



RESEARCH REPORT

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

Benefit Designs: How They Work

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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. 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](#).

Introduction

Benefit designs are a key part of reform efforts. They work in tandem with payment methods to encourage consumers to use the providers that accept new forms of payment and are high value or to seek services they need to improve their outcomes. However, benefit designs have not been the focus of health care reform discussions. This is perhaps because the innovation does not exist in the public sector and is largely restricted to the private sector. In addition, employers and other health care purchasers are facing big challenges trying to get better value for the health care dollar and, because they have the responsibility of paying for a majority of their members' health care, they have a stronger hold over the benefit designs that incentivize their consumers to seek high-value care. While the focus thus far has been on payment reforms, benefit designs could have a similarly powerful effect encouraging high-value health care.

But a single benefit design does not exist in isolation. There is a larger context of other benefit designs, payments, and market forces that are at work and should be considered by those interested in designing benefits. Understanding the context in which the benefit designs is implemented as well as the design of the incentives themselves, other operational issues that stakeholders may encounter with the benefit design, and how they can work in unison with each other and with payment methods can educate purchasers about how to package and design consumer benefits to get better value for the care

they finance. Accordingly, we think it important to understand the options available to employers and other purchasers to achieve better value, to encourage employees to be better shoppers, and to understand both how different benefit designs work in the marketplace and how providers are paid.

Context, Design, and Operational Issues Affect Benefit Design Impact

Analyses of benefit designs often lack understanding of the inherent nuances of each method—the context in which it is implemented, the design of the incentives and their impact, and operational issues that implementers may encounter.

The context in which the benefit design exists can affect the success of the design. For example, benefit designs that operate in markets with a dominant provider system may not have their intended effect. Dominant provider systems have the clout and leverage to demand inclusion in the network or design or to stop the effort by refusing to participate. The dominant provider system may be necessary to ensure adequate consumer access to providers and therefore would need to be included. Including the dominant provider system in the benefit design could lead to higher rates than originally intended, which would defeat the purpose of the effort.

The specific design of the incentives, including the relative cost sharing consumers may face, can also strongly influence the effect on consumers' behavior. A benefit design that uses strong cost differentials may more successfully encourage consumers to seek care from high-value providers or seek high-value services. For example, a consumer in need of a hip replacement has 10 percent coinsurance for care from a high-value provider or 60 percent coinsurance from a low-value provider. If the cost of the hip replacement is \$1,000, the consumer may prefer to seek care from the high-value provider, with a cost difference of \$100 versus \$600. If the cost differentials were less significant—20 percent coinsurance versus 30 percent—the consumer may be less likely to seek care from the high-value provider.

Finally, analyses of benefit designs may often miss the operational challenges that come with their implementation, including, administrative feasibility. Understanding and anticipating operational challenges with benefit designs during implementation can ensure that the designs have their intended impact and not generate unintended effects. However, some of these challenges may be impractical to anticipate and mitigate.

Benefit Design Attributes

Many of those experimenting or interested in implementing benefit designs lack understanding of the nuances involved. Therefore, the benefit designs tend not to be effective in the intended manner. Instructing health care purchasers and other stakeholders about the positives and negatives of each approach and how to mitigate the negative aspects that may be inherent in the approach can help implementers ensure that their benefit designs have their desired effect. And, because none of these methods exist in isolation, understanding how benefit designs work with each other can drive consumers to high-value care. Payment methods also have an effect on the success of benefit designs. They can work together to align the incentives of consumers and providers to encourage consumers to seek high-value care and providers to deliver it.

Advised by a panel of payment and benefit design experts, we selected seven benefit designs used to encourage consumers to seek high-value care through cost sharing. Understanding how each benefit design works—its strengths, weaknesses, and other attributes—will help us find complementary benefit design and payment approaches that combine the strengths and mitigate the weaknesses inherent in the benefit design.

Methods and Analysis

For most of the benefit designs reviewed here, relevant evidence exists in peer-reviewed literature. We do not, however, consider the available research-based evidence definitive, largely because research on benefit designs depends crucially on the specific design and incentive levels and on its organizational context. We think generalizing from the available, somewhat limited literature is potentially misleading. Additionally, attempts to categorize benefit designs have largely not been attempted. What makes our typology somewhat unique is our attempt to present concise summaries of the most salient attributes of these methods.

In addition, we have relied to a large extent on informed, expert opinion, not only by the authors but also by a technical expert panel of payment and benefit design experts who collectively represent views of informed payers and purchasers, providers, payment administrators, academics and consumers. The attributes listed, then, reflect consideration of the peer-reviewed evidence and its limitations, experience of the authors, and the wide and deep expertise of the technical expert panel, producing some consensus judgments as well as informed speculation.

We have selected seven major benefit designs that are most commonly implemented by purchasers and health plans in an attempt to steer consumers toward high-value care. These models are a subset of the broader array of benefit designs presented in another publication of this project, *A Typology of Benefit Designs* (Delbanco et al. 2016).

The discussion within these papers is more oriented to private insurance. The commercial sector has more flexibility and ability to structure benefit designs to fit the needs of employers and use cost-sharing to accomplish objectives than Medicare and Medicaid, in which benefit design typically is fixed by law and regulation. Therefore, concepts described in the attributes papers often apply particularly to private payers.

We organize the discussion of core attributes of benefit designs in the following way:

- **Background information.** An explanation of how the benefit design works and relevant experience with the approach
- **Key objectives.** What the benefit design is designed primarily, sometimes uniquely, to achieve
- **Strengths.** Both theoretical, incentive-related likely advantages and practical, operational ones
- **Weaknesses.** Both theoretical, incentive-related likely disadvantages and practical, operational ones
- **Design choices to mitigate weaknesses.** Opportunities in actual implementation, largely based on the weaknesses identified, to reduce potential detrimental effects
- **Compatibility with other benefit designs and with payment methods.** Given that any benefit design will be strongly interdependent with (1) concurrent methods for the same or related consumers and (2) variations in payment methods, we identify common interactions, both positive and negative
- **Focus of performance measurement.** Here we emphasize the vulnerabilities of benefit designs, for which performance measurement would be particularly desirable
- **Potential impact on providers' prices.** Most discussions of benefit designs focus on the likely impact on health care costs, not on the impact on prices per se, prices being a major determinant of costs

The selected benefit designs are:

- Value-based insurance design (V-BID)
- High Deductible Health Plans (HDHP)
- Tiered Networks
- Narrow Networks
- Reference Pricing
- Centers of Excellence
- Alternative Sites of Care

Value-Based Insurance Design

Value-based insurance design (V-BID) is built on the principle of lowering or removing financial barriers to essential, high-value clinical services based on the tenets of “clinical nuance.” These tenets recognize that (1) medical services differ in the amount of health they produce, and (2) the clinical benefit derived from a specific service depends on the consumer’s using it, as well as when and where they receive the service. Therefore, a specific service that is beneficial to a certain population may not be beneficial to all (e.g., a stent would be beneficial for a consumer with a myocardial infarction but could be intrusive and unnecessary for others without a clear clinical indication). V-BID aligns consumers’ out-of-pocket costs with services, based on the service’s “relative value” for a consumer or population. Therefore, consumers’ out-of-pocket costs are lowered for services considered to be clearly beneficial to them, often based on long-established appropriateness standards. In theory, V-BID could also raise consumers’ out-of-pocket costs for clinically non-beneficial services, though this is not common; virtually all services that are low value for some patients are high value for others. In addition, claims data or other readily available patient data are rarely adequate for determining whether a service is high value for a particular patient or not.

