Consumer-driven health care
How value-based networks can help reduce health costs, improve care

Holding the line on health care costs has long been an ongoing concern of insurers, employers and consumers. In recent years the use of value-based networks for providers has become more popular. These networks are also sometimes referred to as narrow, tiered or high-performing networks.

Essentially, value-based networks encourage members to utilize the more efficient providers — meaning hospitals or physicians — by either narrowing networks, or by lowering copayments or deductibles for providers in different tiers in the network.

“Value-based networks are a variation on the long-established practice of having one level of benefits for in-network providers and another level for those out of network,” says Andrea Gioia, executive director for Product Innovation at UPMC Health Plan. “The difference is, with a value-based network the member can choose the providers he or she prefers based on the criteria that are most important to him or her.”

Smart Business spoke with Gioia about how value-based networks can make sense for employers who are looking to reduce health care costs.

How does a value-based network system work?
A value-based network system is an attempt by insurers and employers to contain costs by offering health benefits plans that offer employees a real choice. Depending on the provider they choose, the employee may be able to pay lower copayments or have a lower deductible.

More financial responsibility falls on the member in terms of decision-making and, as a result, this should encourage initiatives that will provide better information about the cost and quality of health care in order to make more informed decisions.

The health insurer makes the determination about which tier hospitals or physicians will be on. This could be based on the rates the insurer is charged, as well as the quality and efficiency of care being offered. With a value-based network system, when an insurer saves money by getting lower rates from certain hospitals, those savings are passed along to the member in the form of lower out-of-pocket costs such as a lower copayment or a lower deductible.

Quality is determined through claims-based methods, external certification and health information technology.

Why are value-based network systems becoming more available?
A lot of factors are at work, including the fact that there is a demand for more consumer-driven options. Certainly, employers as well as employees are increasingly interested in finding ways to contain health care costs and hold down the cost of premiums. Value-based networks can deliver in both areas.

What could be the consequences of value-based networks?
Ideally, a value-based network system should engage its members in the process. Members have more incentive than ever to be involved in choosing providers and treatment because they are exposed to higher out-of-pocket expenses.

In addition, this could spur competition between providers to cut costs and raise quality standards in order to avoid landing on the higher-priced tiers. Estimates have indicated that tiered products, on average, are priced 10 to 15 percent lower than non-tiered and HMO products.

Health insurers tend to support value-based networks because it gives consumers skin in the game. The consumer will have a financial interest in health care decisions beyond the cost of a premium.

Can value-based networks impact quality?
When a provider’s tier is tied to quality, the potential is certainly there that a value-based network will not only encourage better value but also drive providers to perform better and more efficiently. As cost and quality information becomes more available to consumers of health care, the more likely it will be that consumers will base their health care decisions on this information. This has the potential to drive change in health care in a positive direction.

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