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New Employer-Facing Products Try to Make Health Care Simpler

With many companies currently hammering out what their employee benefits will look like in 2022, some health insurers are hoping to woo clients by rolling out products that promise to make navigating the health care system a simpler, smoother and more personalized process.

For example, Blue Cross Blue Shield of Michigan this March rolled out a multi-tiered portfolio of digitally enabled care management solutions called Blue Cross Coordinated Care. The offering comes in three "levels of support" that give employers a range of options to aid their members: Core, Navigator and Advocate.

Core offers "a holistic, member-centric approach to care management" for members with complex or chronic health care needs, while Navigator goes further and provides clinical navigators to help members manage their health and treatment. Advocate is the most comprehensive offering, combining the features of the other two tiers with "an elevated, high-touch servicing experience provided by a team of Member Advocates who help guide members through their personal health journey to close care gaps and ensure convenient access to providers, employer benefits and other resources," according to the Michigan Blues plan.

"We're definitely trying to meet the pain points of our members, and our large [employer] groups are asking for solutions like this to better manage the health of their members and help them have a better member experience," Marsha Ennis, director of market solutions strategy and performance at Blue Cross Blue Shield of Michigan, tells AIS Health, a division of MMIT.

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More States Consider Public Option in Bid to Lower Costs

With a nationwide public option now looking unlikely under President Joe Biden, an increasing number of states are trying to implement their own government-sponsored alternative to commercial insurance in a bid to lower rising costs.

Colorado almost passed a public option, and Connecticut's leaders are taking a hard look at creating their own. Meanwhile, a committee in Nevada's legislature is debating the merits of implementing a public insurance option that sets a target of reducing average premium costs by 15% within five years and would be available starting in 2026 *(HPW 5/7/21, p 7)*. Although payers and providers have successfully headed off Colorado's public option proposal, and may do so elsewhere, there is increasing pressure at the state level across the country to act on health care costs.

Katherine Hempstead, senior policy adviser at the Robert Wood Johnson Foundation, says the public option proposals are part of a larger push by states on cost.

"Broadly, the accountability of states for health care costs is rising," Hempstead tells AIS Health, a division of MMIT. "I think what you do see is a proliferation of these state offices of health care cost containment. I view the public option as

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kind of a subgenre within that. It's a response to that problem as a pocketbook issue. Health care costs have escalated to the point where I don't think progressive state governments can really act like they've got nothing to do with that. So we may see more attempts to be responsive on this issue."

The proposals reflect the unique market dynamics of the states in question. Colorado legislators developed a public option plan as part of an attempt to cut reimbursement to hospitals and by extension lower premiums. Lawmakers in that state have moved in recent weeks to drop the controversial state-backed health plan and instead compel insurers to lower premiums and hospitals to drop their prices.

In Connecticut, a public option bill is still under consideration, despite stiff insurance industry opposition. The state also is considering a competing proposal that attempts to address rising costs for prescription drugs and expand subsidies on the state's individual and small group exchange. Washington, the only state so far to actually pass and implement a public option, has sought to expand plan competition in rural counties and improve the actuarial quality of all of its plans *(HPW 5/6/21, p. 1)*.

David Anderson, a research associate at the Duke University Margolis Center for Health Policy, says public option legislation has a bigger impact on politics than policy.

"There's quite a bit of power exerted to go do something about health care by your liberal activist groups," Anderson tells AIS Health. "That translated to either go file a 1332 waiver for reinsurance, which some states have done, or go do something about the public option. Which is something to do, but the intellectual clarity as to what problem it's trying to solve has never been fleshed out."

Anderson argues this dynamic is even more true now that major reforms to the Affordable Care Act (ACA) have been passed as part of the American Rescue Plan (ARP), the pandemic recovery bill recently signed into law. In the ARP, subsidies for the ACA individual market were expanded dramatically.

While those subsidies are unlikely to lower systemic health care costs, they will keep plans affordable for beneficiaries, as they cap premiums at 8.5% of an enrollee's income *(HPW 3/19/21, p. 1)*. While those subsidies are set to expire after plan year 2022, the Biden administration has called for the changes to become permanent — which many observers, including Anderson, expect Congress to do at the next opportunity.

