CHRT

ISSUE BRIEF

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# Emerging Health Insurance Products in an Era of Health Reform

At least in part in response to the health coverage changes of the Affordable Care Act (ACA), many health plans are making significant changes to products that they plan to offer in the employer and individual market. While insurers were already moving away from paying for volume and toward paying for value prior to health reform, the ACA has been a catalyst for greater development of an array of health plan products. Many health insurers are anticipating a shift from employer-sponsored to individually-purchased health insurance. Individuals and small businesses may now purchase coverage on the individual insurance exchange and on the Small Business Health Options Program (SHOP) exchange, respectively. Furthermore, the majority of plans offered in Michigan on both the individual and SHOP exchanges are limited or narrow network plans. At the same time, consumers seem willing to consider products that include fewer providers in exchange for lower premiums.[1,2]

This brief focuses on three growing categories of health plan products and provider arrangements in the commercial market:

- Accountable Care Arrangements
- Narrow and Tiered Network Products
- Reference Pricing Strategies

It also describes the characteristics of these new products, explains how they may affect consumers, and provides examples of health plan offerings.



[1] A. Mathews. July 14, 2013. *Price, Price, Price: Health-Insurance Shoppers Have Priorities.* The Wall Street Journal. http://online.wsj.com/article/SB10001424127887323300004578555560447477062.html (accessed 7-27-2013).

[2] N. Bauman, M. Chopra, J. Cordina, J. Meyer, and S. Sutaria. 2013. *Winning Strategies for Participating in Narrow-Network Exchange Offerings in The Post-Reform Health System: Meeting the Challenges Ahead* (Palo Alto, CA: McKinsey & Co.).

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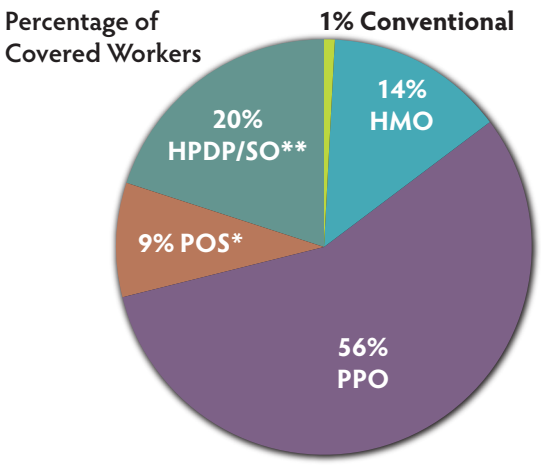
# Insurance Products Today

The vast majority of Americans currently get their health care through health insurers whose networks include most providers in a covered geographic area. In the early 1970s, the federal government encouraged the formation of Health Maintenance Organizations (HMOs) in an effort to control the growth of health care costs.[3] HMOs generally use restricted networks and require authorization from a primary care physician before specialty services are provided. HMOs have had limited market penetration because their restrictions are often unpopular with consumers. A more flexible managed care approach called a Preferred Provider Organization (PPO) has been a more popular product among consumers (see Figure 1 for plan type distribution). In a PPO, health plans contract with some subset of providers in the covered geographic area. Consumers can go to any provider without a referral but with somewhat higher cost-sharing if the provider is outside of the PPO network. FIGURE 1

Health plans and employers have been looking for new products that combine the advantages of PPOs (principally, consumer choice) and the strengths of HMOs (particularly, strong cost controls). Accountable care arrangements, limited network products and reference pricing strategies are major initiatives in the marketplace attempting to achieve this blend.

FIGURE 1
**Distribution of Health Plan for Covered Workers, by Plan Type, 2013**[4]




**Source:** Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2013.

* *A Point of Service (POS) Plan is a mix between an HMO and a PPO. Enrollees have a designated primary care physician, as in an HMO, but consumers may receive care outside of the provider network, generally at a higher cost to the consumer, as in a PPO.*

** *A High Deductible Health Plan (HDHP) is a plan option with lower premiums and higher deductibles than a traditional health plan. An HDHP with a Savings Option (HDHP/SO) includes a Health Reimbursement Arrangement (HRA) or Health Savings Account (HSA) which is a tax-advantaged account that consumers can use to pay for medical expenses.*

[3] P. Kongstvedt. 2009. *The Origins of Managed Care. Managed Care: What It Is and How It Works, 3rd ed.* (Burlington, MA: Jones and Barlett Learning).

