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California Awarded $2.7M Federal Grant to Design Health Care Payment Reform Model

Goal of Reducing Health Care Costs and Improving Californians' Quality of Health

Sacramento – The California Health and Human Service Agency (CHHS) today announced that the state is being awarded a State Innovation Model (SIM) Design Grant of $2,677,693 by the Center for Medicare and Medicaid Innovation (CMMI). This grant will be used to develop a State Health Care Innovation Plan (SHCIP) to improve health care quality and reward value versus volume by changing payment structures.

"California continues to lead the nation in health care reform and today's grant award reinforces the support and confidence the federal government has in the Golden State," said California Health and Human Services Secretary Diana S. Dooley. "We will work with our partners to design a payment reform model that will maximize the value of health care, where value is defined as better quality at lower costs."

This effort will move the state towards the triple aim of 1) improving the health of Californians, 2) improving health care quality and delivery, and, 3) lowering health care costs. The SHCIP will form the basis for a potential second round of funding in 2013 to test California's selected payment reform model over a three-year period.

The SIM Design Grant complements the goals of the recent release of the Governor's Let's Get Healthy California Task Force Report, which outlines a ten year blueprint to make California the healthiest state in the nation and reduce health care costs. The Task Force's goals and priorities will be used as a basis for the State Health Care Innovation Plan. In anticipation of this grant, the California Health and Human Services Agency formed six private sector work groups in line with the Let's Get Healthy California six strategic goals; the work groups will develop private sector implementation strategies and policy recommendations for the SHCIP. Health care payment reforms under California's SIM initiative will maximize the value of existing expenditures rather than invest new funds to reform care delivery.

For more information about Payment Reform Innovation, please visit: www.chhs.ca.gov/Pages/PayRefinnovat.aspx.

Multi-Stakeholder Health Care Payment Reform in California

Framing Report for California's State Innovation Model Design Grant Workgroup

January 2013

Anna Davis, MPH and Peter Long, PhD

Prepared for the California Health and Human Services Agency

Funded by Blue Shield of California Foundation

Multi-Stakeholder Health Care Payment Reform in California

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This report was funded by Blue Shield of California Foundation.

This paper draws on the ideas and research of many practitioners and researchers, whose work is cited throughout. Any errors, omissions, or misrepresentations are the sole responsibility of the authors.

Acknowledgments

We would particularly like to thank the following individuals for their contributions to the ideas and information in this report: Ann Boynton, Mari Cantwell, Francois de Brantes, Suzanne Delbanco, Christine Eibner, Neal Halfon, Katherine Johnson, Neva Kaye, Peter Lee, Jeffrey Levi, Arnold Milstein, Len Nichols, Patricia Powers, Steve Shortell, Jan Spielberger, Diane Stewart, Mary Takach, and Tom Williams.

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EXECUTIVE SUMMARY

Background

There is growing interest in the development of coordinated, multi-purchaser initiatives to reshape care delivery and reward value in health care by changing payment structures. Health care costs in the U.S. are growing at an unsustainable rate, and threaten the country's ability to invest in other priorities such as education and infrastructure. While cost increases are related to a confluence of factors, they are driven primarily by the way in which we organize and pay for care. In particular, many commentators agree that the fee-for-service (FFS) payment structure and high levels of administrative waste are key contributors to cost growth that could be mitigated by payment reform.

The State Innovation Model (SIM) initiative creates a unique opportunity for state-led multi-purchaser payment reform. California applied for a six-month SIM Design Grant from the Center for Medicare and Medicaid Innovation (CMMI) at the Centers for Medicare and Medicaid Services (CMS). Assuming receipt of an award, under the SIM Design Grant the California Health and Human Services Agency (CHHS) will convene stakeholders to design a multi-payer health care payment reform initiative. The goal of payment reform is to maximize the value of health care, where value is defined as better quality at lower costs. In reforming provider payment systems, California seeks to achieve the triple aim of 1) improving health, 2) improving health care, and, 3) lowering health care costs.

The SIM initiative dovetails with the strategic vision of and the goals developed by the Let's Get Healthy California (LGHC) Task Force, which will inform California's approach to the SIM initiative. Using the six goals of the LGHC final report as a framework, CHHS will establish work groups to develop implementation strategies and policy recommendations relating to each goal. Payment reform was highlighted in the LGHC's report under goal six, which focuses on reducing health care expenditures. Together, the recommendations of the six workgroups will form the basis of a State Health Care Innovation Plan (SHCIP) required by CMMI. The culmination of the six-month design phase will result in the submission of a second proposal to

CMMI in the summer of 2013 to test California's selected payment reform model over a three-year period.

The charge for the work group convened around the SIM Design Grant and LGHC goal six will be to recommend a comprehensive payment reform strategy that moves the state toward value-based care; it will be informed by the recommendations of the other five workgroups. With a focus on reducing the rate of health care cost growth, payment reforms under California's SIM initiative will maximize the value of existing expenditures rather than invest new funds in the health care system.

The goal of this report is to set the stage for California's SIM Design Grant process by establishing a shared understanding of payment reform and a common set of resources. Specifically, this report is designed to:

- Establish a typology characterizing methods of provider payment in the health system and define terms related to each payment strategy;
- Describe past and current examples of payment and delivery system reforms in the U.S. and review existing evidence of effectiveness in achieving savings; and,
- Present initial considerations for California's Design Grant workgroup related to possible payment reform models.

Defining Payment Strategies

All payment strategies have inherent incentives which drive provider (and/or consumer) behaviors. By restructuring or targeting payments, it is possible to reshape incentives in a way that leads to greater value. While there are innumerable ways to describe health care expenditure reforms, the core array of strategies is fairly limited. Based on an extensive review of the literature, we have developed a typology of payment strategies with three major domains:

1. Providers are reimbursed for the delivery of services via a ***base payment model***, which may make payments for individual services or people or groups of services or people. Base payment models fall across a spectrum of integration, and include from the most to the least integrated: Global Budgets; Global Payments/Capitation; Condition-Specific Capitation; Bundled Episode Payments; and Fee-for-Service.

2. ***Complementary strategies*** are used to adjust the incentives of the base payment model. Complementary strategies may be grouped into two types:
    a) Methods that adjust payments to create or strengthen incentives in base payments and/or achieve a secondary aim like improving quality, coordination, or value, or advancing health information technology (Health IT). This category includes: Shared Savings/Shared Risk Agreement; Enhanced Payments for Additional Services; Pay-for-Performance; and Provider Warranty.
    b) Methods that provide decision makers (purchasers, providers or patients) with information and incentives to encourage them to make decisions based on relative value. This category includes: Reference Pricing; Tiered or Limited Networks; Value-Based Insurance Design; Technology Assessment/Evidence-Based Purchasing; and Performance Reporting.

3. Investments are made to ***improve health outcomes at a population level.*** This domain of non-clinical preventive and wellness initiatives includes: Global Budgets; Wellness Trusts; Social Impact Bonds; and Community Health Collaborative/Health in All Policies programs.

Status of Payment Reform in the U.S.

Payment reforms have been increasingly implemented throughout the U.S. in both the public and private sectors. There are numerous ways to structure payment reforms, customizing and combining approaches to address the structure of a particular health care delivery system. Most examples of payment reform initiatives have used complementary strategies to modify incentives of existing base payment arrangements rather than altering the base payment. However, there are growing numbers of programs that are attempting to make more fundamental changes to base reimbursement models. Most commentators argue that reforms to base payments are necessary to achieve significant changes in the rate of growth in total health care costs.

Despite the large number of payment reform initiatives nationally, the current evidence for cost savings associated with any payment reform model is thin. Some of the best evidence for the

potential savings associated with payment reforms is based on projection models rather than analysis of specific initiatives. Limited evidence of its effectiveness should not be seen as an argument against reform; it is clear that restructuring provider payments is necessary, and a major goal of the SIM initiative is to generate additional evidence from participating states about effective approaches to payment reform.

Considerations for California's SIM workgroup

Given the typology of payment reform options, limited evidence regarding payment reform from around the nation, and California's unique health care environment, California's SIM Design Grant workgroup might consider the following key issues when evaluating a payment reform strategy:

- The merits of a regional approach
- Provider and purchaser readiness
- Price setting and implementation costs
- Maximizing administrative efficiency
- Targeting interventions to specific populations or services
- Protecting vulnerable populations
- Market consolidation and the regulatory framework
- Consumer perceptions
- Framework for defining costs and savings
- Aligning payment reforms and incentives

Building a broad, multi-purchaser collaborative will be essential to increasing alignment among payers, reducing average administrative costs, and incentivizing purchasers to make investments for the greater common good. The SIM Design Grant workgroup should consider establishing agreement on basic principles of reform and desired provider incentives. This may help the work group to identify a strategy for payment reform in California that can achieve broad adoption across the public and private sectors.

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BACKGROUND

There is growing interest in development of coordinated, multi-purchaser initiatives to reshape care delivery and reward value in health care by reforming payment structures. To this end, the Center for Medicare and Medicaid Innovation (CMMI) at the Centers for Medicare and Medicaid Services (CMS) created a State Innovation Model (SIM) funding initiative. CMMI will support states' efforts to "design and test multi-payer payment and delivery models that deliver high-quality health care and improve health system performance" [1]. One of the goals of CMMI's SIM initiative is to leverage a state's convening role to drive large-scale reform initiatives that can transfer the "preponderance of care" in the state to models that reward value and have potential to reduce costs and improve quality [1].

California applied for a six-month SIM Design Grant from CMMI. Assuming receipt of an award, under the Design Grant the California Health and Human Services Agency (CHHS) will convene stakeholders to design a multi-payer health care payment reform initiative. The Design Grant is expected to result in submission of a second proposal to CMMI in the summer of 2013 to test California's selected payment reform model. This Implementation and Testing Grant, if awarded, could provide between $20 million and $60 million in federal support over a three-year period [2].

The goal of this report is to set the stage for California's SIM Design Grant process by establishing a shared understanding of payment reform and a common set of resources. Specifically, this report is designed to:

- Establish a typology characterizing methods of provider payment in the health system and define terms related to each payment strategy;
- Describe past and current examples of payment and delivery system reforms in the U.S. and review existing evidence of effectiveness in achieving savings; and,
- Present initial considerations for California's Design Grant workgroup related to possible payment reform models.

Why is Payment Reform Needed?

The need for payment and delivery system innovation is derived from unsustainable growth in health care expenditures, which threatens the country's ability to invest in other priorities such as education and infrastructure [3]. Health care costs in the U.S. currently comprise approximately 18 percent of Gross Domestic Product (GDP) [4], more than $8,000 per person per year on average, and far exceed spending in other developed nations [5]. Despite these high expenditures, it is generally acknowledged that the U.S. is not a global leader in health outcomes at a population level. This issue is of particular urgency for local, state, and federal governments, which cover roughly half of current health care expenditures [4].

While cost increases are related to the confluence of a number of factors [3], they are driven primarily by the way in which we organize and pay for care. In particular, many commentators agree that a primary underlying reason for health care cost growth in the U.S. is the fee-for-service (FFS) payment structure [6-8]. FFS payments reward providers based on the volume of care they deliver. They fail to create incentives to promote quality and coordination of care, and commonly result in inefficient overprovision of services.[9, 10] Furthermore, FFS payments may lead providers to marginalize potentially beneficial services or activities that are not reimbursable or are poorly reimbursed [11]. In addition to the FFS payment system, there are other major drivers of cost growth that could be mitigated by payment reforms, including administrative complexity, fragmentation of care, and lack of provider competition.