Generally, V-BID can be used for pharmaceuticals, preventive services (such as screenings, immunizations, and counseling), or services related to particular chronic conditions. The most well-known implementation of V-BID is in Section 2713 of the Affordable Care Act, which eliminates out-of-pocket costs for evidence-based primary preventive services, as determined by the U.S. Preventive Services Task Force and the Advisory Committee on Immunization Practices. Currently, all commercial payers must abide by this rule.

Many experts emphasize designing V-BID around common conditions, particularly because these are high-cost areas with well-established appropriateness standards that define beneficial care and services, though not all health care providers meet these standards. For example, it would be beneficial for a patient with diabetes to receive an annual eye exam, but it would be much less critical for a patient without the condition. In January 2017, the Centers for Medicare & Medicaid Services will implement a V-BID design model test for its Medicare Advantage plans in seven states around seven specific chronic conditions: diabetes, congestive heart failure, chronic obstructive pulmonary disease, past stroke, hypertension, coronary artery disease, and mood disorders. The design model will test whether reduced cost-sharing for high-value services and providers can improve health outcomes and lower expenditures for Medicare Advantage enrollees.

The particular financial burden of health care on sick or low-income consumers is well documented. Increasing out-of-pocket costs often prevent consumers from receiving high-value health care services that they need. When patients do not get the care they need, their outcomes may worsen and they may experience higher rates of emergency visits and hospitalization. In some instances, this means higher aggregate medical spending. By taking these financial barriers away, value-based insurance design has successfully reduced health care disparities in many instances.

Both private and public payers have been experimenting with V-BID programs, and some have implemented them widely. For example, the State of Connecticut Health Enhancement Program for state employees reduces monthly premiums and out-of-pocket costs for clinically beneficial, evidence-based care, if enrollees commit to receive yearly physicals, age- and gender-appropriate screenings, and free dental screenings, among other services. Additionally, enrollees with chronic conditions have lower co-pays for specific services and medications.

Key Objectives of Value-Based Insurance Design

A major objective of V-BID is to encourage consumers to receive the medical services they need by reducing financial barriers to receiving them—typically their out-of-pocket costs. The aim is to prevent the adverse health effects that can arise when patients do not get the care they need. In the long term, the objective of V-BID is to improve the health of a population by increasing the rate at which consumers use high-value treatments.

Strengths

- V-BID encourages consumers who refrain from seeking care due to financial barriers to seek beneficial services. This has the potential to improve their health and prevent costly hospitalizations and visits to the emergency department.
- The financial incentives inherent in V-BID (and the education that typically accompanies a V-BID program) can signal to consumers the importance of seeking certain services, particularly for a given condition. Therefore, patients' use of high-value treatments, including those that help them manage or treat their conditions or diseases, may increase and make them healthier in the long term.

- V-BID can target high-value services for specific conditions, enhancing patient outcomes, reducing wasteful spending, and promoting efficient expenditures, potentially aligning patients' needs with providers' initiatives to improve care and make it more affordable.
- V-BID incentives may resonate particularly with patients who have chronic conditions and are well informed about the care they need.

Weaknesses

- Some experts express concern that V-BID, by increasing use of particular health care services, will lead to higher health care costs in the short term. Available evidence suggests that offsets in spending from improved quality may take time to accrue. Thus, V-BID may not save money in the short run unless the program also raises the consumers' share of costs for low value services.
- While V-BID is meant to reduce financial barriers to care, cost is not always the barrier to patients' seeking the care they need. For example, a person with no financial barriers to care who will not take her medication because she dislikes the side effects may not be any more likely to follow her prescribed regimen with lower out-of-pocket costs.
- Despite the presence of the right incentives, some consumers may still not appreciate the importance of seeking particular services.
- If consumers have a high deductible health plan with an HSA, where the care they seek does not receive first-dollar coverage until the deductible is met, V-BID may have little effect.
- There is concern that the costs of implementing V-BID may be greater than the savings it can produce.

Design Choices to Mitigate Weaknesses

Cost-Sharing

Incentives must be strong enough to encourage consumers to use clinically beneficial services. To strengthen these incentives, implementers can lower the patient's out-of-pocket costs or even provide the patient with a cash bonus, though this practice is rare. In addition, physicians play a vital role in getting their patients to make good health care choices. The American Board of Internal Medicine's Choosing Wisely campaign and the American College of Physicians' High-Value, Cost-Conscious Care initiative are predicated on this idea. Some have discussed structuring V-BID to penalize patients for using low-value services. For example, the Oregon Educators Benefit Board and the Public Employees Benefit Board have structured higher cost-sharing for health services that are recognized as overused and driven by providers' preferences (e.g., surgery for back pain over physical therapy).

Clinical Nuance

V-BID implementers can customize consumer incentives based on a specific type of service or a specific condition, such as diabetes or asthma. Experts contend this approach addresses "clinical nuance" by lowering cost-sharing for services known to improve outcomes for a specific condition. A service that may be high value for one consumer may be harmful to another; not all health care services affect consumers in the same way.

Availability of Price and Quality Information

Making information about health care prices and quality available to consumers can show them the relative value of particular services and point them toward higher-value options and providers. Additionally, consumer-facing transparency tools can estimate a consumer's out-of-pocket costs for particular procedures; with V-BID, this may help distinguish between those that are clinically beneficial and those that are not.

Compatibility with Other Benefit Designs and Payment Approaches

V-BID could work well 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 if designed simply and comprehensibly.

A key feature of V-BID is that it aligns consumers' incentives with most payment approaches that emphasize value over volume. The provision of incentives prompting compatible behaviors from providers and consumers is an important element of a high-performing delivery system. A scenario that offers a clinician bonus for performing a certain service (e.g., eye examination for a diabetic patient) is less likely to succeed if the patient's benefit design does not generously cover the service (as may be the case in some high deductible health plans).

Fee schedules can be structured so that providers are paid for care that is clinically beneficial for the patient and are not paid for care that is not beneficial. For example, a provider would be paid every time a 50-year-old patient seeks a colonoscopy, but not for a patient without known risk factors who seeks a colonoscopy at the age of 31.

V-BID is compatible with payment reforms that maintain fee schedule payments and are tied to providers' performance on quality measures (particularly pay-for-performance). V-BID encourages patients to stay healthy or keep themselves from getting sicker, which may result in better patient outcomes. Delivery of these same services by providers may also be used as a process measure in pay-for-performance programs, shared savings, or shared risk payment arrangements. Ensuring that a high proportion of patients get the preventive services they need can make providers eligible for a bonus payment or to share any cost savings they produce.

Focus of Performance Measurement

The same services targeted by V-BID may also be the subjects of provider performance measures. For the most part, these measures would be process measures, verifying that health care providers are following the processes of care suggested in established guidelines. Such measures may help verify that providers are not withholding care, despite the incentives to do so inherent in some provider payment

methods that put providers at financial risk for overspending as compared to a budget. Using available outcome measures also would be ideal to determine whether improvements in the process of care lead to better results for patients.