[4] Kaiser Family Foundation. 2013 Employer Health Benefits Survey. August 20, 2013. http://kff.org/private-insurance/report/2013-employer-health-benefits/ (accessed 9-9-2013).

# New Product Offerings

## Accountable Care Arrangements

The term "accountable care" was first coined in 2006.[5] Accountable care arrangements are based on three principles: [6]

- **Accountability for Quality:** A group of providers is clinically and financially responsible for the entire continuum of care for a group of patients. Depending on the arrangement, providers, hospitals and health insurers may share responsibility for the patient's care.
- **Shared Savings:** Payers share savings with providers if providers meet certain quality and cost goals and slow spending growth. In certain arrangements, providers may also face payment reductions if they don't meet specified goals.
- **Performance Measurement:** Provider performance is tracked and rewarded based on outcome, process, and patient experience measures.

The concepts leading to Accountable Care Organizations (ACOs) were originally tested for Medicare beneficiaries under a program called the Medicare Physician Group Practice (PGP) demonstration, which began in 2005. The PGP included ten physician groups representing 5,000 providers and 220,000 Medicare beneficiaries. The demonstration resulted in across-the-board improvements in quality measures related to preventive care and chronic disease care, but most groups had more trouble attaining cost savings.[7] Based on the early results of the PGP, the ACO concept was included as part of the Affordable Care Act (§ 2706 – Pediatric ACO Demonstration Project, and §3022 – Medicare Shared Savings Program).[8]

There are two types of Medicare ACOs included in the ACA: the Medicare Shared Savings Program and the Pioneer ACO Model. Providers in Pioneer ACOs have the potential for higher financial rewards and risks than those in the Shared Savings model.[9] Both types of Medicare ACOs include an agreement between the provider and the insurer (Medicare); this arrangement does not change the consumer's benefits. From a consumer's standpoint, the Medicare ACOs are not explicit product choices. That is, patients can go to any Medicare contracting provider; they do not need referrals from a primary care physician, nor are they limited to receiving their care from a provider that is a designated ACO provider.

The Medicare ACO initiative has been in place since 2012.[10,11] Results to date indicate both promise and challenges. In 2012, all 32 Pioneer ACOs demonstrated improved quality measures, but fewer lowered costs.[12] Eighteen Pioneer ACOs had lower costs than projected in the absence of the ACO. Thirteen of these 18 lowered their spending enough to qualify for shared savings, generating $87.6 million in incentives for the 13 Pioneer ACOs, and $33 million in savings for Medicare.[13] Fourteen Pioneer ACOs had costs that exceeded their target budget, but just two of the 14 exceeded their budget enough to require penalty payments (totaling $4.5 million) to Medicare.[14] In July 2013, seven Pioneer ACOs announced plans to shift to the lower risk Shared Savings Program, while two dropped out of the Medicare ACO program altogether.[15] As of August 2013, there were 228 Medicare Shared Savings model ACOs and 23 Pioneer ACOs (covering 4.1 million beneficiaries nationwide).[16,17] At the time of this publication, results for the Shared Savings program had not been released.

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5 E. Fisher, D. Staiger, J. Bynum, and D. Gottlieb. Creating Accountable Care Organizations: The Extended Hospital Medical Staff. Health Affairs, 26(1): w44–w57.

6 The Dartmouth Institute for Health Policy and Clinical Practice. 2012. http://tdi.dartmouth.edu/initiatives/accountable-care-organizations/about-us (accessed 7-25-1203).

7 Centers for Medicare and Medicaid Services. July 2011. Medicare Physician Group Practice Demonstration. http://www.cms.gov/Medicare/Demonstration-Projects/DemoProjectsEvalRpts/downloads/PGP_Fact_Sheet.pdf (accessed 8-9-2012).

8 H.R. 3590, Patient Protection and Affordable Care Act. January 5, 2010. http://www.gpo.gov/fdsys/pkg/BILLS-111hr3590enr/pdf/BILLS-111hr3590enr.pdf (accessed 9-25-2013).

9 B. Pyenson, K. Fitch, K. Iwasaki, and M. Berrios. July 3, 2011. The Two Medicare ACO Programs: Medicare Shared Savings and Pioneer – Risk/Actuarial Differences. http://www.milliman.com/uploadedFiles/insight/health-published/pdfs/14849_Milliman-Report-on-Pioneer-vs-MSSP070811.pdf (accessed 8-9-2013).