The goal of payment reform is to maximize the value of health care, where value is achieved by simultaneously optimizing both quality and costs [9]. A common approach to payment reform is to reduce expenditures by restricting the quantity of services rendered [12]. This can be achieved by limiting health benefits, increasing cost-sharing (co-insurance, co-pays and deductibles), and tightening eligibility criteria among other tools [12]. These methods may lead to near-term savings for purchasers, but they can discourage beneficiaries from using valuable and appropriate services and potentially lead to longer-term cost growth. More systematic and coordinated approaches to reduce health care expenditure growth are advocated widely and have potential to achieve desired improvements in value. It is these latter approaches that provide the framework for the SIM initiatives funded by CMMI.

The Case for Multi-Purchaser Collaboration

While there are numerous examples of payment and delivery system reform programs being operated in the U.S. currently, many programs are implemented on a small scale and involve a specific purchaser and/or a targeted population subgroup. A multi-payer approach to payment reform is ideal for many reasons, including:

- Providers typically have many separate contracts with different payers, with differing contractual requirements, payment levels, and payment strategies. Providers may be more likely to alter practice patterns toward value-based care as the proportion of their business that incentivizes value increases [6].
- Many payment reforms create administrative burdens for providers and administrators; coordinated reforms that create uniform goals and measures across payers may reduce administrative burdens [6].
- Payers and purchasers rarely retain patients over the long-term. Since no individual remains insured by the same payer throughout their lifespan, there is arguably a lack of incentive for insurers to make investments that have delayed benefits (in some cases for decades), and therefore may not yield a return on investment for the insurer who covered the preventive service [13-15]. Payers may be more likely to participate in reforms that will yield delayed returns if other payers make similar investments.

If, for example, a provider receives a relatively modest pay-for-performance payment for meeting quality targets, the impact of the payment will be greatest if it is available for a large proportion of the provider's patients. The critical mass concept holds for many payment strategies, as they may require providers to alter care patterns, data systems, and business practices. These changes on the part of the provider have associated costs and are more likely to be acceptable if a substantial financial incentive is associated with change [6].

State Innovation Models: An Opportunity to Innovate

CMMI created the SIM initiative for "states that are prepared for or committed to planning, designing, testing, and supporting evaluation of new payment and service delivery models in the context of larger health system transformation" [1]. SIM initiatives are expected to include

public purchasers (at least Medicare, Medicaid, and the Children's Health Insurance Program (CHIP)) as well as private payers [2].

CMMI described the Design Grant process as development of "a comprehensive approach to transforming the health system of a state, made up of 'payment and service delivery models'… that drive and reward better health, better care, and lower costs…[and] will also include a broad array of other strategies, including community-based interventions, to improve population health" [1]. The funding opportunity announcement (FOA) from CMMI suggested a wide array of potential strategies that states could consider as levers to influence the structure and performance of the health care system. The FOA also specified particular approaches as out of scope [2]. Relevant excerpted language from the FOA is included in Appendix A.

California's Approach to Payment Reform

In accordance with the vision set forth by CMMI, California seeks to establish a multi-payer collaborative reform effort that will impact the preponderance of care around the state. This may be achieved by impacting a large proportion of individual consumers or by reforming payments for a large share of total health care expenditures.

In reforming payments, California seeks to achieve the triple aim of 1) improving health; 2) improving health care; and, 3) lowering health care costs. The SIM initiative dovetails with the strategic vision of and the goals developed by the Let's Get Healthy California (LGHC) Task Force, which will inform California's approach to the SIM initiative. [16]. Using the six goals of LGHC's final report as a framework, CHHS will establish workgroups to develop implementation strategies and policy recommendations relating to each goal. Payment reform was highlighted in LGHC's report under goal six, which focuses on reducing health care expenditures. Together, the recommendations of the six workgroups will form the basis of a State Health Care Innovation Plan (SHCIP) required by CMMI.

The charge for the workgroup convened around the SIM Design Grant and LGHC goal six will be to recommend a comprehensive payment reform strategy that moves the state toward value-based care; it will be informed by the recommendations of the other five workgroups. Given the goal of the SIM initiative and the LGHC task force to reduce total health care costs, payment

reforms in California will focus on maximizing the value of existing expenditures. While any payment reform may experience initial start-up costs during early stages of implementation, the multi-payer reform initiative that California designs is expected to demonstrate overall cost savings within the three-year SIM testing phase.

The ultimate goal of the SIM initiative in California is to move the delivery of health care from a model that rewards volume of services to one that rewards value. By redirecting incentives in the health care delivery system and through other aspects of the State Health Care Innovation Plan, California seeks to constrain health care spending growth to the rate of general growth in GDP by 2022 [16].

DEFINING PAYMENT STRATEGIES

All payment strategies have inherent incentives which drive provider (and/or consumer) behaviors. By restructuring or targeting payments, it is possible to reshape incentives in a way that improves value. While there are innumerable ways to structure health care expenditure reforms, the core array of possible strategies and tools is fairly limited. Based on an extensive review of the literature, we have developed a typology of payment strategies with three major domains:

1) Providers are reimbursed for the delivery of services via a ***base payment model***, which may make payments for individual services or people or groups of services or people.
2) ***Complementary strategies*** are used to adjust incentives of the base payment model by:
    a) Adjusting payments to achieve a secondary aim like improving quality, coordination, patient experience, use of health information technology, or other dimensions of the triple aim; or
    b) Providing decision makers (purchasers, providers or patients) with information and incentives to encourage them to make decisions based on relative value.
3) Investments are made to ***improve health outcomes at a population level.***

Within each health care payment domain, we have characterized the range of specific models and strategies. A detailed discussion of each specific model within domains one through three is

presented below, including a summary of the key incentives and attributes of each model. Appendix B contains a summary table with a definition of each payment strategy.

(1) Base Payment Models: Payments for Individual Services or People or Groups of Services or People

The payment methods in this domain are the primary ways that providers are reimbursed for patient care. The base payment method is the central driver of provider incentives. Different payment methods are appropriate for various service types and settings. The specific manner in which a base payment agreement is structured can vary by pricing, scope of benefits, utilization management rules, and other parameters.

Base payment methods are arranged in this list from the most to the least integrated. Payments that combine financing for groups of patients or services are designed to encourage care coordination by changing the flow of funds between providers and incentivizing value over volume [17]. This is in contrast to the least integrated payment method, FFS or payment for each service provided. Each strategy is defined below, followed by summary tables highlighting the key attributes and potential challenges associated with each model.

Global Budgets

Under global budget agreements a total fixed budget is prospectively defined for the care of a specific population or organization (e.g., hospital) over a period of time. This budget is divided among individual providers of services. This method of payment creates an incentive for providers to keep costs within the total budget as their profit is based on the amount of unspent funds. Therefore global budgets can incentivize providers to limit both the level of expenditures per encounter and the number of encounters [7]. Providers may achieve these goals through a range of strategies, such as lowering cost structures, coordinating care, and focusing on prevention at the individual or population level.

Global Payment/Capitation

Global payments (also called "capitated rates") are prospective payments for the total cost of care per member, across settings and conditions and for a defined period of time [18, 19]. Global payments are designed to incentivize health systems to limit both the expenditures per encounter and number of encounters. Payment amounts are risk adjusted, and quality monitoring and reporting is inherent in the model [20].

Either "full" or "partial" global payment agreements can be established; full global payments constitute a single payment that encompasses the full array of providers including primary care, specialty, hospital, behavioral health, and ancillary services. Partial global payments can be limited to a specific portion of services or providers, such as physical health services or outpatient services [7]. The majority of existing capitated payments are partial agreements, with a substantial portion of care paid via FFS billing outside of the prospective global fee.

Condition-Specific Capitation

In this strategy, providers receive a prospective per-person payment for all of the care related to a specific condition (usually chronic) over a defined period of time [10]. A condition-specific capitation payment bridges all care settings and providers involved in treatment for the designated condition.

This method is most appropriate for conditions like diabetes, for which patients will have ongoing health care needs, and where coordinated and continuous management is integral to control the condition and avoid acute care episodes. It can also be used for "clusters" of conditions that frequently co-occur [19]. Condition-specific capitation creates incentives for the provider to limit the occurrence or reoccurrence of acute episodes and to invest in health maintenance and self-management of illness, thereby reducing the overall cost of care for the patient's condition. The payment amount varies between conditions and is risk-adjusted for the health status of the individual patient [10].

Bundled Episode Payments

Bundled or episode payments group reimbursement for all of the services used by a patient within a single episode of care related to a specific medical treatment or event [18, 19]. Most examples of bundled payments are for acute episodes, such as a total knee replacement or a heart attack, because these episodes can be clearly defined with start and end points [6]. Payments are made retrospectively based on occurrences of episodes of care. Bundles may include a period of time and services surrounding the index episode, such as 30- or 60-days post-discharge. Payments are risk-adjusted [8].

Bundled payments may bridge multiple care settings and providers, thus incentivizing coordination of care throughout the encounter. Bundling seeks to reduce costs by limiting the level of expenditures per encounter, but it does not address the number of encounters. Providers are not accountable for preventing occurrence or reoccurrence of the event/condition.

Fee-for-Service

As described above, FFS payments involve separate reimbursement for each service used by a patient. This is characterized by disaggregation of payments to a sub-encounter level, such that distinct reimbursements are made for each procedure, resource or facility service, and provider involved in any specific health care encounter.

FFS payments create a strong incentive for providers to deliver as many services as possible for each patient, and to see as many patients as possible. Therefore this mechanism of payment has been described as rewarding volume rather than value.

Summary of Base Payment Model Incentives and Attributes

These base payments are the core driver of provider incentives, and are used to pay for the bulk of services delivered to patients. Each model has inherent incentives and attributes which can lead to differing system and organizational behaviors, as shown in Table 1. All methods except FFS incentivize reduction in costs within each episode. Other than bundled payments, they also incentivize a reduction in the number of episodes.

Table 1: Key Attributes of Base Payment Models

	Crosses Organizations	Crosses Providers	Crosses Conditions	Incentivizes Reduction in Number of Episodes	Incentivizes Reduction in Cost per Episode
Global Budget	✓	✓	✓	✓	✓
Global Payment/Capitation	✓	✓	✓	✓	✓
Condition-Specific Capitation	✓	✓		✓	✓
Bundled Episode Payment	✓*	✓*			✓
Fee-for-Service					

✓ = attribute of the model. ✓* = potential but not necessary attribute of the model.

Table 2 summarizes potential key prerequisites, challenges and benefits associated with partially or fully integrated base payment models, relative to FFS payments. As shown, many of the more aggregated payment methods share common characteristics.