Potential Impact on Provider Prices and Price Increases

V-BID is intended to reduce the barriers, especially economic, that patients perceive to receiving high-value services. It is unclear whether V-BID has any influence on health care prices.

High Deductible Health Plans

High deductible health plans (HDHPs) require consumers to cover 100 percent of their health care costs up to a certain amount—the deductible—at which point their insurance coverage and other cost-sharing arrangements, such as co-pays and co-insurance, begin. According to IRS standards, a plan is considered a high deductible plan, and eligible for a tax advantaged health savings account (HSA), if the out-of-pocket maximum limit is \$6,450 for individuals and \$12,900 for families, and if the deductible is between \$1,300 and \$3,350 for individuals and \$2,600 and \$6,650 for families. While consumers who choose high deductible plans pay more for their care prior to meeting the deductible, they typically have a lower premium contribution. This can be attractive to consumers as premiums continue to rise. Many employers and other health care purchasers believe this arrangement will make employees and their dependents more cost sensitive.

In an HDHP, some services, such as primary preventive services, have first-dollar coverage and are not subject to the deductible. Consumers in HDHPs must understand what is, and is not, subject to the deductible. Often a normal exam has no cost-sharing, but an abnormal one is subject to out-of-pocket costs. For example, a colonoscopy screening would normally be covered as a primary preventive measure. However, it would be subject to the deductible as a secondary preventive measure if the patient were to show symptoms of bleeding. However, for most services covered under an HDHP, the individual is responsible for determining whether care is worth the out-of-pocket costs. The balance of evidence shows that this can be problematic, as greater cost-sharing for the consumer may mean delayed or avoided care, whether or not the care is high value. Higher cost-sharing has been shown to discourage consumers from seeking care, whether that discouragement is appropriate or inappropriate.

HDHPs are often paired with a tax-advantaged account that consumers use to pay for medical expenses, which can help defray their out-of-pocket costs under the deductible. A health reimbursement account (HRA) reimburses the employee for medical expenses approved by the employer. Only an employer can fund an HRA. An HSA is an individual's tax-exempt account to be used for medical expenses as defined by the IRS, with contributions made by the consumer, his or her employer, or both. HSAs are more commonly used with HDHPs, but only for plans that meet the IRS requirements for the size of the deductible.

Key Objectives of HDHPs

When a third-party payer covers a large majority of consumers' health benefits, consumers use more services than they would if they were financially responsible for the costs of health care. The high deductible is meant to counter this phenomenon by requiring consumers to pay the full cost of care up to the point they reach their deductible. Therefore, one key objective of HDHPs is to make consumers more cost sensitive to reduce unnecessary care. Another objective of HDHPs is to encourage consumers to shop for lower-priced providers instead of just consuming less medical care.

Consumers and purchasers of health care are concerned about rising premiums. Therefore, another objective of HDHPs is to create plans that offer consumers lower premiums in exchange for higher deductibles and maximum out-of-pocket costs. However, constraining premiums may not mean lower costs overall for consumers who use or need expensive services; the deductible may more than make up the difference.

Strengths

- Research and results have shown that high deductibles lower health care spending.
- By having consumers bear a large portion of the cost of care upfront, HDHPs can make them more cost and use sensitive and encourage them to choose more affordable care options.
- HDHPs may save consumers money, even with a high deductible, as these plans feature lower monthly premiums, regardless of the effect on spending.
- Patients who have high deductible health plans still receive first-dollar coverage for primary preventive services.
- Patients with an HSA can pay for services subject to the deductible with their tax-advantaged accounts, helping to defray the financial barriers to care.
- If consumers are more cost sensitive and use less care, providers may offer lower-cost alternatives, such as care through telecommunication or care provided by health professionals other than doctors, such as nurse practitioners, registered nurses, or physician assistants.

Weaknesses

- HDHPs decrease health care spending by reducing use, but this holds true for both beneficial and non-beneficial services.
- While primary preventive services have first-dollar coverage, secondary preventive services, such as the care someone with a chronic condition needs to keep an illness from progressing, do not. It is difficult for consumers to make the distinction between what is primary prevention and therefore covered, and what is secondary prevention and subject to the deductible.
- Individuals that use fewer services benefit from HDHPs because of lower premiums, even though they may not meet the deductible. However, frequent users and those with higher medical costs will also enjoy lower premiums, but will need to pay more between the deductible and the cost-sharing after meeting the deductible. Therefore, HDHPs place a disproportionate burden on lower-income and more medically needy consumers.
- Patients with complex conditions requiring many services may quickly reach the deductible, at which point most of the incentives inherent in HDHPs disappear. Yet, patients are still subject to cost-sharing until they reach their maximum out-of-pocket costs. Given that these patients may anticipate this level of spending, they may be unaffected by the incentives to be cost sensitive before reaching their deductibles.
- Most deductibles in HDHPs are such that the variation in price over a year isn't going to give patients the marginal incentive to be cost sensitive. For example, a patient having a baby will likely blow through her deductible during the course of care.
- Deductibles may not be an effective way to create incentives around specific health-care-seeking behavior. Critics of HDHPs suggest that nuanced cost-sharing from first-dollar use could be a more effective tool, such as value-based insurance design.
- While HDHPs are intended to counter the incentives of fee schedules, they can create tension between a provider who has an incentive to provide care and a patient who has an incentive to refuse care.

Design Choices to Mitigate Weaknesses

Size of the Deductible

To qualify as a high deductible health plan by IRS standards, the deductible and out-of-pocket maximum has to be no more than \$6,550 for individuals and \$13,100 for families. The out-of-pocket maximum must be within this range to pair with a health savings account or other tax-advantaged account.

Services Exempt from the Deductible

HDHPs, like other plans subject to the requirements of the Affordable Care Act, must give primary preventive services first-dollar coverage and make them exempt from the deductible. Other services can have first-dollar coverage as well, depending on the incentives the designer wishes to create. However, if the plan is associated with a tax-advantaged account, secondary preventive services cannot receive first-dollar coverage, according to IRS standards. Otherwise, certain secondary preventive services and prescriptions for particular conditions, or other underused services the plan or purchaser wishes to encourage, could be designed to receive first-dollar coverage.

Availability of Price and Quality Information

Price information should always be available to patients who have not met their deductibles, so they can see how much a service will cost them out-of-pocket. Additionally, in conjunction with cost information, quality information can show patients the relative value of particular services or providers and can point them toward higher-value options.

Tax-Advantaged Account

An HRA or HSA can be paired with an HDHP. Patients can draw from these accounts to pay for any qualifying health care service, according to IRS standards, that are then subject to the deductible. For consumers who cannot bear the financial liability under the deductible and choose to forgo needed care, a tax-advantaged account can help defray out-of-pocket costs. Additionally, the account can be used for future health care needs.

Compatibility with Other Benefit Designs and Payment Approaches

Other benefit designs could mitigate some weaknesses of high deductible health plans. HDHPs are often ineffective for certain populations of consumers. Low-income consumers may not have the financial stability to tolerate a high deductible, which may prevent them from seeking needed care. However, some employers allocate premium contributions based on salary to mitigate the effect on lower-income employees. Alternatively, implementers could consider pairing the HDHP with value-based insurance design, which can significantly reduce cost-sharing for services critical to particular patients (i.e., diabetes care for a diabetic). Theoretically, plans could use reference pricing to mitigate these effects by establishing an “up to” amount the plan will cover for a particular service, with any costs above that limit subject to the deductible.