Initially, Hempstead says, the "public option had a special role in trying to create a more affordable option for people that are priced out of the marketplace. So I think that particular purpose of the public option has been overtaken by the [ARP]."

States Get Into 'Health Care Cost Game'

However, she observes that "the broader rationale for a public option just as a way to contain costs and exercise some market power from the buyer side, or on behalf of the public — I think that persists.…States are sort of getting in the health care cost game. I think it's actually a pretty active issue for state governments, because it's such a pain point for consumers."

Colorado's public option debate can fairly be called a saga — and won't actually result in a public option. In 2020, the state legislature came close to passing a bill that would have created a public option similar to Cascade Care, the Washington program that launched in the 2021 plan year. Like Cascade Care, the Colorado plan would have relied on private health insurers to deliver benefits, cover claims and perform the array of administrative tasks associated with health insurance, while reimbursing providers at predetermined rates. In

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Senior Reporter, Peter Johnson; Managing Editor, Leslie Small; Executive Editor, Jill Brown Kettler

Washington, 10 carriers including UnitedHealthcare won contracts to operate such plans.

However, stiff opposition to the Colorado bill from payers and providers alike, along with the uncertainty caused by the COVID-19 crisis, sank the legislation. This year, Democratic legislators returned to Denver and re-introduced a public option bill, House Bill 1232.

However, payers and providers negotiated a compromise position. A new amendment to the bill will require 18% premium reductions across the board from insurers participating in the ACA exchange. If carriers do not hit those targets in the time allowed, the state will intervene to negotiate rates with providers. Reimbursement will not be allowed to drop below 165% of Medicare rates for hospitals and 135% of Medicare for other providers.

Will Compromise Deliver Real Change?

"Even though it's a compromise, I still think it sets a pretty significant standard for what they want the plans to accomplish in three years. That's an interesting thing to look at to see what can be achieved," Hempstead says.

The 18% target is "very serious," she says. But, "you would want to be really attentive to how you're measuring that. Because I think in Colorado, there's probably some low hanging fruit where you could possibly bring the average down." The question for Hempstead, however, is "how many people see change? It'll be interesting to see what happens there."

Anderson is more skeptical of the Colorado plan. "A public option with administratively set rates that are significantly below commercial rates, but with a pretty decent network would solve the problem of high premiums and bad networks and bad benefits for small-group businesses," Anderson explains. "With the ARP passing, a public option that undercuts overall pricing in the market — in the short run, it makes more people who are insured worse off, because people don't quickly react to price shocks. New entrants to markets and active buyers, they're indifferent because they're buying on premium spread, not premium level. And on the whole, money is saved by the federal government. But it's one of those things where it's hard to figure out what problem Colorado is trying to solve."

> **"It's not a crazy idea, but the odds of it getting implemented are tough.**

Connecticut's legislature has proposed a public option bill, S.B. 842, which would allow any individual on the exchange to enroll in the health plan available to state employees. The plan would be administered by the Connecticut State comptroller, whose office manages state employee benefits. The current comptroller, Democrat Kevin Lembo, backs the plan. Enrollees in small-group plans would also be allowed to buy in to the new, expanded public plan.

Another bill to manage health care costs has been proposed by Connecticut Gov. Ned Lamont, a Democrat. He opposes the public option bill. That proposal would introduce a state version of the ACA's health insurer fee, which Congress repealed effective in 2021 and beyond.

The governor's office projects the tax would bring in $50 million annually, which would be spent mostly to offer enhanced subsidies on the state's health exchange. According to the Connecticut Mirror, some of the money could also be directed to other programs, such as reinsurance or a large Medicaid expansion.

"If the entire idea is to get a mass of buyers to get better rates, the policy ratio makes sense," Anderson says in regard to the public option plan backed by Lembo. "They're trying to get better rates so employers can increase cash compensation and decrease health insurance compensation while holding compensation constant. More people are better off, while taking money out of the medical sector. It's not a crazy idea, but the odds of it getting implemented are tough."

Connecticut Carriers Push Back

Payers have expressed strong opposition to both proposals on the table in Connecticut.