Table 2: Specific Prerequisites, Benefits and Challenges of Base Payment Models Relative to FFS Payments

		Global Budget	Global Payment / Capitation	Condition-Specific Capitation	Bundled Episode Payment
P	Requires an Overarching Organization to Manage Payments	✓	✓	✓	✓
P	Requires Insurance Risk Management for Providers	✓	✓*	✓*	
P	Requires Allocation of Patients	✓*	✓	✓	
C	Increases Incentive for Cost Shifting	✓	✓	✓	✓
C	May Harm Access and Quality	✓	✓	✓	✓
C	Increases Administrative Complexity		✓*	✓	✓
B	Increases Financial Predictability	✓	✓	✓	✓
B	Lowers Transaction Costs	✓	✓*		
B	Creates/Increases Incentives for Care Coordination and Quality	✓	✓	✓	✓

✓ = attribute of the model. ✓* = potential but not necessary attribute of the model.
P = Prerequisite, C = Challenge, B = Benefit.

All aggregated base payment methods may require an overarching organization or integrator. This entity takes on responsibility for the defined patient population, receives the aggregated payment, and distributes reimbursement among providers who participated in care delivery. This entity can be a Managed Care Organization (MCO) or an Accountable Care Organization (ACO), but other organizational structures are also able to manage payments of these types [21]. These organizations take on the risks associated with the aggregated payment, which can include both insurance risk – the risk associated with whether patients become sick or develop an illness that requires care, which is outside of the provider's control, and performance risk – the risks associated with their performance providing effective and efficient care to the patient [6].

Some providers may be unable or unwilling to manage insurance risk. However, under aggregated payment models, it is not necessarily clear how individual providers are reimbursed by the overarching organization. More information about the specific characteristics of provider contracts could help to clarify the incentives at the point of care. In many cases, providers may continue to bill via FFS methods, while the overarching organization receives an aggregated payment and uses other tools such as utilization management to contain costs. In these cases, risk does not necessarily reside with the individual provider, and practice patterns may be minimally changed by the aggregated payment.

Aggregated methods may also increase incentives for cost shifting and may reduce quality and access to care. In global budget agreements, these concerns are most relevant when the budget is defined below the population level. Per-person or per-case payments may lead providers to limit care in ways that could harm outcomes. This might occur if providers "skimp" on services, or if they reduce access by limiting hours or other means.

Models that make per-person payments require that patients be assigned to specific providers or provider organizations. This process, called "allocation," can be challenging in some settings and requires either claims-based allocation methodologies or prospective provider assignment/selection systems.

For aggregated payments that cover only a portion of each individual's care, there may be new administrative challenges related to defining "in-bundle" services [8]. This is true both prospectively when designing the payment agreement and retrospectively when making

payments. Capitated or bundled agreements must be clearly defined, which may lead payers and providers to under-specify the service package for the sake of precision and accuracy, leaving out indirectly related services (e.g., a heart attack in a diabetic patient may be partially attributable to diabetes, but not clearly so). For bundled payments in particular, this challenge may be partially mitigated by CMS' National Pilot Program on Payment Bundling and the Bundled Payments for Care Improvement Initiative. Under these programs, CMS is currently working with providers to establish episode-of-care definitions centered around a hospitalization [22-24]. These efforts may yield useful technical information for states and other purchasers interested in pursuing bundled payments, although the programs are still in early stages.

Financial predictability can be improved under aggregated payments, both for providers and for purchasers. Some aggregated payments may lower transaction costs, to the extent that they reduce or eliminate the need for adjudication of claims and other administrative oversight. Others may increase transaction costs. Finally, all integrated forms of base payments are designed to increase incentives for care coordination and quality of care. The strength of this effect is likely to increase as the level of payment integration increases.

(2) Complementary Strategies that Modify the Incentives of the Base Payment Model

Base payments can be refined via complementary strategies, which create or strengthen incentives that are not sufficiently supported by the base payment. Purchasers can use complementary strategies in various combinations to incentivize improvements in performance on quality, value, patient experience or other dimensions of the triple aim.

These strategies are grouped into two major classes: (a) those that adjust payments (either up or down) to achieve a specific secondary aim; and (b) those that provide decision makers (purchasers, providers or patients) with information and incentives to encourage them to make decisions based on relative value. Each strategy is defined below, followed by summary tables highlighting the key attributes and potential challenges associated with each model.

a) Strategies that Adjust Payments to Achieve a Secondary Aim

The primary goal of these complementary strategies is to improve provider performance over time, where performance can focus on any measureable domain such as quality, coordination of care, health information technology (Health IT) adoption, patient experience, or other goals. There are myriad ways to structure payment adjustments, which may depend in part on the nature of the base payment agreement. All of these methods result in a change in the amount of reimbursement that flows to providers. In a revenue-neutral framework, complementary strategies that increase payments would generally be funded by savings from another arena, service or provider.

Shared Savings/Shared Risk

In this strategy, providers are offered a portion of savings achieved for managing the care of a population, with savings based on a target cost benchmark. “Shared savings” agreements can be framed to also incorporate downside risk for providers, such that they are accountable for excess expenditures, thus “sharing risk” with the purchaser [21, 25].

Agreements that allow providers to share in savings and risk seek to increase incentives for high-value care and cost-containment. The most common use of shared savings and shared risk models is within an ACO, which is a single integrated organization that is accountable for the care and health of a defined population [21]. Shared savings/shared risk agreements can be used with most payment models to introduce provider accountability for total costs, and are often tied to particular quality targets in addition to financial goals [26].

Enhanced Payments for Additional Services

This strategy involves increased reimbursement for desirable activities, such as care coordination or patient follow-up. Payments may be enhanced by increasing base payment rates, offering per member-per month (PMPM) bonus payments, or defining newly reimbursable services [6].

A key example of this strategy is the medical home model, in which primary care providers receive enhanced payments to support a higher level of care [6, 27], either for the general population or for specific targeted populations such as those with chronic illness. Supplemental

payments to medical homes are often in the form of additional PMPM payments layered over the underlying FFS system.

Pay-for-Performance

Pay-for-performance (P4P) programs are agreements that establish financial rewards or penalties tied to performance on quality-of-care benchmarks [7]. P4P agreements may focus on meeting specific targets or on improvements over historical performance. Commonly, P4P initiatives are based on process or outcome measures of quality or patient satisfaction, although some innovations in P4P that incorporate cost of care are being implemented [28].

P4P agreements allow purchasers to target specific desired care processes. Many providers already participate in P4P programs under Medicare. Two alternative takes on P4P can be found in practice: penalty arrangements and pay-for-reporting programs.

Penalty Arrangements: Downward Payment Adjustments for Lapses in Quality

This variation on traditional P4P penalizes providers for quality failures, such as the occurrence of "never events" (serious adverse events that are preventable and should never occur) or hospital-acquired conditions [29]. Such programs establish unacceptable outcomes for which providers will not be reimbursed. An alternative approach penalizes providers who do not meet specified quality targets by reducing the underlying base payment by a set amount (usually 1-2 percent) for each year of poor performance.

Pay-for-Reporting

An intermediate step toward true P4P or other reform strategies, pay-for-reporting programs offer incentives to providers in return for submitting data to purchasers or other authorities. Most hospitals currently participate in pay-for-reporting under Medicare.

Provider Warranty

In this strategy, providers explicitly agree to a warranty for their services, such that they must absorb the cost of specific pre-defined failures in care. This method is often used with bundled episode payments or condition specific capitation [30]. Warranties are best suited for care that is

associated with clearly defined complications that may be preventable and are in the provider's control (as opposed to negative outcomes due to patient behavior or other factors).

Warranty agreements can be structured such that the base payment agreement is unchanged, but subsequent payments for complications would be limited, thus requiring the provider to share in the costs. An alternative model would prospectively increase the provider's base payment to include a portion of the predicted costs of potentially avoidable complications. If few or no complications occur, the provider retains the additional payment as revenue/profit; however, if complications do occur the provider will be accountable for the excess costs [30].

b) Strategies that Provide Decision Makers with Information to Allow Them to Make Decisions Based on Relative Value

This second category of complementary strategies uses information to realign the decision making processes of purchasers, providers and consumers. This category includes several "benefit design" tools that strategically modify covered benefits and cost-sharing.

Several strategies create financial incentives for consumers [6]. In most insurance settings (except high-deductible coverage), patients are blinded to cost because they pay a set amount (e.g., a defined co-payment) regardless of the cost of the service. These methods generally attempt to address this feature of insurance by increasing the price sensitivity of consumers.

Reference Pricing

In reference pricing, a purchaser establishes a uniform payment for a specific drug, procedure, service, or bundle of services, which then applies to all providers. Sometimes called a "reverse deductible," it establishes a set maximum amount the purchaser will contribute toward a particular service. Consumers who use a provider charging more than the reference price are required to pay the difference out-of-pocket [31].

This method reduces variation in paid prices. Options for price setting include the median price or the cost of the lowest-price alternative. However, reference prices always incorporate quality standards [31]. A modified version of reference pricing defines a "cap" on potential payment for

a specific service and allows providers to bid rates at or below that level thus achieving "below reference" costs.

Tiered or Limited Networks

Tiered provider networks establish cost- and quality-based classes of providers. Purchasers rank providers into value tiers and use corresponding cost-sharing tiers to make consumers more price-conscious [7, 32]. This method is similar to reference pricing in concept, but is not specific to individual services or bundles of services. Rather, providers such as hospitals are ranked for overall performance [33]. In some applications of tiered networks, lowest-tier providers may eventually become excluded from the network if they fail to improve value over time.

A targeted application of tiered network design (often called "Centers of Excellence") designates high-value providers and restricts beneficiaries to these providers for specific services. This method "channels" patients to specific providers and increases purchasers' negotiating leverage. In some cases purchasers cover travel expenses for patients, and designate Centers of Excellence in low-volume markets that are willing to accept lower payments in return for increased business [34].

Value-Based Insurance Design

In value-based insurance design, purchasers make strategic adjustments to cost-sharing to encourage use of high-value services [32]. This method generally focuses on eliminating or lowering cost-sharing for desirable service use, through initiatives such as formulary management or preventive care promotion programs [35]. The Affordable Care Act employs value-based insurance design in eliminating cost-sharing for preventive services.

An alternative strategy in value-based insurance design offers a cash payment incentive to consumers in return for compliance with desired behaviors, such as quitting smoking, completing a medication regimen, or participating in self-management education programs [36, 37].

Technology Assessment/Evidence-Based Purchasing

Technology assessment programs use comparative effectiveness studies to assess the value of specific services. Such programs are designed to address the prevalence of technologies with

limited efficacy that are widely used [32]. Comparative effectiveness assessments can be used to inform a variety of decisions and actions by consumers, providers, and/or purchasers, including: development of publicly reported ratings or provider decision-support tools such as practice guidelines; exclusion of specific services from benefit packages; or strategic changes in cost-sharing.

This process may be applied to a range of health care services, including surgical devices and procedures, medical equipment, and diagnostic tests [38]. Several states or other entities have pursued evidence-based purchasing that includes cost-effectiveness data [39, 40], and some experts argue it is an essential step for Medicare to pursue [41].

Performance Reporting

In this method, quality and/or price data are disseminated to consumers. Comprehensive price information including provider-specific estimates of out-of-pocket costs for consumers may incentivize consumers to select more affordable or higher quality providers, particularly if the consumer has a high-deductible insurance plan [42]. Purchasers can employ price transparency tools to complement other methods in this category designed to promote value-based care decisions.

