oncology services) would be difficult to exclude from a value network.

Hospitals using only a small amount of their available capacity are likely to be eager to capture additional volume (or defend against erosion of existing volume) so that they can spread their fixed costs over more patients. These facilities may be willing to offer deep discounts in exchange for more volume. By contrast, hospitals with more balanced capacity utilization may see less value in trading price for volume.

Each market is unique. No hard rules govern the way specific providers will respond.

**Regulatory and legislative environment**

State regulations on health-system pricing will also shape the payor’s pricing strategy, since they influence both what the payor can do and how providers will respond. Among the issues that must be considered: Does the state currently have balance billing limitations? What are the usual and customary restrictions on billable charges? Based on the above, what level of reimbursement are providers likely to receive for patients who seek care out of their networks?

**Improving the value delivered**

To date, most payors have focused primarily on three approaches to improve the value delivered through their value networks: reducing reimbursements to providers, taking advantage of existing variations in provider efficiency, and increasing performance-based competition for providers. The most successful value networks we have seen capture value from all three sources, wherever possible.
Reducing reimbursement to providers
How payors approach contracting with providers for reduced reimbursement can heavily influence the level of discounts achieved. Our experience suggests that achieving significant reductions through traditional negotiations is likely to be difficult. However, alternative approaches that reset the context for the negotiations (e.g., by using a request-for-proposal, or RFP, approach or by sending an opt-in letter) can help achieve more substantial savings. Sending an RFP to hospitals, for example, could allow the payor to include all hospitals in the process (avoiding the need to selectively choose up front which ones to work with) and develop a better sense of how willing each hospital is to accept lower reimbursements before negotiations begin.

Taking advantage of existing variations in provider efficiency
In most markets, payors can capture significant value by analyzing, understanding, and taking advantage of existing variations in provider total-cost-of-care performance. This source of value is the one we observe to be most often overlooked by payors, perhaps because it is harder to implement than simply reducing reimbursement levels.

Considerable evidence suggests that there are significant variations in the total cost of care among all provider categories. After analyzing hospital costs in the top 50 metropolitan statistical areas (MSAs), we estimated that simply by directing patient volume to hospitals that are more efficient on a total cost of care basis, savings of $18 billion to $24 billion could be achieved annually. Savings of this magnitude remained even after we accounted for each MSA’s capacity constraints (which would limit the amount of volume that could be shifted to the highest-efficiency providers) and level of fragmentation (the less fragmented a provider base is, the more difficult it is to create a value network). Our calculations also suggested that if capacity constraints were relaxed over time, the savings achieved through value networks could be as much as $36 billion annually in the top 50 MSAs alone.

We have worked with several payors that have successfully introduced value-network products in select MSAs; many of those payors were able to reduce premiums by 10 to 20 percent in the network’s first year simply by taking advantage of existing variations in provider efficiency. Any payor that wants to adopt a similar approach must begin by fully analyzing the efficiency of each provider on a risk-adjusted, total-cost-of-care basis. One provider category should be analyzed at a time to ensure that the comparisons among the providers’ performance are fair. The payor should then include in its value network only the most efficient providers in each category.

Although efficiency on a total-cost-of-care basis can be substantially more difficult to measure and analyze than unit costs (or other common metrics, such unit costs multiplied by length of stay), we have found that selecting the most efficient providers is the most effective way to ensure the delivery of lower premiums (Exhibit 4). This approach can be the difference between developing a truly affordable value network and discovering that the expected savings erode following implementation.
Increasing performance-based competition among providers

Greater use of value networks could foster greater competition among providers. As a result, the networks could accelerate growth in the number of high-performing providers (by rewarding them with increased market share and thus increasing their ability to expand) and create stronger incentives for lower-performing providers to improve. Indeed, evidence already exists that value networks can change provider performance.

For example, a major northeast health system was initially excluded from the new networks that payors were developing in Massachusetts. Less than one year later, it announced a major cost-cutting initiative as a way to improve its overall level of efficiency. The health system cited concerns about the number of patients enrolled in tiered networks who were going to other hospitals as one of the reasons for this effort.
Maximizing value beyond premium price

The approaches just described can help payors reduce premium prices—obviously an important goal, especially now that the exchanges are about to be launched. Over the long term, however, payors may be able to partner in other ways with the providers in their networks to create additional value. The options include:

Moving to value-based reimbursement. Value networks can be a good way to introduce new value-based reimbursement models (e.g., bundled payments, gain sharing, risk sharing) in the commercial market. In turn, the value-based reimbursement models can reinforce the value network’s goal of providing more affordable options to those who most need or desire them.

Scaling new care delivery models. Because new care delivery models, such as accountable care organizations and patient-centered medical homes, require time to ramp up to their full savings potential, combining them with a value network can help marry near-term and longer-term savings, especially when efficiency is the primary criterion for network inclusion. A smaller network of more efficient providers can be a more manageable forum than a broad population of providers when payors are introducing new care delivery models as a way to ensure more affordable products.

Developing additional quality initiatives with providers. A smaller network of more efficient providers may also lend itself to the introduction of other win-win initiatives, such as efforts to increase star ratings or coding accuracy. Having a smaller, more efficient network would not only make it easier for the payor to launch such an initiative, but could also give the participating providers direct, positive incentives. (If the increases in the star ratings resulted in increased network enrollment, for example, the providers would gain more patients.)