"The State Partnership Plan does not have the proven experience to run a health insurance program for its residents," said an April 13 letter signed by Gail Boudreaux, president and CEO of Anthem, Inc.; David Cordani, president and CEO of Cigna Corp.; Karen Lynch, president and CEO of CVS Health Corp.; and Dirk McMahon, president and chief operating officer of UnitedHealth Group.

"We are equally concerned with the Legislative proposals that institute a health insurance tax which would also increase business costs through premium increases," the executives added.

Invoking the insurance industry's large employment footprint in Hartford, the letter added that "the pandemic has demonstrated that employees can work virtually, making it easier for companies to choose where they are domiciled and grow. As a result, it has never been more critical for the State to create a climate that retains

and attracts businesses that will help stabilize the economy. All of us will have to decide where it will be best to deploy our resources long term."

The letter angered state officials. Legislators denounced it, and Lembo told the Hartford Courant that the letter is "very obviously a threat."

Read the Colorado bill at https://bit.ly/3fl5wdr, the Connecticut bills at https://bit.ly/3uPy7y2 and https://bit.ly/3fbV3Rk and executives' letter at https://bit.ly/3ffPu4l. Contact Anderson at david.m.anderson@duke.edu and Hempstead at khempstead@rwjf.org. ✧

by Peter Johnson

Cigna Is Bullish on Individual, Smaller Group Markets

While Cigna Corp. credited its Evernorth health services division as the primary driving force behind its strong first-quarter 2021 earnings, the company's management and equities analysts alike seemed satisfied by the performance of Cigna's health insurance business. And Cigna's executives expressed optimism about the firm's growth in certain commercial markets.

Cigna reported adjusted income from operations of $987 million and adjusted revenues of $10.4 billion for its U.S. Medical segment, and its first-quarter earnings for that segment were "slightly ahead of our expectations," said Chief Financial Officer Brian Evanko during the company's May 7 conference call to discuss financial results. Those results were driven in part by investment income but "partially offset by a non-recurring litigation settlement," Jefferies analyst David Windley advised investors in a May 8 research note.

Cigna's medical loss ratio of 81.8% also beat the consensus estimate of 82.0%, "and prior period reserve development was favorable — a reversal from last quarter when MLR missed on higher COVID cost, and PPD [prior period development] was unfavorable," Citi's Ralph Giacobbe observed in a May 7 note. But Cigna's MLR was higher than the 78.3% it recorded in the first quarter of 2020, which the company attributed to "COVID-19 related impacts and the pricing effect of the repeal of the health insurance industry tax."

Membership Dipped Year Over Year

From a membership standpoint, Evanko said Cigna ended the quarter with 16.7 million total medical customers, down from 17.2 million during the prior-year quarter but up by about 30,000 compared to the fourth quarter of 2020. "As expected, U.S. commercial customer volume declined sequentially due to disenrollment throughout the first quarter, partially offset by new sales in the Select segment," Evanko said, referring to firms with 51 to 500 employees. "And our U.S. government businesses performed well throughout the annual open enrollment periods," he added.

Cigna now expects to grow its membership by "at least 350,000 customers" this year, according to Evanko, who noted that "this includes organic growth throughout the remainder of

MCO Stock Performance, April 2021

	Closing Stock Price on 4/30/2021	April Gain (Loss)	Year-to-Date Gain (Loss)	Consensus 2021 EPS*
COMMERCIAL				
Cigna Corp.	$249.01	14.7%	19.6%	$20.37
UnitedHealth Group	$398.80	19.6%	13.7%	$18.53
Anthem, Inc.	$379.39	27.7%	18.2%	$25.20
Oscar Health Inc.	$22.73			($2.09)
Commercial Mean		**20.7%**	**17.2%**	
MEDICARE				
Humana Inc.	$445.24	16.2%	8.5%	$21.62
Alignment Healthcare, Inc.	$26.54			($0.48)
Clover Health	$9.85	(29.4%)		($0.41)
Medicare Mean		**16.2%**	**8.5%**	
MEDICAID				
Centene Corp.	$61.74	2.4%	2.8%	$5.16
Molina Healthcare, Inc.	$255.10	19.4%	19.9%	$13.14
Medicaid Mean		**10.9%**	**11.4%**	
Industry Mean ex-new MCOs		**16.7%**	**13.8%**	

*Estimates are based on analysts' consensus estimates for full-year 2021.