Summary of Complementary Strategies that Adjust the Base Payment Model

Complementary strategies can be combined with base payments and with each other to fine-tune the incentives experienced by providers and consumers. Table 3 highlights the attributes of complementary strategies as they are most frequently structured. Although some of the strategies are generally structured to focus only on quality (which may include coordination and safety goals), these could be designed to incorporate cost information and focus on value.

Table 3: Key Attributes of Complementary Strategies

	Focuses on:		Incentivizes:	
	Quality	**Value**	**Consumers**	**Providers**
Shared Savings/Shared Risk		✓		✓
Enhanced Payment for Additional Services	✓			✓

	Focuses on:		Incentivizes:	
	Quality	**Value**	**Consumers**	**Providers**
Pay-for-Performance	✓			✓
Provider Warranty		✓		✓
Reference Pricing		✓	✓	✓
Tiered or Limited Networks		✓	✓	✓
Value-Based Insurance Design		✓	✓	
Technology Assessment/Evidence-Based Purchasing		✓		
Performance Reporting	✓		✓	✓

✓ = attribute of the model.

Each of the complementary strategies has a number of prerequisites and potential challenges. These tools do not make fundamental changes to provider payment agreements and may therefore be easier to implement from an administrative and political standpoint. However, they are less likely to result in significant changes to health system functioning. In addition, they generally add to the complexity of payment systems and can be technologically challenging to implement.

Additional prerequisites and challenges specific to each model are listed in Table 4.

Table 4: Prerequisites and Potential Challenges Associated with Complementary Strategies

Strategy	Key Prerequisites and Potential Challenges
Shared Savings / Shared Risk	• Requires patient allocation • May cause providers to avoid high-risk/high-cost patients without adequate risk adjustment • Savings are highly sensitive to method of projecting expenditures • Calculation of savings/risk payments may be delayed by several years • Unclear how to structure agreements after initial “savings” have been achieved
Enhanced Payments for Additional	• Requires patient allocation • Must be funded through savings from other areas to be budget neutral • Does not change volume-based incentives when used with FFS base payments

Strategy	Key Prerequisites and Potential Challenges

Services	• Generally not thought to be a cost-containment strategy in the near-term
	• The medical home model specifically:
	  o Does not directly impact inpatient and specialty care patterns
	  o May be hard for smaller practices that do not meet standards
	  o Enhanced levels of care may not be appropriate for the general population

Pay-for-Performance	• Requires measure definition and data collection; can be administratively burdensome • Real causes of gaps in quality (lack of time or knowledge, fatigue, failures of teamwork) may not be addressed by this method [36, 43] • Improvements in reporting/documentation may be more likely than true improvements in quality/outcomes • May simply reward already high-performing providers • May cause providers to avoid high-risk/high-cost patients without adequate risk adjustment • Must be funded through savings from other areas to be budget neutral • Does not change volume-based incentives when used with FFS base payments
Provider Warranty	• May cause providers to avoid high-risk/high-cost patients without adequate risk adjustment
Reference Pricing	• Method for setting reference price may be complicated; can result in paying some low-cost providers more than they would otherwise receive • Harder to ensure quality standards • Requires extensive consumer education about financial consequences • Requires consumer protections to preserve access to care • May not be feasible in rural areas/areas with limited competition • May not alter behavior of high-income consumers who are less price-sensitive
Tiered or Limited Networks	• Harder to ensure quality standards • Requires extensive consumer education about financial consequences • Requires consumer protections to preserve access to care • May not be feasible in rural areas/areas with limited competition • As providers improve over time, tiers may become more alike

Strategy	Key Prerequisites and Potential Challenges
	• May not alter behavior of high-income consumers who are less price-sensitive
Value-Based Insurance Design	• Services should be carefully selected based on: o Evidence of long-term benefits o Evidence of underuse due to cost barriers • May increase short-term costs as utilization increases in response to reduced cost-sharing • Unclear whether increased utilization of the targeted service (and associated increases in costs) will result in savings in other areas
Technology Assessment / Evidence-Based Purchasing	• Can be costly to conduct adequate comparative effectiveness studies • Some consumers and advocates may object to coverage decisions that incorporate cost data
Performance Reporting	• Unclear whether information alone will influence consumer behavior • Not sustainable because eventually all or most providers will become compliant at which point payments no longer incentivize improvement

(3) Investments to Improve Health Outcomes at the Population Level

This final category of system and payment reforms channels funds toward strategic investments in prevention and wellness initiatives with the goal of improving population health and reducing preventable illness. These investments have the potential to produce long-term savings with delayed but potentially substantial return on investment.

For the purposes of this report, this third category of expenditures will be limited to *non-clinical* prevention and wellness efforts. This includes expenditures such as workplace wellness and hospital community benefit programs, but excludes preventive services and screenings offered by health care providers. Therefore, these strategies do not constitute forms of provider payment, but are rather overarching health system expenditures. A broader conceptualization of this category of reform is possible, but it falls outside the scope of California's SIM initiative.

In a budget-neutral setting, investments for non-clinical prevention and wellness programs may be funded through savings from other areas or may focus on coordinating, redirecting, or restructuring existing expenditures for prevention and wellness. The following section describes specific reforms that invest in population health.

Global Budget

The concept of global budgets, which was discussed as a base payment strategy, carries inherent incentives to promote population health. When a single total budget for health care expenditures is established, providers have a strong incentive to prevent illness. Global budgets could theoretically be structured to incorporate both health care and public health funding streams, thus further integrating these domains of health expenditure and encouraging investments for population health.

Wellness Trust

Wellness trusts can be generally defined as a public health fund managed by a coalition or board that distributes money for prevention and wellness activities at the population level. Wellness trusts can be funded through a range of mechanisms and can vary in scope and size.

State-led wellness trusts would identify prevention priorities and fund agencies and community partners to carry out programs in those areas. Current expenditures made by the health care system, such as hospital community benefit programs [44] or prevention and wellness investments made by employers, health plans, and purchasers could be redirected to a wellness trust. The advantages of organizing these expenditures within a wellness trust are pooling of resources, unified goals and objectives, and coordinated and sustained effort.

A more extreme model for a wellness trust has also been suggested. This approach would create a network of national and state agencies that acts as the primary provider of prevention services in the U.S., carving them out of the health insurance system [14, 45]. This type of approach has not been attempted in the U.S. to date.

Social Impact Bond

A social impact bond is a relatively new concept in which private and philanthropic funders invest in programs designed to meet social goals or promote health and wellness. The programs are delivered by a contracted provider, often a nonprofit. If the program ultimately meets performance targets, the public sector reimburses investors for the program [46, 47]. Currently being implemented in the United Kingdom and in select examples in the U.S. [48-52], and recently given a boost by the White House [53], this method creates a risk-free opportunity for governments to support innovative prevention or social programs, ensuring that they only pay for positive results.

Community Health Collaborative/Health in All Policies

A community health collaborative involves representatives from a broad spectrum of fields including public health, health care, and community-based agencies. Using community monitoring, needs assessment, and shared goal setting, collaborators would work together to promote health outcomes at the community level [54]. This concept can be extended to several other frameworks, including a regional health improvement collaborative [55] or a health in all policies framework, which would incorporate health and wellness objectives into both health and non-health sector policies, programs and expenditures, such as community development funds [56]. This approach, which would not redirect money from the health system, could nevertheless improve population health outcomes. It would use health impact assessments sponsored by states or other convening organizations to incorporate health-related factors into decisions related to infrastructure, housing, education policy, and other arenas, thereby addressing non-healthcare determinants of health including social and environmental factors [57-59].

EXISTING PAYMENT REFORM INITIATIVES AND POTENTIAL COST SAVINGS

Payment reforms have been increasingly implemented throughout the U.S. in the public and private sectors. There are innumerable ways to structure payment reforms, customizing and combining approaches to address the structure of the health care delivery system. Most examples

of payment reform initiatives have used complementary strategies to modify incentives of existing base payment arrangements, rather than altering the base payment. However, there are growing numbers of programs that make more fundamental changes to base reimbursement models. Most commentators argue that reforms to base payments are necessary to achieve significant changes in total health care costs. In general, movement toward more aggregated or integrated payment systems is supported by health care financing experts.

This section of the framing report describes payment reform experiments around the U.S. This is not intended to be an exhaustive list of payment reform initiatives; rather it is designed to provide an overview of the general status of payment reform, to describe the major reforms that are currently in place, and to characterize the strategies that are most commonly used by public and private purchasers. It is important to note that the vast majority of initiatives listed in this section have not been evaluated and therefore no evidence is available regarding their effectiveness. All payment reform demonstrations are further described in Appendix C.

After providing an overview of payment reform activity, this section summarizes the state of current evidence related to the potential or actual results of different strategies, including both cost savings and health outcomes.

Examples of Payment Reform Initiatives

Programs that Alter the Base Payment Method

We identified a range of programs that change the base payment made to providers for a specific patient population or array of services. Appendix C Table 1 contains a summary listing of all identified programs with references to additional resources for each.

Global budget agreements can be found in Oregon [60-62], Massachusetts [63-66], and Minnesota [67, 68], but are relatively uncommon in the U.S. In contrast, global payment/capitation is commonly used, and some extensions of this method to new populations or payers are occurring such as California's Coordinated Care Initiative for dual eligibles [69]. Medicare is operating several major demonstrations in the area of bundled payments focused around inpatient episodes [8, 10, 22, 64, 70-73]. Other bundled payment initiatives include Prometheus payment [74-76], Integrated HealthCare Association Bundled Episode Payment and

Gainsharing program in California [11, 74, 77], and the ProvenCare program in Geisinger Health System in Pennsylvania [64, 74, 78, 79].

Appendix C Table 2 contains more detailed descriptions of selected payment reform initiatives within this domain.

Programs that Use Complementary Strategies to Adjust Incentives of the Base Payment Model

There are numerous examples of programs using complementary payment strategies to increase incentives for quality and coordination, or to encourage value-based care decisions. Appendix C Table 3 contains a summary listing of all identified programs with references to additional resources for each.

Shared savings programs, usually supported by an ACO model, exist in several settings, and are being piloted by Medicare nationally [8, 63, 71, 80, 81]. Several of these programs have achieved savings, and evidence of improved health outcomes also exists. Medical home initiatives that make enhanced payments for additional services can be found in almost any purchaser setting and vary substantially in program design. Savings in several programs have been reported, often in multi-payer settings or in initiatives targeted to chronically ill populations [82-85]. There is also some evidence of savings based on P4P programs although most experts agree that this method alone is rarely associated with substantial savings.

Among strategies that provide information to decision makers to allow them to make decisions based on relative value, reference pricing is the most commonly associated with savings (Appendix C Table 3). Value-based insurance design and tiered networks are common strategies in employer-led payment reforms [35]. There are several examples of other program strategies within this category, but most have not been shown to result in savings or improved health outcomes.

Appendix C Table 4 provides more detailed descriptions of selected payment reform initiatives within this domain.

Programs that Make Investments to Improve Health Outcomes at a Population Level

Two states have established programs that redirect money from the health care system toward population-level prevention and wellness initiatives (Massachusetts [86, 87] and North Carolina [88-90]). Evidence of savings has been established for North Carolina's program only; the others have not yet been the subject of publicly available systematic evaluation. Movement toward use of social impact bond programs also exists although this is a relatively new area of innovation and most programs are still in conceptual phases [46].