Additionally, HDHPs may do little to incentivize patients with multiple complex conditions to be cost sensitive; they may blow through their deductibles quickly. In this case, implementers could consider split-benefit designs—a concept designed by Chernew, Encinosa and Hirth (2000)—which would offer patients who have already met their deductibles either incentives to choose low-cost services or providers, or penalties for not doing so.

There are mixed views on the compatibility of high deductible health plans and payments that operate under a budget, such as different forms of capitation, global budgets, or bundled episodes. In this case, some incentives for consumers and providers are aligned; HDHPs incentivize consumers to be more cost conscious about their care, and the budgeted or capitated payment incentivizes providers to be more efficient or cost effective. However, these arrangements may make it more difficult for providers to manage their patients’ care. Patients with a high deductible health plan may skimp on needed care, which could lead to adverse clinical outcomes. Additionally, it would be operationally difficult to administer the patient’s deductible based on their care if is not on a fee-for-service chassis.

There are similarly mixed views on the compatibility of HDHPs and fee schedules. While HDHPs were originally created to counter providers’ incentive to perform too many services by making consumers cost sensitive, HDHPs create a conflict of interest between the two parties. In this arrangement, the interests of the provider and patient are not aligned, because the provider seeks to deliver care and the patient seeks to avoid it.

Focus of Performance Measurement

If an HDHP provides first-dollar coverage only for primary preventive services, patients with chronic conditions may choose to forgo necessary secondary preventive services, because patients foot the entire bill up until they meet their deductibles and out-of-pocket maximums. Consumers who forgo necessary care may experience adverse consequences. With an HDHP, it would be important to assess whether these patients receive necessary screening treatments by using measures such as blood pressure control, HbA1c testing for diabetics, and so on.

Potential Impact on Provider Prices and Price Increases

HDHPs are intended to create a retail market in which consumers shop for health care services at their own expense—when the services are subject to the deductible. This structure is meant to make consumers more cost sensitive, which in theory could prompt certain providers to lower prices to compete for patients. HDHPs would probably have a greater effect on use of ambulatory care than hospital care, as most hospital care is costly enough to bring consumers well past their deductibles, at which point richer insurance coverage begins.

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.

Narrow Networks

Narrow networks are created using cost and quality criteria to select health care providers from a broader provider network, then establishing strong incentives for consumers to seek care from just that set of providers. Consumers face very high cost-sharing and the risk of balance billing, or in some cases denial of insurance coverage, if they receive care from a provider outside the narrow network. Therefore, consumers are essentially limited to seeking care from a defined group of health care providers.

Narrow networks can be an elective product that consumers choose at the time of enrollment in a health plan—a familiar example is the health maintenance organization (HMO) from the '90s. Today, the exchanges offer either broad or narrow network products. A narrow network product could, for example, place providers in an accountable care organization (ACO) in-network and those providers not in the ACO out-of-network.

Narrow networks are made up of a subsection of the providers in a geographic market; those in the network are “in-network” for all of the services they provide. Therefore, these networks are not organized like centers of excellence around individual service lines. As a result, quality for particular services may be uneven across providers in the narrow network.

While narrow networks impose greater restrictions on a consumer’s choice of health care providers, consumers generally enroll in them to take advantage of lower premiums. Although these networks’ main objective is to lower costs for consumers, some implementers are creating networks to achieve higher value, using quality metrics to design the network. This can deflect the criticism that narrow networks focus solely on reducing costs.

Narrow networks are not equally effective in all markets. They may be less able to lower costs in markets lacking provider competition, in which a dominant provider system must be included to ensure adequate access. Furthermore, a dominant provider group that wants to protect its high patient volume will use its leverage either to stop the effort by refusing to participate in the network or to demand an “in-network” designation while maintaining their higher rates. If the dominant provider commands higher-than-competitive prices and is in-network, the potential savings of a narrow network may not be realized.

Key Objectives of Narrow Networks

The major objective of narrow networks is to steer patients toward a group of providers that offer care at a reasonable cost, while not compromising on quality. With consumers and purchasers concerned about rising premiums, narrow networks can have great appeal in exchange for tighter restrictions on consumers' choice of provider. Additionally, narrow networks can produce higher value than other products.

Another major objective of narrow networks is that, in reasonably competitive markets, they can provide payers with additional leverage in price negotiations with providers. When patients are steered toward a specific set of providers, providers that are not in-network lose patient volumes. To maintain those volumes, they may be willing to negotiate with health plans for lower prices so that they can be included.

Strengths

- Narrow networks channel consumers to a more limited set of providers than is the norm in the market. This approach may increase the likelihood that patients will receive high-value care.
- Narrow networks can alleviate the concerns of many consumers and employer-purchasers about rising premium costs, as participating consumers will pay lower premiums than they would with less restrictive provider networks.
- Narrow networks have the potential to save consumers money because consumers are essentially limited to seeking care from lower-cost, sometimes higher-quality providers.
- In competitive markets, narrow networks can help curb providers' negotiating leverage, since they will be concerned about losing patient volume if they are not designated in-network. Payers, therefore, can gain stronger negotiating leverage, which may enable them to negotiate lower rates than for products with broader provider networks.
- Providers have a greater ability to manage and coordinate care for consumers in narrow networks, because the consumers have limited ability to receive care from out-of-network providers.

- Narrow networks may be less confusing than tiered networks, since they draw a clear line between which providers are in-network or out-of-network and thus, cost-sharing has fewer nuances.

Weaknesses

- Narrow networks can be unattractive to consumers because they restrict their choice of health care providers. Many consumers prefer the freedom to choose and thus may decide not to enroll in a narrow network.
- For implementers, it may be difficult to introduce lower-cost narrow networks in uncompetitive markets. For example, a dominant provider has the leverage to derail the network if it is not included or to demand higher prices that provide no differentiation from pricing in the rest of the market.
- Narrow networks may not actually produce greater cost savings because of selection bias. Generally, younger, healthier populations are more willing to accept restricted provider access for lower premiums. And, because narrow networks are cheaper and may have less generous benefits, they may be unattractive to those who could most benefit from higher-value care.
- A specific provider with highly specialized expertise in a certain service or procedure may not be in-network, meaning no coverage for the consumer who seeks care from that provider. While most payers may allow for exceptions and undergo ad hoc negotiations with out-of-network providers in specific circumstances, some may not.
- Many believe the process of designating providers in-network is often focused only on transaction prices and disregards the quality of care.
- When a member of a care team is not included in the network, for example, an anesthesiologist, the patient can encounter surprise billing that charges out-of-network rates for that provider, even though the surgeon and other providers involved in the care were in-network.

Design Choices to Mitigate Weaknesses

Network Adequacy

When designing a narrow network, it is important to have an adequate number of providers in the network to ensure sufficient access for patients. Without an adequate network—for example in smaller or uncompetitive markets—consumers could face barriers to care if the panel of providers were too small. Smaller or uncompetitive networks could also lack expertise in particular specialties.

Availability of Quality Information

While consumers choose narrow networks for their lower costs, quality across the providers in the network could be uneven. Therefore, information about the quality of the providers in the network can help consumers identify which have better outcomes or expertise in particular procedures or services.