10 E. Fisher and M. McClellan. N.D. Next Steps for ACO Implementation. Accountable Care Organization Learning Network. https://xteam.brookings.edu/bdacoln/Documents/Next%20Steps%20ACOs_Final%20(V2).pdf (accessed 9-10-2013).

11 The Advisory Board Company. September 14, 2011. ACO Timetable: Berwick outlines rough timeline for ACO initiatives. The Daily Briefing. http://www.advisory.com/Daily-Briefing/2011/09/14/ACO-timetable (accessed 9-10-2013).

12 G. Blesch. July 16, 2013. All Pioneer ACOs improved quality; only third lowered costs. Modern Healthcare. http://www.modernhealthcare.com/article/20130716/NEWS/307169958?AllowView=VW8xUmo5Q21TcWJOb1gzb0tNN3RLZ0h0MWg5SVgra3NZRzROR3l0WWRMWGJVL3dlRWxiNUtpQzMyWmVzNW5vWUpibXA=&utm_source=link-20130716-NEWS-307169958&utm_medium=email&utm_campaign=am (accessed 7-16-2013).

13 K. Patel and S. Lieberman. July 25, 2013. Taking Stock of Initial Year One Results for Pioneer ACOs. Health Affairs Blog. http://healthaffairs.org/blog/2013/07/25/taking-stock-of-initial-year-one-results-for-pioneer-acos/ (accessed 9-9-2013).

14 Ibid.

15 Melinda Beck. July 16, 2013. Mixed Results in Health Pilot Plan. Wall Street Journal. http://online.wsj.com/article/SB10001424127887323664204578608252999249808.html?mod=djemalertNEWS (accessed 9-25-2013).

16 R. Lazerow. August 20, 2013. Where the Medicare ACOs are, August edition (Washington, D.C.: The Advisory Board Company). http://www.advisory.com/Research/Health-Care-Advisory-Board/Blogs/Toward-Accountable-Payment/2013/08/NPHS-Where-the-ACOs-are-updated (accessed 8-20-2013).

17 Centers for Medicare and Medicaid Services. May 2013. Fast Facts – All Medicare Shared Savings Program and Medicare Pioneer ACOs. http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/PioneersMSSPCombinedFastFacts.pdf (accessed 8-7-2013).

# New Product Offerings *(continued)*

Private insurers, too, are increasingly developing commercial accountable care arrangements.[18] Some commercial ACO arrangements use an approach very similar to Medicare's: that is, the arrangement is not a specific product choice and does not change the consumer's benefits. Overall, they do not require action on the consumers' part. However, some commercial insurers are developing ACO arrangements that are specific products or do provide consumer incentives to select providers who are in an ACO network.[19] This type of ACO generally offers consumers a smaller network than other ACO models in exchange for lower cost-sharing.[20] Major commercial insurers, such as Aetna, UnitedHealthcare, and Blue Cross Blue Shield-affiliate plans have formed this type of ACO.

## Narrow and Tiered Network Products

"Narrow" and "tiered" are terms used to describe similar types of benefit plans where health plans contract with a limited number of providers and offer different benefit levels depending on the contracting status of the provider and the provider's quality of care. Twenty percent of employers offered limited network products in 2012, up from 16 percent in 2010.[21]

In a narrow network, enrollees must pay most or all of the cost if they see physicians outside of the network (similar to an HMO). In tiered network products, there are varying enrollee benefit levels for different groups of providers based on how the provider performs on cost and quality measures, such as health screenings, blood pressure control, and hospital readmissions. Each tier corresponds to a different level of patient cost-sharing, with the top-ranked providers corresponding to the lowest patient cost share.

Because the provider networks are more restricted, plan enrollees have lower premiums and plan sponsors (employers) have lower costs.[22] This type of plan could be a popular option on the health insurance exchanges, where price will be a deciding factor in plan selection, especially among previously uninsured consumers.[23] Nearly half of the exchange plans in 13 states are narrow network plans.[24] In Michigan, there are 73 plans being offered on the individual exchange and 67 plans for small businesses on the SHOP exchange.[25] The majority of the plans offered on both Michigan exchanges are limited or narrow network plans.