Appendix C Table 5 contains a summary listing of all identified programs with references to additional resources for each. Appendix C Table 6 provides more detailed descriptions of selected payment reform initiatives within this domain.

Payment Reform in California

Many payment reforms are already underway in California through Medicare, Medi-Cal, the current §1115 Waiver, Integrated Healthcare Association (IHI), California Public Employee Retirement System (CalPERS), Pacific Business Group on Health, and numerous commercial initiatives [71]. Many specific strategies for payment reform have been piloted in California, including global payment, bundled payment, shared savings/shared risk within an ACO infrastructure, medical home enhanced payments, reference pricing, tiered and limited networks, and P4P.

Interest in a single payer system exists in California. This approach, as envisioned most recently in 2011 by Senate Bill 810 (Leno) (which did not pass the third reading), would establish a single public entity that negotiates or sets fees and pays claims for all health care services, building upon California's existing payment infrastructure [91]. While this approach has potential merit in terms of health care costs and health outcomes, movement to a single-payer model in the absence of other payment reforms does not substantially alter the incentives experienced by providers and consumers and is unlikely to significantly reduce growth in health care costs.

In California, few reform initiatives are coordinated between payers and populations. The SIM initiative provides an important opportunity to develop and test multi-purchaser payment reforms at a regional or statewide level.

Summary of Available Evidence of Effectiveness

Despite the large number of payment reform initiatives nationally, the evidence base for cost savings associated with any payment reform model is thin. This is due to a range of factors:

- Demonstrating savings is contingent on high-quality data with information about expected costs in the absence of the reform, both of which are not always available.
- Most savings analyses rely on projections of costs from a baseline period, a method which is highly subject to error and which can lead to greatly inflated or deflated calculated savings depending on the assumptions of the projection methodology.
- Many evaluations of payment reform initiatives were completed by a party with a stake in program success, such as the purchaser who sponsored the reform, raising questions about reliability and validity.
- Very minor adjustments in design and implementation of each payment reform strategy can alter the effectiveness of the initiative.
- Many payment reform initiatives use several different strategies concurrently, making it difficult or impossible to determine which strategy caused any observed savings.
- Formal evaluation is lacking for many initiatives, in some cases because they are still ongoing.

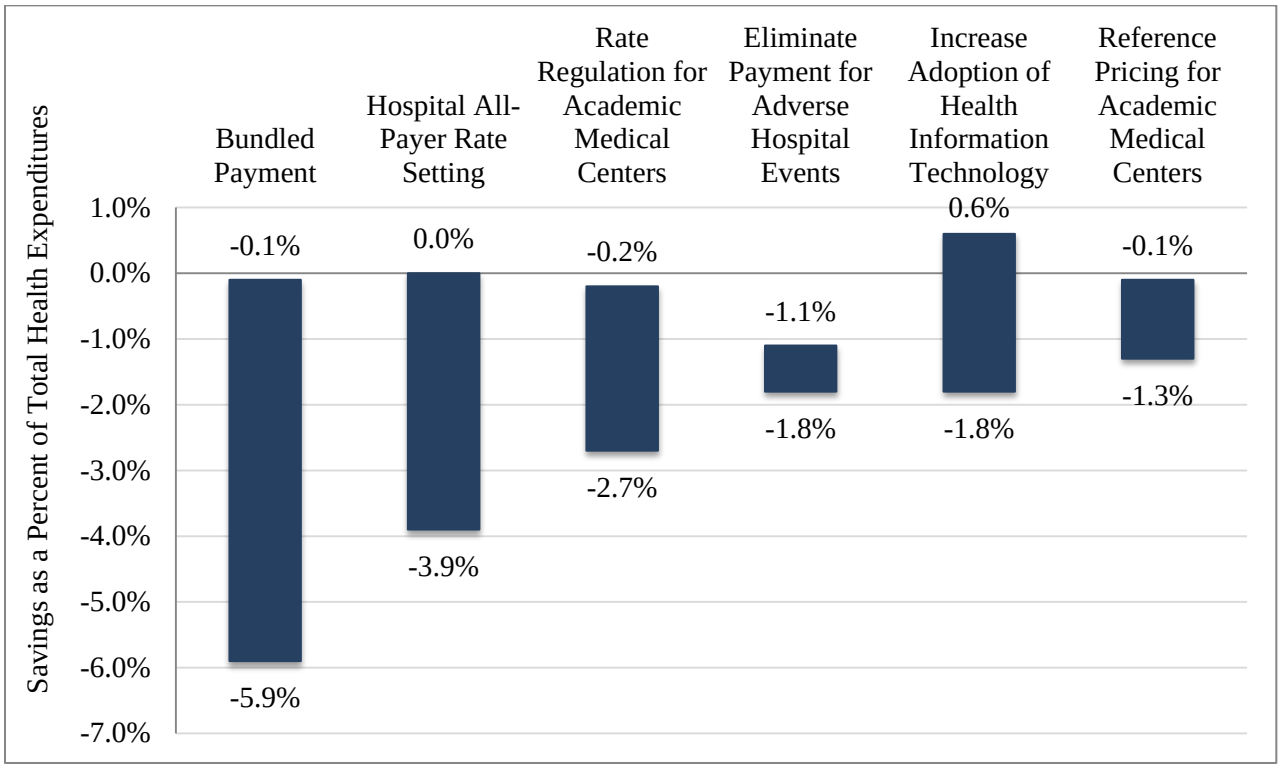
Although there is a general lack of systematic evidence related to savings associated with payment reforms, estimates of potential savings are available in the research literature. RAND Corporation, under contract to Massachusetts, reviewed a range of possible payment reforms and estimated potential savings associated with best-case scenarios related to implementation success [92]. While they did not model the same array of reforms discussed in this paper, they did explore several of the models that are currently common in the literature. Specifically, they considered the following payment and delivery system reform options:

- Bundled Payment Strategies
- Traditional Hospital All-Payer Rate Setting
- Rate Regulation for Academic Medical Centers
- Elimination of Payments for Adverse Hospital Events

- Increased Adoption of Health Information Technology (HIT)
- Reference Pricing for Academic Medical Centers
- Greater Use of Nurse Practitioners and Physician Assistants
- Growth of Retail Clinics
- Medical Homes to Enhance Primary Care – general population
- Decreased Resource Use for End-of-Life Care
- Value-Based Insurance Design
- Use of Disease Management

Among the options considered, the RAND team concluded that bundled payment, all-payer hospital rate setting or rate regulation (a form of reference pricing, similar to that instituted in Maryland), and elimination of payment for adverse hospital events (a type of P4P) were the four methods with the highest potential for cost savings. Their analysis projected potential cumulative savings over 10 years of up to 5.9 percent for bundled payments, as shown in Figure 1 below [92]. The RAND analysis may constitute the best available evidence of the *potential* for savings inherent in each payment reform model.

Figure 1. Estimated Potential Cumulative Savings from Payment Reform Options Over 10 Years, Showing Six Strategies with Highest Savings Potential.



Source: From Eibner, C., et al., *Controlling Health Care Spending in Massachusetts: An Analysis of Options*, 2009. The RAND Corporation [92].

Other research that simulates potential estimated savings from payment reforms is available. The Commonwealth Fund recently published an estimate of cumulative savings over 10 years of roughly $2 trillion if a broad set of policy reforms are undertaken [93]. They modeled the combined effect of 10 "synergistic policies" that included use of medical home for complex patients, bundled payments for hospital services, value-based insurance design, global spending targets, and other strategies. Many other estimates of savings are available in the literature [93, 94], although their focus and methods vary.

Evaluations of specific payment reform demonstrations have also provided some insight into the potential for cost savings. Savings have been associated with bundled payment initiatives including the Medicare Acute Care Episode Demonstration for heart and orthopedic surgical procedures [73], the Geisinger ProvenCare program [64, 73], and the Medicare Participating

Heart Bypass Center Demonstration [95]. There is also evidence of savings from shared savings/shared risk agreements in the CalPERS Global Budget Pilot/Sacramento Pilot ACO [96], the Patient First Shared Savings Program in Alabama [97], and the Medicare Physician Group Practice Demonstration [98]. There were significant variations in savings between participating practices in the Medicare demonstration, highlighting mixed potential for savings based in part on implementation and practice characteristics.

P4P programs have generally been found to have small and short-lived impacts on health outcomes [43, 99]. Some have suggested that mixed evidence with respect to impacts of P4P programs are reflective of improved reporting, trends in hospital performance, volunteer bias among participating providers, and other concurrent quality initiatives, rather than true improvements attributable to P4P [63, 100]. One author found that greater quality improvement was associated with higher P4P rates, suggesting that increasing the size of the bonus payments may be key to achieving desired results [101]. Few evaluations of the cost savings associated with P4P are available, and evidence in this area is mixed [100].

There is evidence of savings from several medical home demonstrations in differing settings and populations [83, 84, 102-104]. However, the specific design of medical home strategies, other aspects of the overall payment system, and methods for evaluating savings were mixed, leading to difficulty reaching clear conclusions about the potential for savings.

Savings have also been achieved in reference pricing programs, including the CalPERS reference pricing program for hip and knee replacements for which preliminary data indicate a 25 percent decrease in cost per case [31]. Arkansas instituted reference pricing for proton pump inhibitors in the state employee health plan and achieved significant reported decreases of roughly 50 percent in PMPM net plan costs for these medications [105].

Researchers from the Trust for America's Health recently produced estimates of the potential return on investment from specific types of population-health programs [106]. Focusing on evidence-based interventions to improve physical activity and nutrition and reduce tobacco use, they incorporated data from the literature on disease prevalence, expected reductions in chronic disease and associated health care costs, and the costs of program implementation. Their analysis demonstrated that that within five years, California could achieve savings of nearly $5 for every

$1 invested in these community-based population health investments [106]. Evidence shows that potential for savings may be greater for specific conditions and populations, indicating that carefully designed and targeted interventions may be appropriate [107]. For example, a separate analysis found that interventions to treat obesity, hypertension and diabetes among middle-aged adults could lower lifetime medical costs for individuals even if interventions were only effective for ten percent of the population at risk. Conversely, smoking cessation programs with the same level of effectiveness would increase lifetime medical costs [108].

CONSIDERATIONS FOR CALIFORNIA'S SIM GRANT DESIGN WORKGROUP

California's Unique Environment

California's health care environment is unique for a range of reasons. California is geographically large and highly populous, with more than 37.5 million residents [109]. Health care resources and trends in rural areas differ from more populous parts of the state. More than 80% of California's geography is defined as rural, and roughly 13% of California's population or more than 5 million people live in rural areas [110]. Health care services in California are provided through four basic financing models: group model HMOs (i.e., Kaiser Permanente), independent practice association (IPA) HMOs (with individually contracted providers), the direct FFS system (i.e., preferred provider organizations (PPOs)), and services for people without insurance financed by the government, charity care and other sources of safety net funding [111].