Selecting Providers

Providers can be designated as in-network based on cost, quality, or both; however, most networks designate providers based on both cost and quality, or based on value. Those that designate solely on efficiency or cost have received significant criticism. Where the designer of the narrow network sets the required level of “value” will also affect how large the network is, and how beneficial this strategy will be in reducing health care expenditures and improving the quality of care.

Appeals Process

For patients with highly specialized needs, a speedy appeals mechanism is needed to allow them to seek care from an out-of-network specialist. If the payer does not grant the appeal, patients will either receive less-than-optimal care (potentially leading to higher spending) or pay the full cost of any care from an out-of-network provider. This financial barrier may mean that patients do not get the care they need for their condition.

Legal Environment

Local laws and regulations can affect the potential success of narrow networks. Laws and state-sponsored educational resources about health care prices and quality can support the development of narrow networks. State laws on “most favored nation” contracting clauses may help the health plan implementing a narrow network by forcing providers to give that health plan the lowest prices and obligating them to charge other payers more. But this can also prevent other health plans from entering local markets, stifling competition. Further, “any willing provider” regulations for health care providers require health plans to accept any qualified provider willing to agree to the plan’s terms and conditions. Where these regulations limit a carrier’s ability to develop selective, high-value provider networks, a plan’s ability to manage costs in a consolidated market may be limited.

Compatibility with Other Benefit Designs and Payment Approaches

When narrow networks were originally used with HMO products, the model required preauthorization—the patient’s primary care physician acted as a “gatekeeper,” referring the patient to other providers for specialty services. This pairing is used regularly today.

Narrow networks often use quality and cost criteria to distinguish in-network providers from out-of-network providers. Therefore, payment methods that incorporate cost and quality performance measures may complement narrow networks. For example, a shared savings or shared risk payment arrangement—like those used to support many ACO models—would tie provider payment amounts to the ability to stay within budget while meeting quality standards. Payers could use the same measures that determine which providers are in-network to judge eligibility to share in any savings. Additionally, consumers could be incentivized to receive their care from providers under risk (in shared risk or capitation arrangements), and not go out-of-network for care.

Focus of Performance Measurement

In the past, there have been concerns that if providers are paid on a capitated basis in a narrow-network-like product, they may stint on care provided to patients. While providers are generally designated based on cost and quality performance, the incentives under capitated payments encourage

prudent spending, as providers are paid a lump sum for all of the care they deliver. Therefore, it would be important to monitor the quality of care using measures that assess whether patients are getting recommended care, specifically secondary preventive services, and assess patients' experience of care. While we currently don't have adequate measures to assess the appropriateness of referrals, they would be an important addition to evaluating the effectiveness of narrow networks.

Potential Impact on Provider Prices and Price Increases

A narrow network in a particular market has the potential to generate competition across providers and provider groups and bring prices down as a result. A narrow network may attract consumers because of the low premiums associated with enrollment as well as the designation of high-value providers participating in the network. Other providers or provider groups may lose patient volume from the new arrangement. To avoid the loss of patient volumes, providers may be willing to give payers favorable prices. However, in uncompetitive markets, dominant providers may have the negotiating leverage with the payer. Large providers, especially, may know the payer will not meet network adequacy requirements without them.

Reference Pricing

When implementing reference pricing, a payer establishes a standard price for a drug, procedure, service, or bundle of services and requires that plan members pay any allowable charges above this price (rather than fixing patients' out-of-pocket costs). Therefore, consumers' out-of-pocket costs are the difference, if any, between the actual price of services received and the established reference price. Generally, the payer provides consumers with a list—sometimes through a consumer-oriented Web site—that reflects providers' prices and whether they meet or exceed the reference price. This allows consumers to make a value-based choice concerning their care, enabling them to weigh the trade-offs between their expected out-of-pocket costs and the provider from whom they wish to receive health care services.

Reference pricing can apply to services that vary substantially in price, yet are commonly perceived to have little variation in quality. These “commodity-like” services are always non-emergent and offered by multiple providers in the market. They may include laboratory services, imaging, colonoscopies, MRIs, and drug prices. While many reference pricing designs are based solely on price, some programs feature high-cost, more complex services, such as hip and knee replacements, for which quality can vary. These programs highlight providers that not only deliver a service at or below the reference price, but also meet certain quality criteria, which can steer patients away from providers with high complication and readmission rates. As well, these designs can deflect criticism from those who perceive reference pricing as purely an attempt to shift the cost of care to the consumer.

While reference pricing provides consumers with strong incentives to choose lower-cost providers for services, it does not restrict consumers from receiving care from particular providers. Even if there is a large difference between the reference price and the allowable charge (the consumer's out-of-pocket costs), consumers can receive care from any provider as long as they pay the difference.

To establish a reference price that will be functional in the market, the payer must consider whether enough providers are offering a selected service at or below the price to ensure adequate access for patients. Without an adequate number of providers at or below the reference price, patients may not be able to get care promptly. On the other hand, if the reference price is set too high, there may be little to no effect on spending.

Key Objectives of Reference Pricing

Many services vary substantially in price within and across regions of the country. A major objective of reference pricing is to eliminate the vast variation in payment amounts (prices) by setting a “cap,” or a reference price, that reflects what health plans and other purchasers think is a reasonable price for that particular service.

Another objective of reference pricing is to encourage consumers to obtain services that vary substantially in price from less-expensive providers. If consumers are seeking those services from less-expensive providers, other providers in the market may lose patient volume and attempt to renegotiate prices with health plans. This could have a downward effect on prices.

Strengths

- Reference pricing has the potential to save the plan, the purchasers, and the system money if incentives are structured so that consumers seek care from lower-cost providers, or if providers lower their negotiated payment amounts to meet or beat the reference price in an effort to maintain or increase patient volumes.
- When reference pricing is used to highlight providers based on price and adherence to quality criteria, it could direct consumers to higher-quality, lower-price providers.
- The reference price chosen can send signals to providers about what the plan and its employer-purchaser customers think is a reasonable price for a particular service. This reference can also inform future negotiations between the health plan and providers; providers may seek renegotiation with health plans to stem the loss of patient volume from exceeding the reference price.
- Because reference pricing is generally established for services that vary widely in price, it can educate consumers about how much prices can vary in health care.
- Reference pricing still allows consumers to have a choice of providers for a given service, letting them weigh the trade-offs between seeing their desired provider and their share of the cost of the service.

Weaknesses

- The applications for reference pricing are typically limited to shoppable “commodity” services—services for which price information is available—that represent a small share of total costs. While reference pricing lends itself well to other, more complicated services for which quality can vary, like hip and knee replacements, it hasn’t often been applied for complex or extremely high-cost services, as it can disrupt care for patients and be more complicated to administer.
- Educating consumers on how to make decisions using available price and quality information can take significant time and resources, but it is necessary to implement a reference pricing program successfully.
- Transparency could also lead providers to raise their prices if the reference price is higher.
- In a market with a dominant health system, implementers may face obstacles in establishing a reference pricing program. Dominant providers may agree to meet the reference price for services for which they compete for patients, but raise prices for services where they have less competition.
- Regardless of the market environment, if a provider lowers its price to meet the reference price, it could try to make up the difference by increasing how often it performs the service or by raising the price of other services not subject to the reference price.