SOURCE: Bank of America Merrill Lynch.

the year in our commercial business, led by the middle market and Select segments partially offset by disenrollment in national accounts." The company also anticipates Medicare Advantage membership to increase "in our target average annual growth range of 10% to 15%," Evanko said, and it expects to continue growing its individual market business.

CEO David Cordani later offered an optimistic view of Cigna's widening footprint on the Affordable Care Act exchanges, where the company has maintained a modest presence since the marketplaces' inception. "We've innovated within the exchanges, we've delivered a proven model, and now we're in an expansion mode relative to additional geographies, in large part with our collaborative accountable care and aligned value-based relationships from the health care delivery system," Cordani said. He added that Cigna is "pleased with the results, both the base results in individual exchange, as well as thus far our early look at the additional enrollment we're seeing because of the expanded SEP [special enrollment period]."

Emails, Letters Spur Better Plan Choices Among California Exchange Members

California's individual health exchange successfully used inexpensive email and letters to encourage consumers to switch to lower-cost coverage that provided them with better benefits, according to new research. The 2019 program from Covered California potentially could be duplicated in other states to help consumers save on coverage, according to the study, which was published in Health Affairs.

During the 2019 open enrollment period for California's Affordable Care Act (ACA) marketplace, Covered California used a randomized intervention to see if low-income beneficiaries, particularly those who earn less than 200% of the federal poverty level, could be encouraged to enroll in silver plans with cost-sharing reduction (CSR) subsidies, which made more sense for them.

Consumers in this bracket are eligible for CSR, or "enhanced silver," plans with lower premiums and out-of-pocket expenses, which increase the actuarial value of the base silver plan from 70% to as high as 94%, depending on income.

However, the Covered California marketplace does not automatically assign CSR-eligible consumers into enhanced silver tier plans, and an analysis conducted by the exchange found that nearly 20,000 consumers had chosen more costly gold and silver plans for the 2019 coverage year, even though they were eligible for an enhanced silver-level plan. Previous research found that consumers chose worse plans due to a lack of awareness, plan complexity and "choice overload," the study said.

The study randomly assigned households to one of three groups: a control group that received no CSR-silver-specific messaging, an email-only group and a mail-plus-email group. Households in the email-only group received a CSR-silver-specific email in early October 2018 and a reminder email at the end of October, and households in the mail-plus-email group received a CSR-silver-specific letter in regular mail in early October plus a reminder email at the end of October. Both the emails and the letters described the average premium and out-of-pocket savings they would see, while also stating they could keep the same carrier and providers.

The average cost of outreach was 30 cents per household, according to the study.

At the end of the study period, 17.7% of the control group had switched to enhanced silver plans. Relative to the control group, being assigned to the email-only group increased the enhanced silver enrollment rate by 2.0 percentage points for an 11% increase in plan switching relative to the control group. Being part of the mail-plus-email group increased the enhanced silver enrollment rate by 3.9 percentage points for a 22% increase in plan switching relative to the control group.

The results could be duplicated in other states, the researchers concluded. "Given that gold enrollment increased not just in California but nationwide after the termination of CSR subsidies, other states are likely grappling with how to guide low-income consumers to the best available plan for which they are eligible. Our intervention points to a low-cost approach for states that could yield reductions in choice errors."

View the study at https://bit.ly/3hpO4XF.

by Jane Anderson

Cigna entered 80 new counties in the ACA exchange market in 2021, Evanko noted, and membership gains during the annual enrollment period were "a little bit above our expectations" even before the SEP began.

Cordani also touted Cigna's partnership with Oscar Health Inc., which he said will help it be "well positioned to take advantage of market growth opportunities in the small employer market, a market we view [as] currently being underserved."

And on the subject of Cigna's recent decision to divest its Texas Medicaid holdings to Molina Healthcare, Inc., Cordani said "we determined it was best for that business to be served by an expert or specialist," noting it had a negligible effect on Cigna's bottom line.