Sharing data to better coordinate care. A smaller network could also make sharing clinical data and coordinating care easier. As a result, payors and providers could work together to identify new ways to improve care quality and make it more cost-efficient.

Co-branding products. In some markets, value networks could be constructed around one or two core health systems, which would give all stakeholders the opportunity to co-brand products. Our research has shown that brand familiarity is likely to play a key role in consumer choice on the exchanges. A co-branded product would enable a provider to get more market exposure for its name and, simultaneously, offer the payor the positive association of the provider’s brand name.

Partnering to improve access. In exchange for inclusion in a value network (and the increase in volume that such inclusion would presumably bring), some health systems may be willing to offer the network’s members preferential access or other special services (e.g., shuttles, dedicated private rooms, same-day appointments).

Many payors now have experience developing value networks. However, in the rush to
meet external timelines, some payors may not have optimized their network configuration or approach. As they refine their value-network strategies moving forward, these payors would benefit from having a deeper understanding of local market dynamics, as well as stronger analytic tools to calculate each provider’s total cost of care (probably the best way to capture value). In addition, payors must consider how they can work more closely with the providers in their networks to create additional value. For all partners in the networks, the goal should be to improve the efficiency of care delivery and enable affordable, high-quality care.

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Appendix: About the research and analysis

This article leverages proprietary research and analysis that McKinsey has conducted over the past 18 months. This appendix describes the major tools and data sources we used.

**McKinsey’s Consumer Exchange Simulation**

With this tool, users (typically, payors) design a suite of insurance products that can then be sold on a simulated online exchange. Consumers browse the exchange, which highlights information on premiums, deductibles, coverage tiers, and other key product attributes, before making a selection. As of the end of 2012, nearly 150,000 consumers across the United States had participated in simulations. On average, each consumer needs about 25 minutes to complete the process.

The first round of simulation requires about five weeks and typically involves some 4,000 local consumers between the ages of 18 and 64, who have incomes above 133 percent of the federal poverty level. An additional round can be conducted for users that want to test detailed product configurations and trade-offs.

The exchange simulation collects a wide range of demographic data about the participating consumers, as well as information on their current coverage, health status, and prior purchase behavior. Thus, the simulation allows users to:

- Assess the impact of different product attributes (including brand name, price points, network designs, and availability of dental care or other additional services) on consumer buying preferences and choices
- See what types of consumers purchased their products, as well as the types that preferred competitors’ products
- Estimate how their product offerings would fare in terms of revenue, margin, medical loss ratio, and market share in a real market
- Understand local market dynamics, competitive issues, and the effect of subsidies on insurance choices

The “real” consumer feedback gives users unique insights into consumer preferences and what their behavior on the exchanges is likely to be, information that is not available through any other source.

Several payors have already used the McKinsey Consumer Exchange Simulation to support product design, off-exchange strategies, and strategies for handling the transition of existing members from employer-sponsored insurance to individual plans.

**McKinsey’s annual Consumer Health Insights (CHI) survey**

This unique survey provides information on the opinions, preferences, and behaviors of more than 14,500 consumers, as well as the environmental factors that influence their healthcare choices. The survey also enables insights into the current market...
environment and can be used to make predictions about the choices and trade-offs consumers are likely to make in the post-reform environment.

The CHI collects descriptive information on all individuals who participate in the survey and their households. It also assesses shopping behaviors; attitudes regarding health, healthcare, and the purchase and use of healthcare services; awareness of health reform; opinions about shopping for individual health insurance and using an insurance exchange; preferences for specific plan designs (including trade-offs among coverage features, such as benefits, network, ancillaries, service options, cost sharing, brand, and price); employee perceptions of the employer’s role in healthcare coverage; attitudes about a broad range of related supplemental insurance products; opinions, use, and loyalty levels regarding healthcare providers; and attitudes and behaviors regarding pharmaceuticals and pharmacies.

We supplement the information from the CHI with data from other sources, such as information on a consumer’s estimated lifetime value to a payor, consumer behavior, and marketplace conditions. This combination provides a holistic view of healthcare consumers that is not available through other sources.

We have used CHI data in a range of customized analyses that address both current and post-reform healthcare issues. We expect that payors and others will use the information primarily in applications that assist with product design, marketing strategies, consumer segmentation, consumer targeting, network configuration design, and assessment of new channel opportunities.

**McKinsey Predictive Agent-based Coverage Tool (MPACT)**

MPACT is a micro-simulation model that uses a comprehensive set of inputs and a distinctive approach to modeling consumer and employer behavior to project how health insurance coverage may change post-reform. MPACT contains 300 million “agents” representing all residents of the United States. Each agent is characterized by his or her county of residence, type of insurance coverage, and eight demographic variables. Over the course of the micro-simulation, agents in each geo-demographic segment make health insurance purchasing decisions depending on their eligibility, prior purchasing behavior, demographics (including health risk status), subsidy eligibility, penalty impact, and other factors.

**Provider Reform Impact and Stress-test Model (PRISM)**

McKinsey’s PRISM analytic takes hospital financials, MPACT county-level covered lives projections, the Firm’s national hospital operational benchmarking database, and legislated changes to project hospital performance market-by-market. “Add-on” modules include projections of financial impact and utilization of services at the level of clinical service lines (e.g., cardiology, orthopedics), a bad-debt modeler, and a rapid outside-in module, that takes outside-in data to project the impact of reform on hospital economics. PRISM has built-in flexibility to model a range of scenarios, based on reform- and non-reform-related factors.