

US health insurers have attempted to use network and payment levers in multiple ways to reduce medical costs. In recent years, they have returned to a strategy from the 1990s: creating more limited provider networks to shift patient volume to more cost-efficient providers and, in some cases, secure additional fee-schedule concessions. In addition, they have embraced value-based payment as a way to reward providers for delivering high-quality care at lower cost, improving performance over time, or both. Each approach has achieved fairly widespread use, but neither has yet realized its full potential.

Most payers today have a limited provider network for at least one line of business. These value networks, whether narrow or tiered, are used in over half of individual market offerings and are being rolled out extensively in Medicare Advantage. They have enabled premium reductions upward of 18 percent when compared with broad network products in the Individual market.¹ Many consumers find the trade-off between cost and provider choice compelling.^{2,3} Adoption of value networks in the employer-sponsored insurance (ESI) market remains comparatively low, however. In recent years, pricing pressures have led payers to create a surge in offerings for the small-group market, and many employers have shown interest in them. Yet, in a recent survey we conducted, only 6 percent of employers with small-group plans reported adoption, even though many carriers are offering substantial discounts on products based on value networks.^{4,5} Similarly, only 9 percent of employers with large-group plans reported adoption.

Value-based payment has also been adopted broadly in some markets, although the level of financial commitment to new payment models—and, not surprisingly, the level of impact—still falls short of the potential. Recent estimates suggest that roughly 34 percent of dollars paid to providers are now in contracts that have some type of performance clause.⁶ These models are expanding in scale and complexity as they are applied to more geographies and populations. In most cases, however, the potential rewards associated with these models are relatively modest; in only a small fraction of cases (we believe less than 20 percent in Medicare models, for instance) is there downside risk associated with underperformance.⁷ In our experience, a provider's level of "skin in the game" is among the most important predictors of the impact of value-based payment.⁸ Finding ways to raise the stakes (both positive and negative) for providers to adopt and perform under value-based payment models is therefore likely to be essential to transforming care delivery.

Given these facts, we believe an opportunity—even an imperative—exists to reconsider the design and implementation of both value networks and value-based payment. Doing so could enable payers to better understand the barriers that hinder the impact of each approach, and to rethink how they might capture the full potential of each. It could also allow them to contemplate the transformational impact of the two strategies in combination. Exhibit 1 contains a list of key actions health insurers should take when they are considering joint deployment of value networks and value-based payment.

¹ Coe E et al. Hospital networks: Perspective from four years of the individual market exchanges, McKinsey white paper. May 2017.

² McKinsey 2018 Employer Health Benefits Survey.

³ Anand P et al. Understanding consumer preferences can help capture value in the individual market. McKinsey white paper. October 2016.

⁴ McKinsey 2018 Employer Health Benefits Survey.

⁵ The large-group discounts for narrow-network products quoted in public rate filings span a broad range, from 5 percent to more than 30 percent.

⁶ Health Care Payment Learning and Action Network (LAN). *Measuring Progress: Adoption of Alternative Payment Models in Commercial, Medicaid, Medicare Advantage, and Fee-for-Service Medicare Programs*. October 2018.

⁷ LAN survey results estimate that one-eighth of all healthcare spending in 2017 was associated with downside risk models. While the number of Centers for Medicare & Medicaid Services' accountable care organizations has more than tripled in the past five years, fewer than 10 percent are assuming downside risk. Similarly, a few state innovation model (SIM) programs are starting to incorporate risk. We believe the trend is similar in the commercial segment.

⁸ Berg M et al. The seven characteristics of successful alternative payment models. McKinsey white paper. January 2019.

Barriers to maximizing potential

Many payers have implemented value networks and value-based payment as independent strategies. In fact, many payers (and provider executives) perceive value networks and value-based payment as being at odds with each other: they often conceive of narrowing

networks as a quick fix to drive down costs by weeding out high-priced providers, and value-based payment as a long-term partnership to enable performance improvement in a purely win-win way. We believe that this understanding of the two strategies has deterred payers from integrating them and led to the suboptimal performance of both.