[18] M. Petersen, D. Muhlestein, and P. Gardner. August 2013. Growth and Dispersion of Accountable Care Organizations: August 2013 Update (N.P.: Leavitt Partners Center for Accountable Care Intelligence). http://leavittpartners.com/wp-content/uploads/2013/08/Growth-and-Dispersion-of-ACOs-August-20131.pdf (accessed 8-21-2013).

[19] A. Higgins, K. Stewart, K. Dawson, and C. Bocchino. September 2011. Early Lessons From Accountable Care Models In The Private Sector: Partnerships Between Health Plans And Providers. Health Affairs 30(9):1718–1727.

[20] Ibid.

[21] B. Eggbeer and D. Morris. N.d. Narrow, Tailored, Tiered and High Performance Networks: An Emerging Trend. http://www.wellcentive.com/downloads/Narrow%20Tailored%20Tiered%20and%20High%20Performance%20Networks.pdf (accessed 7-11-2013)

[22] M. McQueen. August 17, 2013. Less choice, lower premiums. Modern Healthcare. http://www.modernhealthcare.com/article/20130817/MAGAZINE/308179921 (accessed 8-19-2013).

[23] A. Mathews. July 14, 2013. *Price, Price, Price.*

[24] M. McQueen. August 17, 2013. Less choice, lower premiums.

[25] C. Buhs. October 1, 2013. DIFS Releases Individual Premiums for Health Insurance Marketplace. Michigan Department of Insurance and Financial Services. http://michigan.gov/difs/0,5269,7-303-13222_13250-313516--,00.html (accessed 10-1-2013).

# Reference Pricing Strategies

Insurers and employers are also using benefit designs to direct consumers toward services or providers that a health insurer considers cost-effective.[26] Reference pricing is a benefit design in which the insurer pays a defined amount ("reference price") toward covering the cost of a service. If the patient selects a service or provider that charges more than the reference price, the patient is responsible for the additional cost. Reference pricing is generally applicable to services that exhibit a wide range in prices but only a narrow range in quality,[27] such as pharmaceutical drugs, lab tests, diagnostic imaging, and acute surgical procedures.[28]

In an effort to control costs and introduce price competition, reference pricing is gaining traction among employers. In June 2013, Aon Hewitt reported that while only 8 percent of midsize and large employers currently offered reference pricing plans, more than 60 percent of employers were considering reference pricing for future use.[29] WellPoint, a major insurer, announced in June 2013 a new reference pricing program that will include over 900 different services, including lab tests and hip and knee replacements. After completing a pilot with the California Public Employees' Retirement System (CalPERS), WellPoint found costs of hip and knee replacements decreased by 19 percent with better or similar outcomes from lower cost providers and hospitals.[30] However, the results have not been consistent for all insurers. Cigna, for example, found that employees did not select the lowest price provider and therefore had higher out-of-pocket costs.[31]

[26] J. Robinson and T. Brown. August 2013. Increases In Consumer Cost Sharing Redirect Patient Volumes And Reduce Hospital Prices For Orthopedic Surgery. Health Affairs 32(8): 1392–1397.

[27] J. Robinson and K. MacPherson. September 2012. Payers Test Reference Pricing and Centers of Excellence to Steer Patients To Low-Price and High-Quality Providers. Health Affairs 31(9): 2028–2036.

[28] Ibid.

[29] A. Mathews. June 25, 2013. WellPoint Helps Cut Employer's Health Cost. Wall Street Journal. http://online.wsj.com/article/SB10001424127887323998604578567982013011300.html (accessed 8-30-2013).

[30] Ibid.

[31] Ibid.

# Health Plan Examples

Commercial health plans are offering a variety of plan options, including plans that limit provider choice in exchange for a lower consumer cost share. The following tables include illustrative examples of health plan offerings FIGURE 2 and how the plans work FIGURE 3.