HMO enrollment in California is higher than in any other state, at roughly 42 percent in 2010 [17]. A majority of Medi-Cal beneficiaries were enrolled in managed care plans in 2010 [112], and Medi-Cal managed care enrollment has increased since that time with the transition of seniors and persons with disabilities from Medi-Cal FFS to Medi-Cal managed care in 2011 and 2012. However, overall enrollment in HMOs has declined over the last decade, while enrollment in PPOs and other FFS plans has increased [112]. There is significant geographic variation in HMO penetration, with some regions experiencing penetration (in 2006) in excess of 60 percent (Sacramento, Sonoma/Napa) while others are below 25 percent (Central Coast, Northern) [111].

Supply of providers, geographic factors, and other characteristics of California's substantial rural population pose unique challenges in health care access and delivery in rural areas.

The health care market has distinct regional subdivisions, but many parts of the health system in California are associated with national companies and have large geographic coverage in the state [111]. Depending on the region, different health plans and hospitals may have dominant market share [111]. A trend toward hospital and provider group consolidation exists in the state [71]. More California physicians participate in medical groups or IPAs than in other states [17, 113], and it is estimated that at least 25 percent of these providers are paid via salaried arrangements [114]. However, relatively little is known about how individual providers are compensated by provider organizations. More than 75 percent of total health insurance revenues in California in 2010 were accounted for by five insurance carriers – Kaiser, Anthem Blue Cross, Health Net, Blue Shield, and United Healthcare [112].

These factors, when taken together, have implications for multi-stakeholder payment reform in California. Given the framework for understanding payment reform options, evidence regarding payment reform from around the nation, and California's unique environment, the following section outlines key considerations for California's SIM Design Grant workgroup. This section was developed with input from the many key informants who were interviewed as part of the research process.

Considering a Regional Strategy

Because of the diversity of health care markets in California, differing levels of managed care penetration, and some regionally dominant hospital systems, most experts recommend a regional approach to payment reform. To unify the overall state experience, the core goals and principles of payment reform could be uniform across different markets. Counties or regions with greater readiness could be the first to implement reforms, or reforms could be simultaneous but specialized across regions.

Each region or market will have differing characteristics, readiness, and players. Experts suggest that any effort toward payment reform should begin by completing an analysis of health care markets. Given the short duration of the SIM Design Grant period, the workgroup might consider

building on existing market assessments and expert insight to the greatest extent possible, to answer a wide range of questions: For what services is divergence between cost and outcomes greatest? Are specific purchasers or employers influential in the market? To what extent do providers function as an integrated health system? How much price variation is present in the market? These insights could then be used to identify promising avenues of reform for each market or region. The Center for Studying Health Systems Change has recently updated market analyses focused on six California regions that can provide valuable insight [115, 116]. If the SIM workgroup identifies a need for additional market analysis, Catalyst for Payment Reform has developed a publicly available market assessment tool which may be useful for this purpose [117].

Provider and Purchaser Readiness

Readiness for payment reform at all levels of the health care system is an essential consideration for the SIM Design Grant workgroup. There are many aspects of readiness that could influence the design of a payment reform initiative in California such as adequacy of provider supply or extent of support from organizational leadership; we highlight three critical areas below:

Health Information Technology

Data capacity is essential to fully understand utilization patterns, identify opportunities for improvement, and effectively coordinate care. All payer claims databases (APCDs) are a possible mechanism to support health IT needs, and have been implemented or are underway in 10 states, including California (supported by the Pacific Business Group on Health) [63, 118]. While experts suggest that APCDs can support payment reform initiatives, they are not a mechanism to control costs on their own [118, 119].

In addition, individual providers and provider organizations may need to achieve specific health IT capacity goals to support changes in care delivery inherent in payment reform. While electronic health records (EHRs) are expected to facilitate improvements in health care quality and value, estimates from 2009 indicate that only roughly 16 percent of hospitals and 22 percent of office-based providers had an EHR in use [120]. EHRs may be necessary to support population health management, proactive patient engagement, and other characteristics of

integrated care inherent in models like ACOs or medical homes. However, implementing an EHR is costly and can take several years to complete.

Insurance Risk

Under many payment reform models, providers are expected to take on increasing risk for the care of their patient population; in some cases including both insurance risk and performance risk. Many providers may be unable (do not meet appropriate size threshold) or unwilling to take on insurance risk, which is the risk that a patient will become ill and require treatment, a factor that is outside of the provider's control. Some experts argue that this feature of global budgets or global payments make these models less likely to be successful than bundled payments, which do not require providers to take on insurance risk.

Administrative Systems

Purchasers/payers may also lack capacity to undertake some payment reforms due to the structure of claims adjudication systems. In many cases, these systems would require upgrades to manage changes to provider reimbursement. For example, purchasers that switch to a more aggregated payment structure such as bundled episode payments would need to develop a method to determine which claimed services are "in-bundle" and which are not. This allows the purchaser to distribute FFS payments for out-of-bundle service, while reimbursing via bundled payments for the defined episodes of care [6]. Providers may experience similar barriers related to the structure of administrative systems. Payment reforms that do not change the existing base payment model may be easier for providers and payers to adopt.

Some have suggested that an effective response to varied readiness for reform is to allow providers and purchasers to participate in reform incrementally or to begin with ready and willing providers [6]. However, a core principle of the SIM initiative in California is to adopt an approach to payment reform that will receive broad participation and buy-in. Providers and payers may be more willing to invest in changes to administrative systems if reforms are quickly scaled and generally uniform across purchasers; building new administrative capacity for pilot projects or reforms that impact only a small share of total business is not cost-effective.

Price Setting and Implementation Costs

Appropriate price setting is critical to maximize the effectiveness of any given payment strategy. Setting prices too high may dilute provider incentives to offer efficient and coordinated care. Conversely, setting prices too low may cause payments to be insufficient to cover appropriate services for high-quality treatment and could lead providers to undertreat patients or otherwise restrict access to services for the sake of financial stability [10].

Price setting under any reform strategy will also impact the implementation costs associated with the reform. Many payment reform programs will have substantial implementation costs, both from the near-term changes in infrastructure and business practices to make the initial transition and from the long-term costs associated with making payments to providers. If the implementation costs outpace the level of savings in direct health care costs achieved from reform, the net effect may be negative. In designing a cost neutral payment reform initiative, this concept is of particular importance.

An initial period of start-up costs may be required in early stages of program implementation, to facilitate change and establish provider buy-in [6]. However, a model that does not ultimately lead to a reduction in the total cost to purchasers will only serve to change the ways in which funds flow to providers without achieving savings.

In programs that do *not* successfully achieve savings, it may be possible to adjust the set price to strengthen incentives or reduce implementation costs sufficiently to realize savings. Therefore, monitoring of implementation costs and savings and flexibility in setting prices are important to ultimate success.

Maximizing Administrative Efficiency

Administrative costs constituted roughly 7% of total U.S. health expenditures in 2009 [5]. Nevertheless, administrative complexity has been estimated to be one of the top six areas of waste in the U.S. health care system accounting for as much as $389 billion in waste in 2011 [12]. Payment reform has potential to increase or decrease administrative complexity.

Administrative simplification could be established as a priority in the design of California's payment reform initiative, regardless of the specific payment strategies employed.

Targeted Interventions

There are two basic ways of thinking about targeted reforms: the first would focus on current cost-drivers such as individuals who are high-risk. The second would focus on maintaining the health of low-risk populations.

Targeted reforms may have a higher likelihood of achieving savings in the demonstration period. Moreover, if targeted reforms can yield greater short-term success, such an approach may help establish momentum and buy-in among purchasers, providers, and other stakeholders.

Specific candidate targets for reforms might include conditions or services that affect a large number of patients or those where there is strong leadership or wide interest in change. Other criteria for targeted reform might be services that constitute a large volume of expenditures, or where there is evidence of overutilization, or services where high variation in cost or quality is observed [17]. Some experts have suggested specific types of service that may be good candidates for reform, such as end-of-life care, which constitutes a large share of total medical expenditures, or maternity care for which prices are varied despite a fairly predictable course of treatment.

Experts suggest that reforms will be most successful in achieving substantial cost savings if they shift incentives for hospitals and specialists in addition to or versus primary care providers. Hospitals account for a large share of total medical spending and may have greater potential to yield savings than outpatient providers.

Advocates also argue that there may be high potential for cost savings and improvements in quality of care for particular populations such as the chronically ill or other high-cost/high-risk individuals [32, 121-123]. Other potential population-based parameters for payment reform may include individuals with behavioral health comorbidities or individuals who are likely to become ill or disabled in the absence of intervention. However, some experts argue that focusing on high-cost individuals may perpetuate the short-term "illness" focus of the health system, to the extent that they fail to maintain the health of low-cost populations.

Any targeted reform should be selected based on evidence for tractability of costs and outcomes and potential savings. Historically, reform initiatives have in some cases been implemented in settings where savings were unlikely due to limited mutability of disease progression, high cost of intervention relative to potential savings, or other factors. Evidence-based selection of potential targets for payment reform is essential, particularly in light of the short duration of the SIM testing phase.

Protecting Vulnerable Populations

There are important concerns that payment reforms could negatively impact already vulnerable populations by creating or increasing incentives for providers to avoid these patients if reform initiatives are not appropriately structured [63]. Most payment methods require careful risk adjustment to mitigate these potential adverse incentives, and any program that is implemented should be monitored for impacts on disparities in access and outcomes.

Another area of concern related to vulnerable populations involves payment reforms that require increasing out-of-pocket contributions when consumers make low-value choices. Some argue that vulnerable groups may have less ability or opportunity to select a high-value provider, particularly if they must travel to access that provider. Therefore, such programs may need careful design considerations to ensure adequate consumer supportive services [6].

Market Consolidation and the Regulatory Framework

A major goal of payment reform is to better integrate care. Strategies that incentivize increased provider coordination and/or lead to creation of integrated provider organization such as ACOs have potential to reduce duplicative services, improve quality of care and produce savings. Moreover, increases in patient volume and market share can be an incentive for providers to meet value goals, particularly if they have excess capacity or experience low demand. However, to the extent that providers or organizations control an increasing share of the market, competition may decrease and, in time, those providers may gain undue market leverage.

Economists generally agree that market consolidation is a major driver of increasing costs. Several experts argue that California already experiences insufficient provider competition. In

fact, some suggest that one goal of payment reform might be to generate increased competition between provider groups [33, 124-127]. While increasing competition on its own may be unlikely to reduce expenditures, it is an important underlying feature of successful payment reform.

After selecting candidate payment reform strategies, the Design Grant workgroup should assess any necessary statutory or regulatory changes or waivers from the federal government. The impacts of regulatory structure on reform options in California, including legislative and political feasibility, are an important factor that are best acknowledged and addressed early in the Design Grant process.

Consumer Perceptions

A fundamental challenge in payment reform is that consumers may perceive lower cost to mean lower quality and providers often believe that higher quality requires higher cost [6]. Experts agree that consumers are highly price-sensitive and will select a lower-cost provider when information is available to support similar quality among low and high-cost options. Consistent price and quality information that includes a clear explanation of consumer cost-sharing is essential to support value-based decision making. Movement toward clearly distinguishing cost and quality will be an important step toward expenditure reductions.

Framework for Defining Costs and Savings

The Design Grant workgroup must establish a framework for how California will define savings under the SIM initiative; the CMMI Model Testing requires that the payment reform achieve savings over the three-year demonstration period. Savings can be achieved at many levels, ranging from the patient level to the provider organization level, the payer/purchaser level, the regional level, or the state level. Defining savings at a broad level will help prevent increases in cost-shifting. Understanding the savings goal early in the design process will help the workgroup create a successful payment reform model.

