Tiered Provider Networks:
Steps to Cost Containment?

A DISCUSSION FEATURING:

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FORUM SESSION ANNOUNCEMENT

FRIDAY, JUNE 24, 2011
11:45AM–12:15PM—Lunch
12:15PM–2:00PM—Discussion

LOCATION
Reserve Officers Association
One Constitution Avenue, NE
Congressional Hall of Honor
Fifth Floor
(Across from the Dirksen Senate Office Building)

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Average annual employer-sponsored health insurance premiums more than doubled between 2000 and 2010 to $5,049 for individual coverage and $13,770 for family coverage. In this context of high and rising health insurance premiums, some insurers have developed, and employers have adopted, tiered provider networks (sometimes called high-performing networks) that aim to “sensitize employees to the real cost of health care.”

In a tiered network plan, health insurers classify hospitals or physicians into tiers (typically 2 or 3) using cost (per episode, service, or stay) or some combination of cost and quality metrics. Consumers in those plans then pay higher cost sharing to use the higher cost or less efficient providers in the plan’s network. For example, in Blue Cross Blue Shield of Massachusetts’ “Hospital Choice Cost-Share” plan (discussed below), consumers pay a copayment of $500 for an inpatient stay at one of the “high-value” hospitals, and $1,500 for an inpatient stay at one of the “high-cost” hospitals. While not requiring the use of providers in the lower cost or more efficient tier, this type of plan design attempts to induce consumers to incorporate cost or efficiency differences into their choices of providers and encourage providers to become more efficient. Such plans have raised concerns for some providers and others about the accuracy of the information used to assign providers to tiers, particularly the methods used to assess efficiency.

RENEWED INTEREST IN TIERING

Although tiered provider networks are not a new design, evidence that prices vary dramatically among providers in the same local market due to provider market power may be contributing to renewed interest in tiered network products among both employers and consumers. In a 2010 paper, Paul Ginsburg with the Center for Studying Health System Change observed that “[b]enefit designs that encourage patients to compare providers on the basis of price are not common today, but are developing.” In its 2010 National Survey of Employer-Sponsored Health Plans, Mercer found that 24 percent of employers with over 20,000 employees and 12 percent of employers with more than 500 employees used plans with a tiered or high-performing network in 2010. In Massachusetts, where (i) most people are required to be insured and (ii) variability in provider prices and the lack of a correlation with available quality measures have been the subject of recent scrutiny from the Attorney General, there are several examples of longer standing tiered network options as well as new insurance products with tiered networks. The Massachusetts’ Group Insurance Commission (GIC), which purchases health
insurance for public employees, retirees, and their dependents, has offered several health plans with tiered physician networks since July 2007. In January 2011, Blue Cross Blue Shield of Massachusetts added the “Hospital Choice Cost-Share” plan mentioned above for small businesses and individuals. In exchange for lower premiums, plan enrollees pay additional cost sharing for six categories of services (labs, X-rays and imagining, high-tech radiology, inpatient care, outpatient surgery, and physical, occupational, or speech therapy) if they choose to use one of 15 “high-cost” hospitals and lower cost sharing if they use any one of 53 “high-value” hospitals or independent centers. This plan is in addition to Blue Cross Blue Shield’s and other insurers’ tiered benefit offerings already available in the state. Massachusetts also issued a regulation in February 2011 that “requires carriers to offer selective or tiered network plans that cost 12 percent less than ‘full-network’ plans.” In 2004, Aetna began offering self-funded employers plans with the “Aexcel” physician network that tiers 12 specialties using quality- and case mix–adjusted episode costs. Such plans are now available in about 40 markets across the country. In January 2011, Aetna also began offering its “Choose and Save” plan to self-funded employers in some markets. It groups hospitals into two tiers according to cost, and consumers in the plan pay more to use the higher cost hospitals.

TIERING AND ITS DISCONTENTS

Tiering is widely used in pharmacy benefit design and is familiar to most consumers in that context. In contrast to the relative simplicity of tiering a drug benefit, researchers have observed that tiering providers is difficult because of the complex factors underlying meaningful cost and quality comparisons for a given service or episode of care. This complexity and the effect that poor methodology or computation errors can have on physicians and patients has led the American Medical Association (AMA) and researchers at RAND to question the reliability and other aspects of metrics used to assign providers to tiers, inform consumer decision making, and determine consumer cost sharing. In 2010, the AMA and nearly all state medical societies sent letters that cited this research on the unreliability of physician profiling and efficiency measures to the chief executive officers and chief medical officers of 47 health plans across the United States. In the letter they ask health plans to “work with the AMA, and the physicians and state medical societies for each state in which you offer health coverage, to formally reevaluate your physician rating program(s) and demonstrate that they are reliable, accurate, and
valid; drive quality improvement efforts; and address the concerns raised in RAND’s research findings.”