Design Choices to Mitigate Weaknesses

Selecting the Services

Reference pricing can be used with “commodity” services that have significant price variation, but are considered to have little to no variation in quality. For example, the concept was first applied to drug pricing, as pharmaceuticals—particularly brand versus generic—vary significantly in price. Commodity services are typically offered by multiple providers in the market and may be high margin, making providers more willing to compete on price. Additionally, some research suggests consumers are more likely to shop around for these services. However, reference pricing has also been used successfully on complex, high-cost procedures such as total joint replacements, where quality is more likely to vary and the potential for savings is far greater.

Setting the Price

Various factors must be considered when setting a reference price. The payer starts by analyzing the range of prices it is currently paying, at the local, regional or national level, and determining what it believes to be a reasonable price that won't create unintended negative consequences. An adequate number of providers must be at or below the established price to ensure that enough patients have access to the targeted service or procedure. If the price is too low, patients may have a hard time finding a provider at or below the reference price. Providers also have the potential to increase their prices for other services to make up for the loss in revenue. CalPERS (the California Public Employees' Retirement System) set its reference price for knee and hip replacement to include two-thirds of the hospitals in its PPO network. However, if the price is too high, reference pricing will have little to no effect on spending.

Another factor to consider when establishing the reference price is geography. Most reference pricing programs set the reference point locally or regionally, because health care prices vary significantly across (as well as within) markets, but this can be difficult to explain to a population of employees spread out across the country.

Availability of Price and Quality Information

Transparency can help consumers see the vast variation in price and quality that exists for particular procedures. In addition, price transparency, in the form of provider lists or online tools, can inform consumers about which providers are at, below, or above the reference price, which can help them weigh the trade-offs between the price and the provider. Additionally, for more complex care involving more than a single service or procedure (such as an isolated lab or imaging test), transparency tools can inform consumers about what services are and are not included in the reference price (e.g., all aspects of a hip replacement including rehabilitation, or just the surgery itself). This way, patients will know if they need to pay an additional share for elements of their care not included in, or subject to, the reference price.

Quality Performance

Health care providers' performance on the quality and safety of care they deliver can also be built into the design of a reference pricing program. Ideally, providers willing to accept the reference price can

deliver acceptable quality and access. A variety of reference pricing benefit designs incorporating quality can be considered, from a quality threshold providers must meet to earn reference pricing incentives, to lower consumer cost-sharing for higher-quality providers (even if they do not charge the lowest price).

Environment

Reference pricing may not function well in highly consolidated markets where dominant providers could pressure payers to not implement this approach, or could use their leverage to negate its benefits by generating more revenue with other services. Second, the laws regarding price and quality transparency can have an effect. Such transparency is critical for reference pricing. Whether reference pricing is in place due to state laws and programs, or because the private sector fulfills the need, it cannot operate without transparency.

Compatibility with Other Benefit Designs and Payment Approaches

Reference pricing could be used in high deductible health plans (HDHPs). Consumers with HDHPs that receive an expensive procedure, such as a hip or knee replacement or maternity care, could have their deductible kick in only if the cost of care is above the established reference price. Therefore, the health plan would cover the cost of the procedure up until the reference price, with any charges above it subject to the deductible.

Reference pricing is most often used to constrain the cost of shoppable “commodity” services, which involve a discrete service or procedure (e.g., a lab or imaging test). It therefore pairs well with fee schedules, which associate a specific price with each discrete service or procedure. Reference pricing puts downward pressure on prices, which could help counter the inherent inflationary incentives of fee schedules. However, reference pricing does nothing to counter the volume incentives of fee schedules; thus, physicians may respond to reference prices by simply doing more of the procedure or service to account for reduced prices.

It is easier to pay fee schedules for commodity services (rather than complex services) through reference pricing because there is one single service performed. For a single-day encounter (e.g., a colonoscopy) it is much easier to control the patient’s out-of-pocket costs than it would be for a

complex procedure with related services (e.g., hip replacement with physical therapy). A provider performing more complex procedures could reflect the price of the procedure by itself as meeting the reference price, but tack on additional high-cost services to the patient's bill. Patients would then face bills that did not reflect the original price offered them and would be subject to more costs than expected. Additionally, for complex high-price procedures, patients could easily reach their deductibles or even their out-of-pocket maximums.

Reference pricing can pair well with bundled payment from both the consumer's and the provider's perspective. For the consumer, it means that the reference price is all-inclusive, referring to the entire episode of care as opposed to an individual service within an episode of care. As a result, the consumer should not experience any unexpected additional costs associated with the episode. For the provider, higher patient volumes could be a welcomed reward for agreeing to accept bundled payment and adhering to the reference price. However, reference pricing does nothing to counter the volume incentives of bundled payments; thus, providers may respond to reference prices by simply doing more procedures to receive more bundled episode payments to make up for reduced prices.

Focus of Performance Measurement

Reference pricing is often established for services that vary substantially in cost but are perceived as having little to no variation in quality. Therefore, quality has not generally been a consideration in designing a reference pricing program. Other programs, such as those not designed for commodity services, may address vast variation in both prices and quality. For these programs, the health plan can do one of two things: (1) use quality metrics specific to the service selected, so that the consumer can make informed choices about the trade-offs between different providers, or (2) highlight providers or facilities that not only deliver a service at or below the reference price, but also meet certain quality assurance standards. If quality becomes an integral part of a reference pricing program, the implementer can use it to highlight particular providers who meet the reference price.

Potential Impact on Provider Prices and Price Increases

In a competitive market, if reference pricing successfully incentivizes consumers to make cost-effective decisions about a service, it may draw some consumers away from higher-priced providers and toward lower-priced providers. The threat of lower patient volumes could lead to price negotiations between

the payer and providers in the market, which could lead to lower prices. However, providers may raise prices for other services to make up the difference.

Centers of Excellence

Centers of excellence (COEs) are designated groups of providers that meet high standards for both the quality and the cost of care for a particular service or set of services. Unlike network strategies that sort by provider organization, health care payers designate COEs for specific procedures or other services where both quality and cost vary significantly. Common examples are non-emergent and complex specialty services, such as total joint replacement, heart surgeries, spine surgeries, bariatric surgeries, cancer and transplants. In return for COE designation, which provider groups hope will draw more patients to them, they may be willing to accept a lower negotiated price or alternative payment arrangement, such as a bundled episode payment. In addition, the purchaser or health plan typically designs the health benefits to make selection of the COE financially favorable for the patient. Therefore, the purchaser or health plan benefits by creating a source of high-value care for their members. The patient benefits because the COE program points them to a preferable source of care, an improvement and an alternative to the uneven quality and payment amounts they were subject to previously.

COEs are established through contracts between either a payer or an employer and a provider group. Consumers' use of a COE is largely voluntary. To encourage consumers to obtain the service they would like to receive from these high-value providers, payers or employers lower or waive out-of-pocket costs for their members or offer them a reward or cash bonus for seeking care. And because COEs can sometimes be situated in geographies that are inconvenient for the consumer, payers or employers often cover the travel costs for both the patient and a companion. If the patient has to travel for the service and needs coordination and follow-up post procedures, most COEs have agreements with providers in the patient's local market to follow up with the patient.

The Wal-Mart Associate Health Plan currently has COE contracts with five leading hospitals that perform heart, spine, cancer, and transplant surgeries—Cleveland Clinic, Mayo Clinic, and Geisinger Medical Center to name a few. Wal-Mart employees bear no out-of-pocket costs if they receive care from one of the five centers. Associates on Wal-Mart's HSA plan must meet their annual deductibles before the plan will make any payments, due to federal tax laws.