Aligning Payment Reforms and Incentives

The workgroup should consider beginning the process of designing a payment reform strategy by establishing agreement on the core principles of reform and desired provider incentives. Several specific aspects of payment reform that are critical to align across payers and purchasers to the greatest extent possible are outlined by Harold Miller (2008), including: the types of providers and patients who will participate, the methods of measuring quality and value, and the payment levels and types of services to be included. Above all, purchasers must agree on the incentives to be fostered by the reformed payment system [6].

In addition to alignment at the purchaser/payer level, payment reform could seek to better understand the incentives experienced by individual providers. More detailed information about how payments are dispersed from provider organizations to individual providers would be helpful in assessing and increasing alignment of incentives at the organizational and practice levels.

CONCLUSIONS

Provider payment methods have inherent incentives which drive care delivery systems and behavior. Payment reforms seek to better align payment systems with goals and priorities for long-term health and wellness, while achieving reductions in cost growth. There is broad national discussion about health care payment reform underway, and examples of initiatives in the public and private sectors abound. We developed a typology of health care payment models to better describe the range of possible strategies for payment reform. There are three major domains of health care payment strategies for reform:

1) Providers are reimbursed for the delivery of services via a ***base payment model***, which may make payments for individual services or people or groups of services or people.
2) ***Complementary strategies*** are used to adjust incentives of the base payment model by:
    a) Adjusting payments to achieve a secondary aim like improving quality and coordination; or

b) Providing decision makers (purchasers, providers or patients) with information to allow them to make decisions based on relative value.

3) Investments are made to ***improve health outcomes at a population level.***

There are many possible variations on the specific strategies within each domain and most reform initiatives combine multiple approaches to achieve specific aims and meet local market needs. Incremental reforms that make small adjustments to the incentives felt by providers and consumers are commonly found around the nation. These programs use complementary strategies to modify the incentives of the base provider payment method, without modifying the fundamental way in which providers are reimbursed for services.

Some argue that incremental reforms do not sufficiently alter incentives in the health system to yield the substantial changes in health care costs needed. Reforms that change the base provider reimbursement method may be most suitable if they can be successfully implemented.

Ideally, payment reforms and their associated incentives will be coordinated between purchasers to maximize their impact on system, provider, and consumer behavior. A coordinated multi-payer approach to payment reform is ideal for many reasons, including the complex nature of provider contracting, the administrative burdens associated with changing care delivery and business practices, and the delay in savings associated with many services and strategies, such as prevention-focused initiatives [6, 13-15].

No single payment reform strategy is clearly identifiable as the ideal approach to be adopted under California's SIM initiative. There are many ways in which provider and consumer incentives can be modified to more closely align care with the triple aim of better health, better care, and lower costs. The SIM initiative creates an opportunity for California to build broad engagement in reforming the health care system. The charge for the SIM Design Grant workgroup will be to recommend a comprehensive payment reform strategy that moves the state toward value-based care.

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APPENDIX A: Excerpted Language from the State Innovation Model Funding Opportunity Announcement

Funding Opportunity Announcement, Section 5. A. iv. [2]

"As part of the development of their State Health Care Innovation Plans and designs for new payment and service delivery models, states must consider levers and strategies that can be applied to influence the structure and performance of the health care system, such as:

a) Creating multi-purchaser (including Medicare, Medicaid, CHIP, and state employee health benefit programs) strategies to move away from payment based on volume and toward payment based on outcomes;
b) Developing innovative approaches to improve the effectiveness, efficiency and appropriate mix of the health care work force through policies regarding training, professional licensure, and expanding scope of practice statutes, including strategies to enhance primary care capacity, and better integrate community health care manpower needs with graduate medical education, training of allied health professionals, and training of direct service workers;
c) Aligning state regulatory authorities, such as certificate of need programs (if applicable), to reinforce accountable care and delivery system transformation or developing alternative approaches to certificate of need programs, such as community-based approaches that could include voluntary participation by all providers and purchasers;
d) Restructuring Medicaid supplemental payment programs to align the incentives with the goals of the state's payment and delivery system reform Model;
e) Creating opportunities to align regulations and requirements for health insurers with the broader goals of multi-purchaser delivery system and payment reform;
f) Creating mechanisms to develop community awareness of and engagement in state efforts to achieve better health, better care, and lower cost through improvement for all segments of the population by:
    a. developing effective reporting mechanisms for these outcomes;
    b. developing community-based initiatives to improve these outcomes;
    c. developing potential approaches to ensure accountability for community-based outcomes by key stakeholders, including providers, governmental agencies, health plans, and others;
    d. coordinating efforts to align with the state's Healthy People 2020 plan, the National Prevention Strategy, the National Quality Strategy, and the state's health IT plan; and
    e. coordinating state efforts with non-profit hospitals' community benefits/community building plans;

g) Coordinating state-based Affordable Insurance Exchange activities with broader health system transformation efforts;
h) Integrating the financing and delivery of public health services and community prevention strategies with health system redesign models;
i) Leveraging community stabilization development initiatives in low income communities and encouraging community investment to improve community health. For example, the Federal Reserve Bank's Healthy Communities Initiative was designed to enable cross-sector approaches to revitalizing low-income communities and neighborhoods and improving community health;
j) Integrating early childhood and adolescent health prevention strategies with the primary and secondary educational system to improve student health, increase early intervention, and align delivery system performance with improved child health status;
k) Creating models that integrate behavioral health, substance abuse, children's dental health, and long-term services and support as part of multi-purchaser delivery system model and payment strategies;
l) Creating or expanding models such as the Administration on Community Living's Aging and Disability Resource Centers and CMS' Money Follows the Person Program and Balancing Incentives Payment Program to strengthen long-term services and support systems in a manner that promotes better health, reduces institutionalization, and helps older adults and people with disabilities maintain independence and maximize self-determination; and
m) Other policy levers that can support delivery system transformation. Part of the expectation for states participating in the SIM initiative is that they will assess and consider the application of policy authorities available to them to create a successful and sustainable health system transformation.
n) Leveraging health IT, electronic health records (EHRs), and health information exchange technologies, including interoperable technologies, to improve health and coordination of care across service providers and targeted beneficiaries."

Funding Opportunity Announcement, Section 5. B. iv.

"The following are areas that are out of scope and will not be considered under the State Innovation Models initiative:

1. Medicare or Medicaid eligibility changes;
2. Coverage or benefits reductions in Medicare or Medicaid or any changes that would have the effect of rationing care;
3. Increases in premiums or cost-sharing;
4. Increases in net federal spending under the Medicare, Medicaid or CHIP programs;
5. Medicare payments directly to states, including shared savings;

6. Medicaid FMAP formula changes;
7. Changes to the EHR incentive program for eligible professionals and eligible hospitals;
8. Changes in State Financial Alignment Models;
9. Reductions in Medicare beneficiary choice of provider or health plan, or Medicaid choice of provider or health plan beyond those allowed today; or changes to maintenance of effort requirements
10. Changes to CMS sanctions, penalties, or official denial of participation currently in effect."

APPENDIX B: Brief Definitions of Payment Strategies within Three Domains

Appendix B Table 1: Three Major Domains of Health Expenditure

1. BASE PAYMENT MODELS	
Global Budget	Provides a total *fixed dollar amount for the care of a defined population* over a set period of time. Can also be structured to provide a budget for a specific organization such as a hospital.
Global Payment/Capitation	Provides a *fixed dollar amount for the total cost of care per member* across settings and conditions for a defined period of time.
Condition-Specific Capitation	Provides a *fixed dollar amount for the total cost of care per member for a specific condition*, across settings and over a defined period of time. This method would be used encompass all care for chronic conditions like diabetes or asthma.
Bundled Episode Payment	Provides a *single grouped reimbursement for all of the services delivered to a patient within a single treatment or episode of car*e over a defined period of time. This payment may bridge settings and providers, but is linked to one episode of treatment for a specific condition or procedure.
Fee-for-Service	Provides *distinct reimbursement for each service* used by a patient.
2. COMPLEMENTARY STRATEGIES THAT ADJUST INCENTIVES OF THE BASE PAYMENT MODEL	
a. Adjust payments to achieve a secondary aim like improving quality and coordination	
Shared Savings/Shared Risk	Allows providers to receive a portion of the savings achieved for managing the care of a population, with savings based on a target cost benchmark. Shared savings agreements can

	also be structured to incorporate "downside" risk for providers, such that they are accountable for excess expenditures.
Enhanced Payments for Additional Services	Provides additional or enhanced payments to providers for care coordination activities and other beneficial activities that are generally not reimbursable. Payments may be issued via per member bonuses, through creation of new billing codes, or by elevating base payment rates. An example is the additional payment made to primary care providers under the medical home model.
Pay-for-Performance	Establishes financial rewards or penalties for providers or provider groups tied to performance on quality of care benchmarks. Also called Value Based Purchasing.
Provider Warranty	Creates financial incentives to reduce costs associated with avoidable complications, by requiring providers to incur part of the costs for these events through an effective warranty that they will not occur. Can be structured to include potential for shared savings.
b. Provide decision makers with information to allow them to make decisions based on relative value	
Reference Pricing	Purchasers establish a uniform, reasonable maximum amount they will contribute toward a specific drug, procedure, service, or bundle of services, which the purchaser then applies to all providers. Consumers pay the difference in cost if they use a provider whose cost is higher than the reference price.
Tiered or Limited Networks	Purchasers establish cost- and quality-based tiers of providers and use corresponding cost-sharing tiers to encourage consumers to use higher value providers. This method may be extended to establish "Centers of Excellence," high-value providers for specific services. Consumers may be restricted to these providers, or may be able to use non-designated providers but at a much higher out of pocket cost.
Value-Based Insurance Design	Purchasers use strategic adjustments to cost-sharing to encourage consumers to use high-

	value services. This method generally focuses on eliminating or lowering cost-sharing for desirable service use.
Technology Assessment/Evidence-Based Purchasing	Uses comparative effectiveness methods to assess the value of specific services. These assessments can be used in publicly reported ratings, provider decision-support tools and practice guidelines, and benefit package or cost-sharing decisions by purchasers.
Performance Reporting	Quality (and sometimes cost) data are publicly reported for use by consumers.
3. INVESTMENTS TO IMPROVE HEALTH OUTCOMES AT A POPULATION LEVEL	
Global Budget	The concept of global budgets, which was discussed as a base payment strategy, carries inherent incentives to promote population health. When a single total budget for health care expenditures is established, providers have a strong incentive to prevent illness.
Wellness Trust	A public health trust fund managed by a coalition or board that establishes coordinated prevention strategy at the community or population level and manages and distributes money for these activities. Wellness trusts can be funded from various sources, such as by pooling current prevention/wellness expenditures by hospitals, health plans, employers, and purchasers, and can vary in scope and size.
Social Impact Bond	Private or philanthropic investors fund programs with social or prevention goals, with capital and profit returns guaranteed by the government but contingent on program success.
Community Health Collaborative /Health in All Policies	Representatives from a broad spectrum of fields including public health, health care, and community-based agencies would collaborate to promote health outcomes at the community level. A health in all policies framework would incorporate health and wellness objectives into non-health sector policies, programs and expenditures, using tools such as health impact assessment to inform policy and program decisions across sectors.