Going forward, "we continue to see Medicaid and government services first and foremost as an attractive growth opportunity within our Evernorth service portfolio," he added.

Overall in the quarter, Cigna reported an adjusted earnings per share of $4.73, beating the Wall Street expectation of $4.37, and it raised its full-year EPS estimate to "at least $20.20." The company said Evernorth was the main driver of its favorable performance, as that segment delivered 13% year-over-year growth in both revenue and adjusted income from operations.

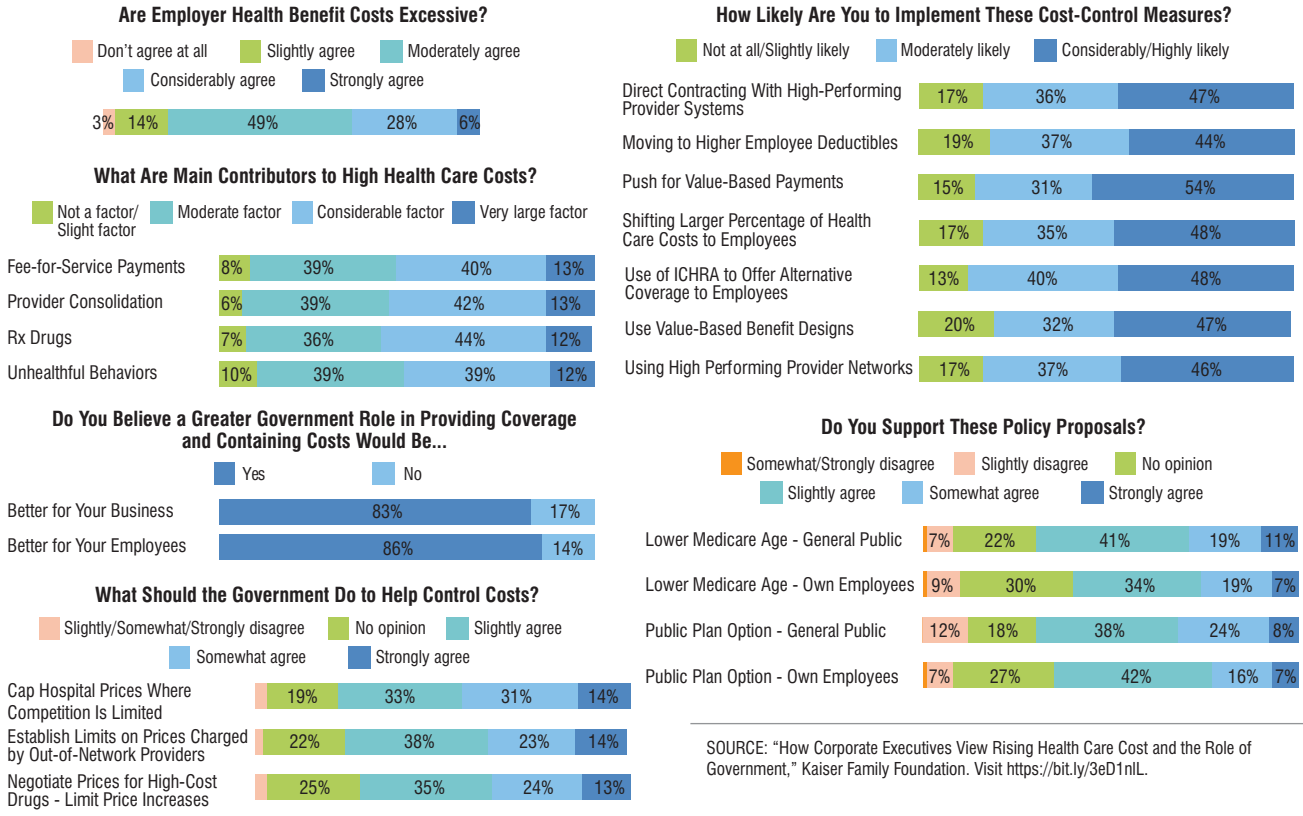
Read Cigna's earnings release at https://bit.ly/3y3ZypI. ✧

by Leslie Small

Many Large Employers Want Government to Help Control Health Care Costs

by Jinghong Chen

The majority of large private employers say that health benefit costs are excessive and a greater government role in providing health care coverage and containing costs would benefit their business and employees, according to a recent survey by the Purchaser Business Group on Health and the Kaiser Family Foundation. Based on the responses from key decision-makers at 302 large private employers with at least 5,000 employees, the survey found that 87% of respondents believed the cost of providing health benefits will become unsustainable in the next five to 10 years. Meanwhile, the majority of respondents said they were likely to implement cost-control practices, such as value-based benefit designs and use of an individual coverage health reimbursement arrangement (ICHRA).



