



RESEARCH REPORT

Payment Methods and Benefit Designs: How They Work and How They Work Together to Improve Health Care

Tiered Networks

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Payment reform promises to substitute value for volume. Yet, value- and volume-based approaches typically are implemented together. All payment methods have strengths and weaknesses, and how they affect the behavior of health care providers depends on their operational design features and, crucially, on how they interact with benefit design. Those seeking greater value for their health care dollar are also turning to innovation in benefit design, which also typically involves the implementation of more than one approach at a time—each with its own strengths, weaknesses, and effect on consumer health care behavior. Although payment and benefit design each has received significant attention independently, the intersection between the two has received little if any. The Urban Institute partnered with Catalyst for Payment Reform to explore how established and proposed payment methods and benefit design options work on their own and together. We also examined how payment and benefit design can be blended to improve health care delivery. This chapter is one of the seven benefit designs discussed in the report *Benefit Designs: How They Work*. All reports and chapters can be found on our project page: [Payment Methods and Benefit Designs: How They Work and How They Work Together to Improve Health Care](#).

Tiered Networks

Tiered networks are created by designating groups of network providers into levels, or tiers, based on the value—cost and quality—of the care they provide. The providers that deliver care that is high value—low cost and high quality—are in the highest tier, while those that provide care that is low value are in the lowest tier. Accordingly, tiered networks are also called high-performing networks. However, few providers have even levels of quality across service lines, even though the provider group is considered high or low value as a whole.

In general, to channel consumers to high-value providers, tiered networks offer different out-of-pocket costs for consumers per tier. Patients who seek care from high-value, or preferred, providers have lower out-of-pocket costs. Differential cost-sharing by tier allows the consumer to make trade-offs between the choice of provider and the cost of care.

Cost-sharing distinctions can be made for co-payments (per day or per visit), co-insurance, deductibles, or the out-of-pocket maximum. For example, a consumer may have a lower co-pay, co-insurance, and deductible for a provider in tier 1, and a higher co-pay, co-insurance, and deductible for a provider in tier 2. Health care consumers have some experience with these different levels of cost-

sharing if they have ever elected a preferred provider organization (PPO) for their health insurance product or used prescription drugs that are tiered in a formulary.

Tiered networks may not be equally functional in all markets. In a competitive provider market, tiered networks give payers the opportunity to sort providers according to value. Being placed in a lower tier can threaten a provider's patient volumes, so to remain competitive through placement in a higher tier, providers may renegotiate to lower their prices. In contrast, tiered networks may not be viable in markets with a dominant provider group or system that provides the majority of services. If the dominant provider system receives the bulk of patient volume in the market, the provider system will want to protect that volume and will have the leverage to do so since, without it, consumers may not have adequate access to care. Therefore, dominant providers have the leverage either to stop the effort to create tiered networks, or to demand placement in their preferred tier regardless of their value.

In Massachusetts, where some markets are particularly challenging, legislation requires plans to offer a select or tiered product with a base premium at least 12 percent lower than that of similar non-select or non-tiered plans.

Key Objectives of Tiered Networks

The main objective of tiered networks is to channel consumers to “preferred providers” that are high value—offering high-quality care at a relatively low cost. Consumers' cost-sharing varies with provider tiering designations: consumers pay lower costs out-of-pocket if they receive care from a high-value provider in the highest tier and pay higher out-of-pocket costs if they receive care from a low-value provider in the lowest tier.

Another major objective of tiered networks is that in reasonably competitive markets, they can provide payers additional leverage in price negotiations with providers. If patients are steered toward providers in the top tier, providers in the lower tiers will likely lose patient volumes. To maintain those volumes, they may take a more reasonable stance in negotiations.

A third objective of tiered networks is to preserve consumer choice. Tiered networks allow consumers to weigh trade-offs between their out-of-pocket costs and their choice of provider.

Strengths

- Cost-sharing differentials by tier can channel consumers to higher-value providers.
- Differential cost-sharing by provider, rather than outright restrictions, allows consumers the opportunity to weigh trade-offs between costs and the providers they wish to see.
- The use of differential cost-sharing in the tiered network results in lower premiums for consumers than comparable non-tiered options, as well as potential cost-sharing for care received from the higher tiers.
- In competitive markets, tiered networks may motivate health care providers to earn their place in the preferred tier by improving the quality of their care or reducing their prices. As a result, health plans strengthen their negotiating position and providers may renegotiate their prices to be placed in a higher tier and retain, or increase, their patient panel.