Key Objectives of Centers of Excellence

Employers and payers typically create COE programs to address variations in quality and costs for particular high-cost services, thus enabling patient members to select care from a site offering high-quality, more affordable care.

Another objective of COEs is to ensure that the care patient-members receive is appropriate. For example, some COE programs compensate providers for thorough evaluations of patients, to ensure that the care the patient seeks is appropriate and necessary. If it turns out the patient needs the care, then another larger payment is made to cover the costs of those services.

Lastly, COE programs aim to offer a high-value alternative while preserving patient choice. Generally, centers of excellence programs are voluntary; it is up to the consumer to choose to use them. Consumers are not penalized if they seek the service from another provider, but they may have higher out-of-pocket costs as opposed to low or no out-of-pocket costs. Therefore, another objective is to preserve consumer choice, allowing them flexibility to choose where they would like to receive the service.

Strengths

- COE programs give patients incentives to seek care from higher-value providers. This can lead to better, more appropriate, and less-expensive care for both the patient and the employer or payer.
- If COE providers are compensated for thorough evaluations of patients before performing the procedure or service, the procedure or service should be appropriate and necessary, starting with the right diagnosis and ending with an effective treatment plan.
- The development of COEs can create national markets for elective procedures and other care episodes, which may stimulate consistency and efficiency and create competition for local providers that otherwise may be able to command high prices. This could lead non-designated providers to offer price reductions and improve the quality of the care they provide.
- A national contract may be attractive to provider organizations because it would include many lives, which may translate into larger price concessions by the COE.

- COEs may offer better discharge planning and better continuity of care for the patient after an operation or service. Most COEs have agreements with providers in local markets to follow up with patients after a procedure or service.
- Generally, COE programs are voluntary, giving consumers the ability to make decisions about their care, rather than restricting them to a particular provider or group of providers. A COE can maintain consumer choice while improving patient care.

Weaknesses

- There may be high administrative costs in creating a COE program—search costs, determining criteria and who meets them, negotiations, and claims administration, among others. If the COE requires high setup costs but represents a small amount of savings, it may not be worth the effort.
- The highest-value provider group, contracted as a COE for a specific service or procedure, may be located in a completely different geographic region than the consumer population. This may be inconvenient for consumers and families, as they face travel costs—in direct expenditures and time—to seek care. Therefore, consumers may opt to seek care from a more conveniently located provider.
- COEs move the health care system toward setting up national markets for elective procedures. Local provider groups that perform these procedures face the possibility of shutting down if they no longer receive revenue for high-paying services, reducing local access to the services that are the focus of the COE program.
- The providers in the COE may be paid to ensure that the care the patient seeks is necessary. Even if they decide the care is unnecessary, the patient may return home and seek that service from another provider.
- Poor communication between the COE and patients' other providers, such as their primary care physicians, or other local specialists, could hurt the continuity of care.

Design Choices to Mitigate Weaknesses

Selecting the Services or Procedures

COE programs are most commonly implemented for non-emergent complex services where expertise may be concentrated among particular providers, for which there are established guidelines, or where there is high variation in cost and quality across providers. The first COEs were created for organ transplants due to the high cost and specialized nature of the procedures. Others have been designated for hip and knee replacements, cancer, and complex spine, heart, and bariatric procedures, among others.

Selecting the Providers

Most COE programs select one or more provider groups that have expertise in the service or procedure of interest and that offer high-quality care for that procedure. Cost is also a consideration, and price negotiations will generally involve a discussion about offering a lower price or accepting an alternative payment arrangement in return for a higher patient volume. It is also important for the provider group to have medical travel destination experience.

Voluntary or Mandatory

The use of COEs by consumers can be voluntary or mandatory. Most COEs are voluntary, giving consumers the ability to weigh trade-offs and decide which providers they wish to see. But in a voluntary program, consumers may not use the COE if the incentives are not strong enough or they lack information on the COE option. On the other hand, if the COE is mandatory, consumers may push back due to inconvenience (e.g., geographic) or disruption of the patient-provider relationship.

Cost-Sharing or Consumer Benefits

The incentives (out-of-pocket costs) to encourage consumers to use the COE should be significant. Strong incentives can be created through either lowering or waiving out-of-pocket costs. The plan or

purchaser may also offer consumers a cash bonus to seek care from the designated COE, helping cover consumers' travel costs.

Communication

Systems to facilitate communication and care coordination between the COE and patients' regular providers are essential. After patients undergo their care at the COE, resources should be available to help them manage their health after the procedure. Most COE programs have agreements with patients' local or regular providers to follow up with the patient after an operation.

Availability of Price and Quality Information

Price and quality transparency can show consumers the value of the care a COE offers versus that of the same service delivered by other providers. Such transparency, combined with the incentives to use the COE, may encourage consumers to choose the COE.

Compatibility with Other Benefit Designs and Payment Approaches

COEs could be paired with narrow network products. Narrow networks restrict consumers' choice to a limited set of providers in a market. These providers may not be the best providers for given services and procedures. Therefore, a COE would give consumers a high-value option for the service they seek.

Incentives to use alternative, less expensive sites of care, specifically telehealth services, would be compatible with COEs. Telehealth would allow patients who live a significant distance from the COE to follow up with the COE after an operation without the costs of additional travel. The COE would be able to learn firsthand about the patients' progress and coordinate as needed with the patients' regular or local providers.

Most COEs, like all other health care professionals, are commonly paid fee schedules. However, COE programs are increasingly compensating providers with bundled payments for a procedure or other episode of care. Because the providers in the COE are designated for a particular set of services or procedures, a package price that includes all the services the patient will receive may be most

effective and allows the purchaser to budget more accurately. If the payment arrangement centers on bundled episode payment, the payer must offer alternative compensation for the COE when it determines after evaluation that a patient is not an appropriate candidate for care.

COE contracts are more likely to allow for innovation in payment and delivery because the health plan can promise the COE higher patient volumes in exchange for lower negotiated fees or alternative payment arrangements.

Focus of Performance Measurement

COEs are designated using quality and cost criteria. The quality measures used in selecting providers to serve as COEs could be flawed, meaning greater use of these providers will not lead to higher-value care for their consumers. Further, health care providers with leverage could demand to be designated COEs, even if their performance does not meet the criteria. To validate the criteria used for provider selection, payers would ideally to assess the quality of patient care the COEs deliver, particularly with outcomes measures. It may also be important to look at the effect of the COE program on the incidence of the procedure or service the COE addresses. With attractive cost-sharing arrangements, consumers might be more likely to seek care than before, particularly for elective procedures. While the care may be appropriate for most, it may not be appropriate for all, and the COE program could lead to overuse.

Potential Impact on Provider Prices and Price Increases

If there is significant, meaningful enrollment, the development of COEs can establish a national market for services and procedures, inserting competition for local providers where there may have been none. In these contracts, the COE typically grants pricing concessions for a large regional or national book of business, which is significantly lower than competitors' prices. The threat of losing patient volume to providers either within or outside of the market may encourage local providers to renegotiate their prices.