Exhibit 1

Priority checklist for the integrated deployment of value networks and value-based payment

<p><i>Design an integrated strategy informed by the specific needs of each customer segment and the specific provider landscape</i></p>	<ul style="list-style-type: none"> <input type="checkbox"/> Have a research- or other fact-based understanding of the key demands of each of your customer segments (e.g., what subsegment of your group market is price-sensitive and most likely to be attracted to a value proposition centered on both value networks and value-based payment) <input type="checkbox"/> Have a research- or other fact-based understanding of your specific provider landscape (e.g., utilization, cost, and referral patterns; market dynamics of independent vs system-owned providers; degree of current and likely future consolidation; strength of vertical integration and clinically-integrated networks; financial performance and population health capabilities of strategically important providers) <input type="checkbox"/> Know which value-based payment models and value-network configurations should be deployed in each segment, based on customer needs and provider landscape <input type="checkbox"/> Have one or two high-value, near-term strategic opportunities to serve as use cases for an integrated approach to value networks and value-based payment (e.g., a tiered network that integrates revised value-based payments for included providers)
<p><i>Align on a common definition of provider “value”</i></p>	<ul style="list-style-type: none"> <input type="checkbox"/> Use a common metric for provider performance (e.g., total cost of care) for all contracting and value-based payment functional units. (See Exhibit 2 for an example.) Be clear about how you will incorporate measures of quality performance <input type="checkbox"/> Invest in analytic capabilities to automate risk-adjusted, value-based scoring for your major types of providers. Be able to integrate the analytic findings with geospatial and market insights, and to rapidly model medical cost savings potential for different network configurations
<p><i>Communicate the benefits and implications of an integrated value proposition to providers</i></p>	<ul style="list-style-type: none"> <input type="checkbox"/> Know, from a strategic perspective, who your optimal provider partners are in each customer segment <input type="checkbox"/> Engage providers before launch to clearly explain what is at stake with network inclusion, offer transparency into your multi-year approach to “value” and performance measurement, and link network performance to value-based contracts <input type="checkbox"/> Consider how providers will assess the value of a combined offering (e.g., direct financial impact, reduced administrative burden from potential downsizing of traditional medical management programs)
<p><i>Communicate the benefits and implications of an integrated value proposition to customers</i></p>	<ul style="list-style-type: none"> <input type="checkbox"/> Have a go-to-market strategy for your value-network offerings that capitalizes on deeper alignment with value-based payment arrangements <input type="checkbox"/> Have a plan to update consumer-facing digital concierge tools (e.g., online directories, member referral services) with additional insights into provider performance, to reinforce member care patterns advantageous to both your value networks and value-based contracts
<p><i>Streamline the operational model across value networks and value-based payment programs</i></p>	<ul style="list-style-type: none"> <input type="checkbox"/> Have an operating model across value networks and value-based payment programs that integrates the following: <ul style="list-style-type: none"> —Governance —Resourcing and capability building —Execution and implementation timelines

Four barriers, in particular, have limited the impact of value networks and value-based payment:

Some employers perceive narrow networks as an inferior option for consumers, rather than a better value for money. To the extent that value network designs are based solely on unit-price comparisons, they have the potential to reinforce perceptions that narrow networks are inferior to broad networks. However, some payers (in Medicare Advantage especially and, in select instances, in the Individual and ESI markets) have designed more exclusive networks based on a broader set of criteria than just unit price—for instance, using total cost of care measures instead. These payers can then market the networks as delivering a better value for the money (at a minimum) or as a way to gain access to a more exclusive set of high-performing providers. That said, in the ESI market, expected network performance is still predominantly assessed based on unit costs in spreadsheets created by benefits consultants, and in these assessments, the more exclusive networks may appear less competitive.