Weaknesses

- Tiered networks may be infeasible in highly consolidated markets, as it may be difficult to place dominant providers into lower tiers. Providers with clout can demand placement in a preferred tier and maintain higher prices as a condition of their network contract.
- Unlike prescription drugs, in which tiering is used for biologically or functionally equivalent products, physician and hospital services are less commodity-like and require judgments on the complex factors underlying meaningful cost and quality comparisons.
- State regulations make it illegal to pay providers in a PPO through any risk-based approach like capitation or shared risk. This may make providers less accountable for the care they provide their patients.
- Smaller markets may have too few providers to make tiered networks functional or meaningful.
- Many tiered network plans don't have large enough differentials between tiers to alter consumer behavior.

Design Choices to Mitigate Weaknesses

Network Adequacy

A tiered network must be sufficiently large to ensure consumers adequate access to high-value providers. If too few providers participate, especially in higher tiers, patients may experience difficulty gaining access to designated high-value providers, for whom they have lower out-of-pocket costs.

Availability of Price and Quality Information

Transparency about how providers are tiered is critical to informing consumers about which providers are high value and why. Transparency may also help reduce confusion when providers' designation changes from year to year. If the information is also made available to providers in the network, it can help them direct patient referrals to high-value providers.

Selecting Providers

Providers can be designated into tiers based on cost or quality considerations. Some tiered networks base their designations solely on the cost. For example, the lowest-cost providers could be placed in tier 1 and the highest-cost providers in tier 3. Other tiered networks designate providers based on both cost and quality, or on value. This is a more favorable approach for consumers who wish to receive higher-quality care. However, the ability to use quality as a criterion depends, in part, on its availability, including adequate sample size.

Cost-Sharing

The range of consumer cost-sharing from tier to tier can be minimal or significant. Minimal cost differentials may not change how consumers select providers, whereas a large differential may significantly affect their behavior, strongly encouraging them to seek care from higher-value providers.

Legal Environment

Local laws and regulations can affect how conducive the environment is for tiered networks. Laws ensuring transparency of quality or prices can support their implementation. Other laws or regulations supporting competition among providers, from antitrust to prohibitions on “most favored nation” contracts, can also enhance tiered networks’ opportunities to succeed.

Compatibility with Other Benefit Designs and Payment Approaches

Value-based insurance design (V-BID) could be used with tiered networks. Blue Shield of California implemented a program called Blue Groove, which provided enrollees with V-BID subsidies for receiving care from higher-tier providers. If the consumers received care from lower-tier providers, they would not be eligible for V-BID subsidies. While Blue Groove never took off, this model could be successful with a simple and comprehensive design.

Tiered networks should use quality and cost criteria to distinguish one provider from another. Therefore, payment methods that incorporate quality and cost performance measures may be especially compatible. For example, a shared savings payment arrangement—like those used to support many ACO delivery models—would tie providers’ payment amounts to their ability to meet cost and quality targets. These same measures could be used to determine provider tiers as well as their payments. The incentive to be cost conscious might be particularly effective on providers in lower tiers who have the least desirable combination of cost and quality. Therefore, the incentives in both tiered networks and shared savings work in parallel to improve quality and lower costs to the system.

Tiered networks lack hard restrictions on patients’ choice of provider, similar to Medicare ACOs, which have no restrictions on choice. Therefore, it is difficult to make providers accountable for those patients through risk-based payments because providers have little to no control over their use of health care services.

Pay-for-performance may also be compatible with tiered networks. By meeting or improving against quality standards, providers in lower tiers gain recognition and extra income, which may help offset the potential loss in revenue from decreased patient volume. In addition, providers that consistently meet quality standards have the chance to be moved into a higher tier.

Focus of Performance Measurement

Ideally a tiered network would be built upon strong quality measures that address key areas of concern (high cost, high variation in performance) as well as objective cost criteria. With a tiered network, it would be important to track both changes in consumers' selection of providers, as well as whether those changes affect the quality of care or patient outcomes. However, if the same quality measures are used for tiering providers and measuring effects, it may be possible to miss trends in the quality of care (good or bad) in areas that are not the focus of measurement.

Potential Impact on Provider Prices and Price Increases

A tiered network in a competitive market has the ability to leverage pricing negotiations between a payer and provider organizations. If a tiered network successfully attracts consumers to enroll, competing providers may be willing to renegotiate prices with health plans in the market. However, this is less effective in a highly consolidated market where dominant provider systems exist. They would have the leverage to demolish the network if not placed in a top tier; therefore, there would be no effect on provider prices or price increases.

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A [technical expert panel](#) advised the project team and reviewed the reports at different stages.

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