SOURCE: "How Corporate Executives View Rising Health Care Cost and the Role of Government," Kaiser Family Foundation. Visit https://bit.ly/3eD1nlL.

Carriers Aim to Be Navigators

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Another new set of products comes from UnitedHealthcare, which in April introduced what it termed "various enhancements to its integrated approach to specialty benefits." For example, the insurer is offering a Net Cost Guarantee for self-insured firms and a premium savings program called uBundle for fully insured companies, both of which can save employers money by integrating medical and specialty benefits (e.g., vision, dental and disability).

Offering Delivers Automatic Payout

UnitedHealth also launched a program called BenefitAlly, which relies on data analytics to trigger an automatic payout to members when they experience a qualifying accident, critical illness diagnosis or hospital stay — provided their employer opts for medical and specialty coverage through the same carrier.

Finally, UnitedHealth says that later this year it will add vision, dental and financial protection aggregate claims information to its existing Health Plan Manager, which gives employers an "analytics-driven roadmap to help improve health outcomes, mitigate expenses and empower employees to take charge of their health."

Tom Wiffler, the CEO of United Healthcare's Specialty Benefits segment, tells AIS Health that the new products are aimed at making both employers' and employees' lives easier.

"Employers nowadays are really looking for simplicity when it comes to all aspects of benefit offerings [and] administration, and really making sure that the plans they do purchase are targeted at the right things within that employee population so that those employees can really stay focused on what's important, which is contributing to their own business — not being distracted by health care administrivia and trying to be their own navigator," Wiffler says.

Health insurers have increasingly been rolling out such products ever since "disrupters" such as Accolade, Inc. came on the scene and promised to do a better job than traditional carriers at helping customers navigate the health care system, says Mark Hope, senior director of health and benefits at Willis Towers Watson.

Those disrupters "got into the market and started pushing and nudging, and the carriers kind of looked at what was going on and said, 'OK, we can probably do better,'" Hope tells AIS Health. As a result, "they've all got products and they've been pushing the products for a number of years, to varying degrees of success."

Products Aren't 'One Size Fits All'

Hope says such offerings from carriers usually come in varying levels — low, medium and high touch in terms of member interventions — and have price points to match.

"Not everyone's going to jump to the most expensive model because they might not need it or might not want to pay for it, but you can start with something that's maybe a lighter version of that all-in model that still gives you a lift from where you are today," he explains.

Blue Cross Blue Shield of Michigan used such a strategy when designing its Coordinated Care portfolio, wagering that different employers would have varying budgets and needs, says Aji Abraham, vice president of health plan business and market solutions. In fact, the Blues plan is aiming to take a proactive approach in its discussion with employers, telling them that "based upon your prior experience, based upon what the data shows, based upon the needs of your membership, and to some degree, based upon the geography where your membership is and the state of the health care system in that geography, we think this is the right solution for you," Abraham tells AIS Health.

The Blues insurer is initially rolling out the Coordinated Care portfolio to large, self-funded employers and selling "at least some pieces of it" as a buy-up, according to Abraham. Such firms are known to be especially concerned about the rising cost of health care (see infographic, p. 6). "The ultimate vision, though, is to find a way to make this cost effective enough that we can drive it to potentially all segments of the business," he says.

While the new suite of products has only been available for a few months, some large firms have already signed on, and "we're in the midst of a bunch of RFPs [requests for proposals] where this is a piece under consideration and something that the employers are actively examining," Abraham says.