Large employers interested in narrow networks have been challenged in finding compelling offerings and guiding employees toward them. The large-group market lacks a true national narrow-network offering, but payers are mobilizing to fill this gap.⁹ While many narrow networks exist within local markets and individual states, they may not deliver an attractive business case for overall savings for large employers. Realizing savings from these networks is further complicated by an as yet unmet need for benefit decision-making and plan-selection infrastructure to help employees understand the trade-offs with narrow networks.

Insufficient financial stakes (e.g., the prevalence of upside-only arrangements) have limited the ability of value-based payment to compel providers to transform their business models. In the absence of downside-risk arrangements, providers face little penalty for not proactively

managing patients' utilization across the network. For many payers, it can be difficult to create a compelling reason for hospitals to eliminate unnecessary admissions with any form of value-based payment short of capitation, simply because of the high gross margins of incremental admissions for most commercial populations. Although many hospitals are wary of accepting capitation, it creates a strong incentive to reduce admission rates and enable greater control over patient volume for other services.

Subscale penetration of both value networks and value-based payment in the ESI market has limited the business case for provider business model transformation. While narrow networks have been adopted by many consumers in the Medicare Advantage and Individual markets, they often do not impact a significant portion of the total patient panel for most physicians and hospitals. The same is true for value-based payment models with both upside and downside risk (whether bundled payments, total-cost-of-care risk sharing, and/or capitation). In both cases, if participation applies to only a subset of a provider's patients, the provider may have an incentive to make incremental changes (in referral patterns, for instance) but is rarely motivated sufficiently to invest in new capabilities or make major changes in capital planning.

Benefits of joint deployment

We propose that value networks and value-based payment need not be at cross-purposes. On the contrary, we believe that payers can achieve their full value only when they are deployed using an integrated approach. Joint deployment delivers at least five major benefits:

Bolder differentiation of true winners

Narrow and tiered networks, by definition, draw a line in the sand as to which providers are preferred over others. As we discussed, the selection of preferred providers is often based on lower unit prices, and the providers

⁹ For instance, Aetna has implemented Aexcel performance networks in 39 markets; the networks give blue-star designations to high-performing providers in 12 specialties and offer lower cost-sharing requirements for members who visit these providers. Cigna has expanded its SureFit narrow networks into 18 markets across the country.

are rewarded with additional volume through benefit design or preferred network position. In contrast, value-based payment often rewards providers for driving down the total cost of care, or for both cost and quality improvements relative to their historical performance. Thus, the incentives for value networks and value-based payment can be out of sync—a provider may “succeed” in one but not the other.