FIGURE:2
**Marketplace: Examples of Commercial ACO and Limited Network Activity**

| Insurer/Plan | Type | Covered Lives | Geographic Scope | Peer Reviewed Results |
|---|---|---|---|---|
| **Aetna/Aetna/ Accountable Care Solutions** | ACO with tiered network | 130,000 members at end of 2012; 375,000 projected members by end of 2013 | 27 markets in 17 states and D.C. in 2013 | None. Self-reported 8-15% medical cost savings in year 1 through combination of plan design, unit cost discounts and cost, quality improvements |
| **Blue Cross Blue Shield of Massachusetts/ Alternative Quality Contract (AQC)** | ACO with limited provider panel | 612,547 members in 2010 | Massachusetts | • 2.8% average decrease in spending per member over 2 years<br>• 0.3 percentage point annual improvement in adult preventive care quality measures |
| **Blue Shield of California** | ACO with limited provider panel | 161,000 members in 2013 | California | • 12.1% decrease in inpatient days in year 1*<br>• 15% decrease in hospital readmissions within 30 days in year 1*<br>• $37 million savings to CalPERS over 2 years* |
| **Cigna/Care Network** | Tiered network available to employer-sponsored group plans | Not Available | 71 markets in 33 states and D.C. in 2013 | None. |
| **UnitedHealthcare/ UnitedHealthcare Signature Value Flex** | Tiered provider network HMO | Not Available | California | None. Self-reported savings of $22 million for 86,000 members in California pilot |

**Source:** Compiled by CHRT using data from Aetna, Blue Cross Blue Shield of Massachusetts, Harvard Medical School, Blue Shield of California, Cigna, and UnitedHealthcare.

* *Results for a peer-reviewed study for a pilot of 42,000 CalPERS members, Blue Shield of California's first ACO — initiated in January 2010.*

# Health Plan Examples *(continued)*

FIGURE:3
**How They Work: Examples of Commercial ACO and Limited Network Activity**

| Insurer/Plan | Members Sign Up for Specific Provider(s)? | Benefit Design | Provider Payment Method | Quality Provisions |
|---|---|---|---|---|
| **Aetna/Accountable Care Solutions** | No | Varies by plan sponsor; generally lower out-of-pocket costs to see ACO designated provider | Fee-for-service with incentive savings and penalty payments | 24 quality measures, including:<br>• 30 day readmissions rate, generic prescribing rate, diabetes care (e.g., lipid measurement)<br>• Cardiovascular care (e.g., annual monitoring)<br>• Preventive care (e.g., cancer screening) |
| **Blue Cross Blue Shield of Massachusetts/ Alternative Quality Contract (AQC)** | Yes, select primary care provider | HMO or POS Plan design | Annual global budget (providers receive set amount for care per enrollee); performance incentives for quality goals | • 32 ambulatory care measures (e.g., preventive screenings, diabetes control)<br>• 32 hospital care measures (e.g., pneumonia care, hospital-acquired infections) |
| **Blue Shield of California** | Not Available | Not Available | Annual global budget with shared financial responsibility among medical group, hospital, insurer | Include inpatient days, 30-day readmissions rate, length of stay |
| **Cigna/Care Network** | No | Tiered network for primary care and 21 specialty categories; lowest co-pay, coinsurance for Care Network designated physicians | Physician reimbursement is unchanged by Care Network designation | Highest tier physicians if ranked in upper 1/3 of physicians for quality and cost efficiency across specialty in geographic market |
| **UnitedHealthcare/ UnitedHealthcare Signature Value Flex** | Yes, select primary care provider and "Flex Network," must remain in network for plan year | Flexible HMO benefit designs; up to 3 provider "Flex Networks" based on cost, quality metrics; lowest copays and/or premiums in Flex Network 1 | Not Available | Quality rating based on HEDIS®, CAHPS®, and other nationally recognized quality measures |

**Source:** Compiled by CHRT using data from Aetna, The Commonwealth Fund, Blue Cross Blue Shield of Massachusetts, Blue Shield of California, Society of Actuaries, Cigna and UnitedHealthcare.

# What Does This Mean for Consumers?

Commercial plans are testing and sometimes combining accountable care arrangements, narrow and tiered networks, and networks of providers that accept reference pricing for pre-defined services. Development of these products started before the passage of health reform. However, with the ACA's coverage expansions, consumers may seek more affordable insurance coverage options that include these designs.

Because most of these types of arrangements are new products or not yet fully developed, there is limited data regarding their impact on cost and quality. Except in a few cases, such as the Blue Cross Blue Shield of Massachusetts' Alternative Quality Contract (see Tables 1 and 2), results from these new products are generally based on preliminary outcomes as reported by the health plans. While much is unknown about the longer term impact of these products on cost and quality, consumers need to understand all components of these benefit designs in order to choose the best plan for their needs.


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