Cost Concerns Linger for Employers

On the one hand, the COVID-19 pandemic has heightened employers' appreciation for the value of health benefits and helping workers navigate the health care system, Abraham adds. But he also points out that many employers are in "a cost-sensitive environment right now" given the economic effects of the pandemic. "So I don't want to leave the impression that they have unlimited dollars they can spend, but they are looking at what they can do to help keep their members healthy."

Similarly, Wiffler says employers are showing interest in UnitedHealth's new offerings.

"We've had [a] tremendous response," he says. "We've been on this journey of more seamlessly integrating benefits — both administratively and clinically — but we've gotten even more interest from employers and distribution partners (brokers and consultants). We're not just touting these capabilities; we're putting our money where our mouth is vis-à-vis the net cost guarantee. We're willing to commit that when you bundle with UnitedHealthcare, you may save up to 4% in your annual medical costs, so that resonates."

Wiffler also has high hopes for the BenefitAlly offering.

"We think this is a game-changer because many times these benefits are selected at the point of annual enrollment, and members don't realize they have them," he says. "So, they may have an accident or they may have a cancer diagnosis — things that would really shake them both physically and many times financially. What we've decided is, we can be much more proactive, we've developed the automated processes to enable a check being cut, and oftentimes it's the difference between a person having to make a choice between paying a medical bill or a mortgage, or cutting back on a grocery run. It's been great for us to see how we can use technology to make these benefits really come to life."

Hope observes that among the employers that have already implemented insurers' care coordination solutions, the experience has been mixed. "We've seen some that are very successful — either with the way that it was rolled out or how it's being managed by clients or the consultants that they're working with — and some where they're kind of doing OK and where you find opportunities for improvements and you make the checklist and you start pushing it down," he says. Typically, there's room for improvement in how members are being connected with third-party solutions that a client has plugged in, such as platforms that manage diabetes or musculoskeletal conditions.

Still, "for many, we've been pleasantly surprised at how impactful they have been at getting people to the right places," Hope says.

Read about UnitedHealth's offerings at https://bit.ly/2SFB9GI and the Michigan Blues' at https://bit.ly/3w6PIBD. Contact Abraham at aabraham2@bcbsm.com, Hope via Ed Emerman at eemerman@eaglepr.com and Wiffler via Martin Elder at martin.elder@sweeneyvesty.com. ✧

by Leslie Small

News Briefs

✦ ***Centene Corp. has appointed Drew Asher as its new chief financial officer (CFO) and executive vice president, replacing Jeffrey Schwaneke, who is rotating to manage the firm's HealthCare Enterprises venture capital division***. Asher joined Centene in early 2020 when the company acquired WellCare, where Asher was CFO for six years. In the year since, Asher has managed Centene's Specialty division. Schwaneke will help manage "a portfolio of high growth companies independent of Centene health plans, designing differentiated platform capabilities and delivering industry-leading products and services to third-party customers." Read more at https://bit.ly/2SFFzxg.

✦ ***Amazon.com Inc.'s Amazon Care subsidiary closed its first deal to offer app-based care services to an employer,*** according to press reports. The contract is with fitness equipment firm Peloton Interactive, Inc.'s recently acquired subsidiary Precor. The tech and e-commerce giant revealed in March that it would make Amazon Care available to enterprise clients which, like Precor, are based near Amazon's Seattle headquarters, and said it will eventually roll out employer offerings nationwide. Press releases from Amazon have positioned the employer-facing offering as an in-network, virtual primary and urgent care provider for self-insured employers. Read more at https://bit.ly/33G6ewb.

✦ ***Paramount Advantage, a health plan subsidiary of integrated health system ProMedica, is suing the Ohio Dept. of Medicaid over the state's decision to not renew its Medicaid managed care contract.*** Lori Johnston, president of Paramount Health Care, told the Columbus Dispatch that the decision could force the payer to lay off 1,000 workers. Affiliates of UnitedHealth Group, Humana Inc., Molina Healthcare, Inc., AmeriHealth Caritas, Anthem, Inc. and CareSource all won contracts, while Centene Corp.'s proposed award was deferred due to an ongoing lawsuit in which the state accuses the firm of overcharging for PBM services. Read more at https://bit.ly/3fkkL66.