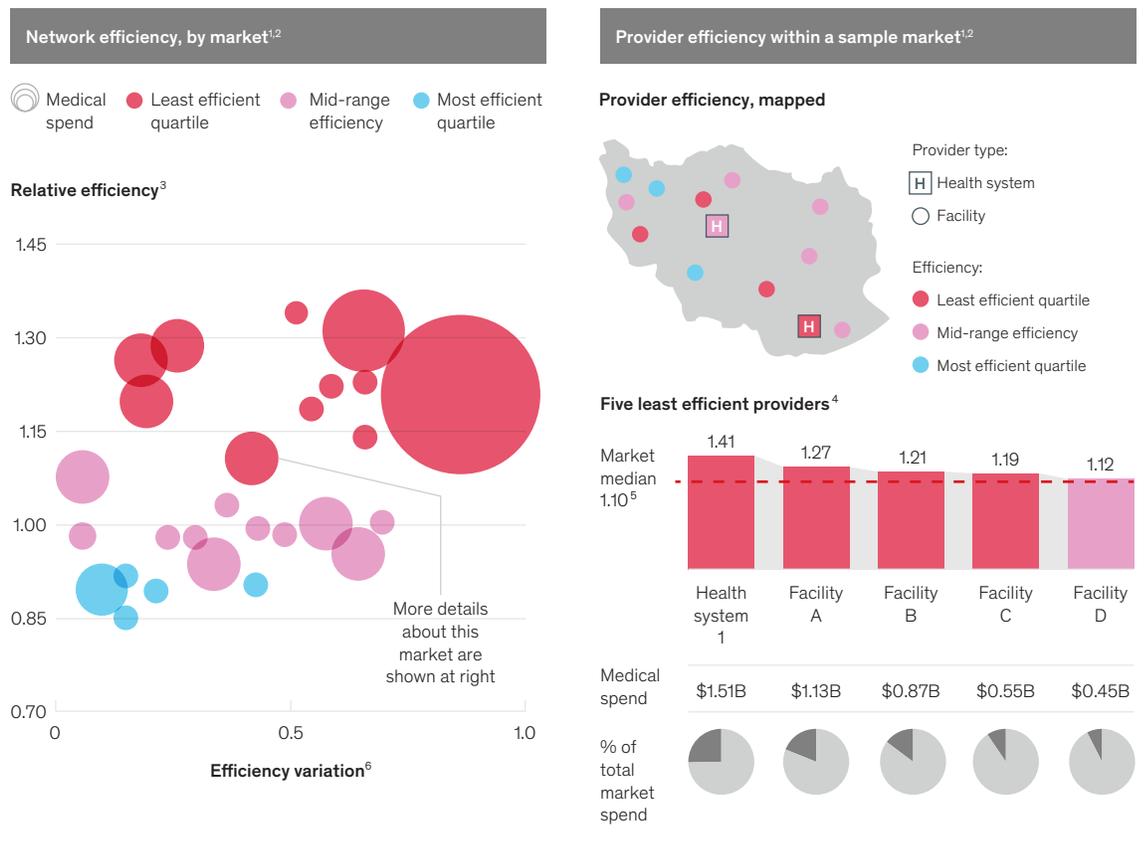
Payers can unlock synergy by applying a single definition of value to both their network design and payment strategies. One approach is to evaluate providers on their risk-adjusted, total

cost efficiency (not unit price alone), and then apply that definition to both strategies. Exhibit 2 illustrates what a value-based assessment of networks and providers might look like in a dashboard format. This approach can deliver advantages to both providers and payers. For instance, providers are more likely to engage in improving cost efficiency if they are rewarded with both preferred status in a network and incentives from their value-based payment contract. Payers are more likely to find that preferred providers, as a group, are able to achieve greater cost-efficiency improvements than nonpreferred providers. In other words,

Exhibit 2

Value-based assessment of networks and providers

ILLUSTRATIVE EXAMPLE



¹ Illustrative, based on a dummy claims dataset.

² Relative efficiency index, based on the risk-adjusted total cost of care for all attributed members participating in the network. For example, an efficiency score of 1.10 indicates a risk-adjusted total cost of care that is 10% less efficient than the median score (1.00) across all markets.

³ Relative efficiency, based on the risk-adjusted total cost of care for all attributed members participating in the network.

⁴ Higher scores indicate less efficient providers; lower scores indicate more efficient providers.

⁵ Median provider efficiency of this market, expressed as an index to the median provider efficiency of all markets (not shown).

⁶ Measure of variation of providers within a market: difference between 75th and 25th percentile provider efficiency, divided by the median provider efficiency.

Source: Excerpted from McKinsey Network Performance Dashboard

the “winners” in a value network that includes value-based payment are more likely to deliver the best value to members.

Integrated deployment of the two approaches can also reorient contracting decisions to focus on total performance. Strong performance in value-based payment arrangements would become a key enabler to placement in a value network.

In practice, strategic and regulatory considerations (e.g., network adequacy) may require occasional deviations from integrated deployment. Further, even if a single definition of value is used, the performance threshold to earn a preferred position in a value network will likely differ from the threshold to succeed in value-based payment. Thus, payers should establish a time frame for achieving performance goals so that the value networks do not prematurely exclude providers that may be costly today but are capable of strong performance improvement.

A more compelling value proposition for employers

Customer messaging around value networks has historically focused on delivering lower premiums in exchange for narrower access to providers. This value proposition has been compelling for some, especially individuals and employers who wish to avoid the high levels of cost-shifting to members typical of high-deductible health plans. Payers sometimes co-brand products with providers to enhance this value proposition with perceived quality and name recognition.