Benefit Designs for Alternative Sites of Care

Alternative sites of care are locations where patients can receive the care they need at a lower cost than from traditional venues such as hospitals. Examples of alternative sites include worksite clinics, urgent care centers, retail clinics, and telehealth services. In addition to alternative sites being less expensive for payers and purchasers, patients who seek care from alternative sites often have lower out-of-pocket costs than if they receive care from traditional sites like the emergency department, other hospital-based clinics, or other more costly sites.

Alternative sites can also be more convenient for consumers than traditional sites of care. For example, worksite clinics are located in or near the employee's workplace, allowing them to receive necessary services during their workdays. Urgent care centers are often closer to where consumers live than hospital emergency department. Retail clinics, such as those within a Walgreens or CVS, are universally located and generally easy to access. Telehealth services are offered via telecommunications, allowing patients to seek care without leaving their homes or workplaces. Therefore, alternative sites can be both less expensive and more convenient for consumers.

For example, consumers are offered telehealth services both to reduce inappropriate use of costly health care services and to enhance access to care, as many office visits can be handled over the phone. With savings that can range from \$300 per year for an individual to over \$1,000 per year for a family of four, telehealth translates into lower out-of-pocket costs for consumers. Additionally, telehealth can make communications with providers easier, especially if time or geographic barriers separate the consumer and the provider. However, most consumers today receive telehealth services from physicians other than their own, though this is likely to change over time.

For consumers to use alternative sites of care over traditional venues, benefits can be structured so that out-of-pocket costs (co-pays, co-insurance or deductibles) are lower for receiving particular non-emergent services from the alternative site. For example, a patient seeking an ear check for possible infection at a retail clinic could pay \$40, compared to \$84 for an in-person visit to a primary care doctor's office.

Alternative sites will generally be less expensive for consumers than the emergency room or another costly site. However, more and more consumers are electing narrow network products at enrollment. For products that restrict from which providers consumers can seek care, an alternative

site may end up being more expensive (e.g., a \$40 flat fee at a retail clinic versus a \$30 deductible at the doctor's office). Narrow networks should aim to include less expensive alternative sites of care.

Key Objectives of Benefit Designs Supporting Use of Alternative Sites of Care

A major objective of benefit designs that encourage the use of alternative sites of care is to shift care from expensive sites, like the emergency department or the hospital, to less costly sites. Thus, consumers' out-of-pocket costs are reduced for sites that are less costly than traditional venues.

Another objective of alternative sites of care is to reduce barriers to consumers receiving appropriate care when they need it. Many consumers face difficulties with access because their geographic location lacks providers or because of their workday.

Strengths

- By providing incentives for consumers to use alternative sites of care, they may be more likely to get the care they need and seek it from a less expensive location.
- Many consumers face logistical barriers to receiving necessary care because of geographic location or their work schedules. Alternative sites can enhance access to medical care by providing consumers with more convenient options, such as clinics at their worksites or in their local pharmacies, or care through telecommunications.
- Consumers who do not receive coverage for services rendered in the emergency department, or face high out-of-pocket costs for hospitalizations, may have less expensive options for receiving the care they need.
- If consumers are receiving care at alternative sites rather than the emergency department or another expensive site, health care costs could decrease.

Weaknesses

- The site where patients have the lowest out-of-pocket costs may not be the highest quality for the service they seek. The service may require particular infrastructure or tools that an alternative site will not have.
- Alternative sites may be inconvenient for some consumers. Certain patients may not have the technology to accommodate telehealth services. Others may not have the ability to transport themselves to an ambulatory surgery center or another clinic and would be more likely to call an ambulance to visit the emergency department.
- If the alternative site has no connection with the patient's primary care physician, continuity of care may suffer and the doctor-patient relationship may be disrupted.
- Alternative sites take volume away from emergency rooms. Therefore, they may affect hospitals' ability to pay their high fixed costs.
- If a patient is enrolled in a narrow network product, an alternative site may not be less expensive unless the network includes the alternative site in-network.

Design Choices to Mitigate Weaknesses

Cost-Sharing

Consumer out-of-pocket costs are typically structured so that they are lower at an alternative site than at a traditional site of care. This distinction is meant to incentivize the consumer to seek care from the lower-cost site. Benefits can also be designed to waive costs entirely. The incentives must be significant enough to change traditional consumer care-seeking patterns.

Selecting Alternative Sites

Traditionally, alternative sites are chosen because they are less expensive and perhaps more convenient for consumers than traditional sites of care. In some cases, alternative sites may not be

convenient for a patient population. Therefore, geography and patients' resources should be considered when implementing cost-sharing.

Availability of Price and Quality Information

Transparency tools can show consumers the relative value of receiving care from one site versus another (i.e., alternative sites versus traditional). This information can help point consumers toward higher-value options. Additionally, providers should have access to information about the relative value of care received from alternative versus traditional sites. Access to this information can help providers make referral decisions that are less expensive and more convenient for the consumer. Through their involvement in these referrals, providers can ensure continuity of care. Additionally, transparency tools often provide helpful information such as providers' hours of availability.

Data for Care Continuity

Health information technology that allows communication across multiple sites of care and multiple providers is essential for continuity of care. Without it, communication between providers at an alternative site and the patient's primary care physician will be more labor intensive, or even absent.

Compatibility with Other Benefit Designs and Payment Approaches

Value-based insurance design (V-BID) could be used with alternative sites to lower patients' cost-sharing for receiving clinically beneficial services at clinically beneficial sites. For example, a patient would have lower out-of-pocket costs if they were to receive an immunization at a retail clinic versus at a hospital or another more costly site.

V-BID could also be used to decrease consumers' use of the emergency room. For example a program could require patients who wish to go to the emergency room during their providers' office hours to first contact their primary care physician by phone. If patients do not follow this protocol and visit the emergency room during their primary care physician's office hours, their cost-sharing could be significantly higher.

Narrow networks should include some alternative sites of care in-network; otherwise the cost for a consumer to receive care from an alternative site may be more than the cost of receiving care at a traditional venue.

Cheaper alternative sites of care work well with the fee schedule, if the payment amount represents a downward adjustment of the fee schedule compared to payment amounts for the same care at traditional sites.

Worksite clinics may work well with capitation (a per member per month payment). If the provider is at risk for the cost of care, the incentives of the provider—to spend under the capitated amount—and the consumer—to seek lower-cost care—align.

Telehealth services offered by health care providers to extend office hours may pair well with capitation or other population-based payment. With these payment designs, providers have an incentive to minimize unnecessary use of higher-cost services.

Focus of Performance Measurement

Any shift in the place patients obtain care should be monitored for its influence on both spending and quality of care. Ideally, those who introduce benefit designs to encourage the use of alternative sites of care would track patients' satisfaction, access to care, and resolution of patients' health care needs. If alternative sites of care are too narrow in their capabilities, patients may need to seek additional care, diminishing their workplace productivity and potentially adding to costs.

Potential Impact on Provider Prices and Price Increases

Alternative sites of care introduce competition for traditional sites of care. By changing incentives for patients, use of services in high-cost sites of care is likely to decrease. If patients are directed to more cost-effective sites of care, where providers are paid a lower fee for their services, other providers in the market may lose patients and associated revenue. The loss of patient volumes can be of great concern to providers. Therefore, they may renegotiate their fees to compete with more cost-effective sites of care. Competition may lower prices, but alternative sites may also have lower cost structures, contributing further to their ability to charge less than traditional sites.

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