Tiered networks and concerns about their underlying data have also led to legal action against insurers and plan sponsors. In 2007, New York Attorney General [now Governor] Andrew Cuomo, citing state consumer protection laws, brought a complaint against CIGNA, Aetna, and United Healthcare for their physician ranking programs.18 The state’s concern was that consumers were being deceived and confused by plan rating practices. In settlements the insurers “agreed to take several steps to improve their [physician] ranking program, including ensuring transparency, fairness and due process, and independent oversight.”19 The settlements with the plans established minimum requirements for the accuracy, transparency, and oversight of tiering programs that “have become benchmarks for many health plans when it comes to designing a tiering system.”20

In 2008, the Massachusetts Medical Society took action against the physician tiering program implemented by the GIC in Massachusetts. The complaint against the GIC and two insurers alleged “that patients have been defrauded and harmed and physicians have been defamed by the GIC’s Clinical Performance Improvement (CPI) Initiative, a program that ranks (or ‘tiers’) individual physicians in one of three tiers, using various cost and quality measures.”21 The Massachusetts Medical Society requested that the court stop the program or require that it conform to standards including “transparency, fair notice, formal feedback and correction processes, meaningful physician involvement in the development of the CPI, demonstrate the program’s accuracy, validity and reliability, and submit their programs to an independent oversight authority.”22 In a motion to dismiss all counts in the case, the Suffolk County Superior Court ruled in 2009 that claims regarding defamation and consumer protection can proceed and dismissed the remaining claims.23 The case has yet to be decided. The GIC continues to make tiered networks available in the health insurance options offered to its employees and retirees. Due to the complexity of the calculations and the implications for providers and consumers, concerns about calculating cost and quality metrics, the transparency of tier determination methods, and the communication of that information to consumers are likely to be an ongoing subject of debate.
DO TIERED NETWORKS CHANGE BEHAVIOR?

Despite the anticipation that tiered networks would influence consumers’ choices and the controversy over ratings and rankings of providers, questions remain whether tiered provider networks can effectively steer patient choice of provider or influence providers' costs. In a hypothetical tiered network setting, researcher Anna D. Sinaiko, PhD, found that tiered provider networks with relatively small copayment differences have a somewhat limited influence on consumers’ choices of physicians, particularly when contradicted by other trusted information. She also found that financial incentives to choose among physicians have different effects depending on the severity of the (hypothetical) condition or physician specialty. Additional research is needed to understand how consumers act on that information in their actual choice of provider and the magnitude of the differences in out-of-pocket payments that drive consumer choices in a real situation. Such information could inform tiered plan design and patient education strategies. The optimal design for tiered networks remains to be determined, as does the effect, if any, tiering has on provider pricing, and ultimately health care spending over time.

SESSION

At this Forum session, speakers will discuss experience with tiered provider networks for privately insured populations. Anna Sinaiko, PhD, has published several studies looking at tiered provider networks available to public employees in Massachusetts. Speakers from two insurers, Andrea Walsh, executive vice president & chief marketing officer with HealthPartners in Minnesota and Amy Oldenburg, head of national provider networks with Aetna, will discuss their tiered network products for large employee groups. They will focus on the development of tiering methods, health care market conditions that influence the adoption and viability of tiered networks, cost sharing differences, consumer and provider response, and effect on premiums. Rakel Meir, JD, associate general counsel with Tufts Health Plan, will discuss legal issues related to tiering, provider contracting, and the recently expanded legal and regulatory framework for tiering in Massachusetts.
KEY QUESTIONS

- What types of providers are tiered in private insurance products? How are provider tiers developed? Where do the cost and quality data come from to establish tiers? What factors affect the validity and reliability of cost and quality metrics?

- What are cost-sharing differences across tiers in currently available tiered products?

- What has been the patient response to tiered networks? How big do financial incentives have to be in order to change patient behavior? What kind of information about cost and quality is most useful to consumers?

- How do providers respond to tiered networks? What are the legal issues surrounding tiered networks? Have lawsuits established a standard for accuracy and transparency that satisfies providers’ concerns?

- What effect do tiered networks have on overall premium costs? Out-of-pocket costs?

- What are characteristics of markets where tiered networks are feasible? How does provider concentration in some areas limit effectiveness of tiered networks?

ENDNOTES


7. Stephanie Poe, e-mail communication with author, May 24, 2011.


10. The cost sharing difference does not apply to emergency care. The reported premium savings for Hospital Choice Cost-Share plan is 5 percent. Blue Cross Blue Shield of Massachusetts press release, February 2011.


17. AMA, “Letter Addressed to CEO and Chief Medical Officer of 47 Health Plans Around the Country Regarding the RAND Studies.”


19. Meir and Shaw, “The Link Between Quality and Medical Management.”

20. Meir and Shaw, “The Link Between Quality and Medical Management.”

22. Massachusetts Medical Society, “MMS Files Legal Action Against the Group Insurance Commission, Its Executive Director, and Two Health Plans.”