However, integrated deployment with value-based contracts—wherein value networks are constructed around the providers delivering the greatest value to members and succeeding in value-based arrangements—increases payers’ ability to communicate to employers that their value networks deliver real value (not merely cheaper providers). Further, payers can demonstrate that their value networks

support the same definition of value that is used to evaluate providers in value-based arrangements, and that both programs have been intentionally designed to work together to positively affect affordability, clinical quality, and member experience. Benefit design, particularly in commercial products, can further reinforce members’ use of preferred in-network providers. The extensive performance reporting typically associated with value-based contracts offers a ready evidence base to support this message to employers.

Stronger case for provider adoption of downside risk

Too often, payers and providers seek to negotiate value-based payment arrangements outside the structure and timing of the base fee-for-service contract, as a kind of post-hoc amendment—“icing on the cake,” so to speak. In our experience, providers (hospital systems in particular) are apt to accept financial risk only if it is directly tied to the negotiation of the network contract, with the negotiation having the same consequences for network participation as other terms and conditions.¹⁰

Providers will continue to have little incentive to adopt downside-risk arrangements unless value-based payment either generates an opportunity to capture greater market share (through alignment with more restrictive networks) or poses a threat (exclusion from restrictive networks if they fail to accept downside risk). Integrated deployment with value networks therefore has the potential to accelerate the adoption of more financially meaningful value-based contracts.

Trading off two methods for influencing referrals

A provider’s ability to promote referrals to more efficient providers is a key source of value in value-based arrangements. However, providers traditionally find this challenging when insurance products allow patients to go to any provider (as in products based on

¹⁰ We include in the definition of “financial risk” those situations in which a provider accepts a lower-than-desired fee schedule coupled with an “upside-only” opportunity to earn additional rewards based on savings generated for the payer or plan sponsor. Such a structure allows for value-based payment to become a tool for overcoming an impasse in a fee-for-service contract negotiation, since it creates real “skin in the game” for the provider while also limiting its total exposure.

a preferred provider organization) or to providers that are not necessarily the most efficient (as with narrowed networks designed around unit price instead of efficiency). Integrating the design and implementation of value networks and value-based payment allows for deliberate choices about how to link the levers or trade off one lever for the other. For instance:

- By relying on the incentives for at-risk physicians to steer volume to certain hospitals, a payer may be able to keep other hospitals in the network, and by doing so, continue to maintain in-network rates for emergency admissions to those hospitals.
- By restricting the post-acute care network for a given population of patients (and ensuring benefit designs complementarily reinforce in-network usage), a payer may be able to give a physician group or hospital system increased confidence in its ability to control costs and thus persuade it to accept risk for the total cost of care.

Improving operational efficiency

Integrated deployment of value networks and value-based payment can eliminate the operational inefficiencies that have resulted from deploying them separately. For instance, payers can streamline the work of fee-for-service and value-based network and payment teams because their work now rests on an integrated type of expertise focused on total cost efficiency. Analytics, reporting, and transparency tools

for providers, customers, and members can be simplified. Marketing and sales teams can go to market with a value proposition based on a single definition of value.

In the long run, maximizing the potential of value networks and value-based payment may also allow payers to scale back traditional medical management programs, especially if participation in narrowed networks encourages providers to take on greater financial risk (and opportunity for reward) in their value-based arrangements. We estimate that this approach has the potential to markedly lower administrative spending on medical management.¹¹

We believe that value networks and value-based payment can deliver significant value to both consumers and employers by improving the affordability of high-quality care. Admittedly, value networks may not appeal to all consumers, and some providers may be reluctant to accept the terms of either value-based payment programs or participation in value networks. Payers will need to realistically assess their position in each of their markets and acknowledge that a weak position is likely to constrain their options for designing an integrated approach. Nevertheless, we believe that a more coordinated and aligned approach to the design and implementation of these two strategies could foster the increased adoption and impact of each.

¹¹ Singhal S, Coe E. The next imperatives for US healthcare. McKinsey white paper. November 2016.

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