APPENDIX C: Summary of Existing Payment Reform Demonstrations

The following tables catalog major or notable payment reform experiments that are currently underway or have been completed around the U.S. Appendix C Table 1 lists initiatives that alter the base payment methodology. Appendix C Table 3 lists initiatives that use complementary strategies to change provider or consumer incentives. Appendix C Table 5 lists initiatives that make investments to improve health outcomes at the population level. Appendix C Tables 2, 4 and 6 provide detailed descriptions of selected initiatives within each domain.

This is not intended to be an exhaustive list of payment reform initiatives in the U.S. Rather it is designed to provide an overview of the general status of payment reform, to describe the major reforms that are currently in place, and to characterize the strategies that are most commonly used by public and private purchasers. Cost savings and/or health outcomes are denoted if the authors identified documentation of evaluation findings that support these outcomes in the literature. It is important to note that the vast majority of listed initiatives have not been evaluated, and therefore no evidence is available regarding their effectiveness.

Appendix C Table 1. List of Payment Reform Initiatives that Change the Method of Base Payment

PROGRAM SUMMARY				EVIDENCE OF OUTCOMES	
Strategy	**Program Name**	**Context**	**Purchaser(s), population, services**	**Costs**	**Health**
Global Budget	Rochester Hospital Global Budget Agreement [68, 128]	New York	All-Payer agreement with hospitals in Rochester, NY, during 1980s	✓	
Global Budget with Shared Savings	Oregon Coordinated Care Organizations (CCO) [60-62]	Oregon	Medicaid managed care, encompasses physical, behavioral and dental health care		
Global Budget with Tiered Providers	Patient Choice Model [67, 68]	Minnesota	Members of employer-based, commercial plans		
Global Payment with Pay-for-Performance	Alternative Quality Contract (AQC) [63-66]	Massachusetts	Blue Cross Blue Shield of Massachusetts	✓	

PROGRAM SUMMARY				EVIDENCE OF OUTCOMES	
Strategy	**Program Name**	**Context**	**Purchaser(s), population, services**	**Costs**	**Health**
Global Payment	Coordinated Care Initiative [69]	California	Dually eligible Medicare and Medi-Cal beneficiaries in eight demonstration counties		
Bundled Episode Payment	CMS Bundled Payments for Care Improvement initiative [8, 22, 71]	National	Medicare		
Bundled Episode Payment	CMS National Pilot Program for Payment Bundling [8, 64, 70, 71]	National	Medicare		
Bundled Episode Payment	Acute Care Episode Demonstration for heart and orthopedic surgical procedures [8, 10, 72-74]	National	Medicare beneficiaries at participating hospitals in Texas, Oklahoma, New Mexico and Colorado.	✓	
Bundled Episode Payment	Participating Heart Bypass Center Demonstration [95, 129, 130]	Regional	Medicare, four selected hospitals	✓	
Bundled Episode Payment; transitioning to also include Condition-Specific Capitation	PROMETHEUS Payment [8, 74-76]	National	Hospitals; selected acute care episodes and surgical procedures in Pennsylvania, Illinois and Michigan. Also being developed for chronic conditions.		
Bundled Episode Payment	Diagnosis Related Group Hospital Inpatient Payment Methodology [131]	California	Medicaid		
Bundled Episode Payment	Integrated HealthCare Association Bundled Episode Payment and Gainsharing program [11, 71, 74, 77]	California	Members of Commercial PPO, HMO, Medicare Advantage, and Medi-Cal Managed Care programs		

PROGRAM SUMMARY				EVIDENCE OF OUTCOMES	
Strategy	**Program Name**	**Context**	**Purchaser(s), population, services**	**Costs**	**Health**
Bundled Episode Payment	Minnesota Baskets of Care Program [67, 74, 132]	Minnesota	Optional program that does not apply to services paid for by Medicare, state public health care programs through fee-for-service or prepaid arrangements, workers' compensation, or no-fault automobile insurance.		
Bundled Episode Payment, Provider Warranty	ProvenCare [64, 74, 78, 79]	Pennsylvania	Geisinger Health System Surgical procedures	Implied	

Source: Authors' review of the literature as of November 2012.

Appendix C Table 2. Descriptions of Selected Programs that Alter the Base Payment Method

The **Alternative Quality Contract (AQC) in Massachusetts** is a global payment program between Blue Cross Blue Shield of Massachusetts and 11 provider groups. The program makes a fixed global payment per member adjusted for the health of the patient, to cover all care services delivered. Several methods are used to increase incentives for value: providers may elect to participate in a P4P system, receiving bonus payments of up to 10 percent based on quality of care targets. In addition, some providers have 50 percent shared savings/shared risk agreement, and all providers are required to purchase a reinsurance policy to cover excess spending. Independent researchers found reduced medical spending and improved quality relative to a comparison group with FFS reimbursement. Although average expenditures increased in both the AQC group and the control group, the increase in the AQC group was lower, leading to a 2.8 percent average savings over two years.[63-66]

The **Minnesota Patient Choice Model** uses a global budget system for defined populations. Under this program providers organize themselves into delivery systems, and bid on the risk-adjusted total cost of care for a population. Providers continue to use FFS billing codes, but the fee levels that are actually paid are adjusted to keep total payments within a budget. The budget is based on the provider's bid but is risk adjusted to account for the characteristics of the actual covered population. Care systems are divided into tiers based on costs and quality, and consumers pay increased out of pocket expenses if they select a higher-cost care system.[67, 68]

Appendix C Table 3. List of Payment Reform Initiatives that Employ Complementary Strategies to Adjust Base Payment Incentives

PROGRAM SUMMARY				EVIDENCE OF OUTCOMES	
Strategy	**Program Name**	**Context**	**Purchaser(s), population, services**	**Costs**	**Health**
A. Adjust payments to achieve a secondary aim like improving quality or coordination					
Shared Savings/Shared Risk over capitated payments, using target global PMPM budget	CalPERS Global Budget Pilot/ Sacramento Pilot ACO [11, 96]	California	Enrollees in CalPERS Blue Shield HMO plan	✓	
Shared Savings	Patient First Shared Savings Program [97, 133]	Alabama	Medicaid, primary care providers	✓	
Shared Savings	Medicare Physician Group Practice Demonstration [63, 80]	National	Medicare	✓	✓
Shared Savings/Shared Risk within a global budget target, with no change to existing FFS or capitated payments	Health Care Delivery Systems Demonstration (HCDS) [134-136]	Minnesota	Non-dually eligible adults and children in Medical Assistance and MinnesotaCare enrolled under both fee-for-service and managed care programs		
Shared Savings/Shared Risk over FFS payments	Medicare Shared Savings Program (MSSP) [8, 71, 81]	National; forty states	Medicare		
Shared Savings/Shared Risk over FFS payments; transitioning to partial capitation	Pioneer Accountable Care Organization [81]	National	Medicare		
Medical Home enhanced payment	Boeing Intensive Outpatient Care Program [137]	Washington	Boeing self-funded non-HMO plan enrollees in Puget Sound	✓	✓

PROGRAM SUMMARY				EVIDENCE OF OUTCOMES	
Strategy	**Program Name**	**Context**	**Purchaser(s), population, services**	**Costs**	**Health**
Medical Home program enhanced payment with base FFS payments and shared savings agreement	Priority Care [138, 139]	California	High-intensity primary care for CalPERS beneficiaries in Anthem PPO, Humboldt County		
Medical Home enhanced FFS payments	Colorado Children's Medical Home Initiative [140]	Colorado	Medicaid and CHIP		
Medical Home Grants, with Shared Savings incentive	Chronic Care Initiative [82, 85, 141]	Pennsylvania	Six major commercial payers, Medicaid managed care and Medicare managed care	Implied	✓
Medical Home PMPM enhanced payment with base FFS and P4P agreement	High Value Patient Centered Care Demonstration [139, 142]	Oregon	High-intensity primary care for complex patients in five health plans and four state purchasing groups.		
Medical Home PMPM enhanced payment	Medicaid-Medicare Advanced Primary Care Demonstration Initiative (APC) [8, 143-145]	Eight states	Medicare joining established multi-payer efforts in Maine, Vermont, Rhode Island, New York, Pennsylvania, North Carolina, Michigan, and Minnesota.		
Medical Home PMPM enhanced payment	Maine's Multi-payer Patient Centered Medical Home Pilot [140, 146]	Maine	Medicaid, Medicare FFS, and commercial payers		
Medical Home PMPM enhanced payment	MaineCare Primary Care Case Management (PCCM) program [147, 148]	Maine	Medicaid		

PROGRAM SUMMARY				EVIDENCE OF OUTCOMES	
Strategy	**Program Name**	**Context**	**Purchaser(s), population, services**	**Costs**	**Health**
Medical Home PMPM enhanced payment over FFS or capitated payments	New York Medicaid's Statewide Patient-Centered Medical Home Incentive Program [149]	New York	Medicaid		
Medical Home PMPM enhanced payment over FFS payments	Accountable Care Collaborative [102, 150-152]	Colorado	Medicaid FFS enrollees	✓	
Medical Home PMPM enhanced payment over FFS payments	Wellpoint's New York PCMH Demonstration [84]	New York	Wellpoint	✓	✓
Medical Home PMPM enhanced payment over FFS payments with regional community health teams; transitioning to include Shared Savings	Vermont's Pay-for-Population Program /Vermont Blueprint for Health [140, 153-155]	Vermont		✓	
Medical Home PMPM enhanced payment over FFS payments, with health IT adoption grants	Chronic Care Sustainability Initiative (CSI-RI) [68, 141, 156, 157]	Rhode Island	All Medicaid-contracted health plans, all state regulated commercial insurers, several large employers, Medicare Advantage plans, and Medicare fee-for-service		
Medical Home PMPM enhanced payment over FFS payments, with Shared Savings	Accountable Communities ACO [147]	Maine	Medicaid		

PROGRAM SUMMARY				EVIDENCE OF OUTCOMES	
Strategy	**Program Name**	**Context**	**Purchaser(s), population, services**	**Costs**	**Health**
Medical Home PMPM enhanced payment over FFS payments; some payers also offered pay-for-performance bonuses	New Hampshire Citizens Health Initiative Multi-Stakeholder Medical Home Pilot [84]	New Hampshire	Four commercial payers	✓	--
Medical Home PMPM enhanced payment over FFS, with pay-for-performance bonuses	Colorado Multi-Payer Patient-Centered Medical Home Pilot [83-85]	Colorado	Medicaid, Medicare, UnitedHealthcare, Anthem-WellPoint, Aetna, Cigna, Humana, and the state's high-risk pool carrier	✓	✓
Medical Home PMPM enhanced payment over FFS, with pay-for-performance bonuses	SoonerCare Choice [140, 158]	Oklahoma	Medicaid	✓	✓
Medical Home PMPM enhanced payment over FFS, with pay-for-performance bonuses and regional community health teams	Adirondack PCMH Multi-payer Demonstration [159]	New York	Medicaid, CHIP, Medicare FFS, commercial payers		
Medical Home PMPM enhanced payment with regional community health teams	Community Care of North Carolina (CCNC) [8, 85, 104, 160]	North Carolina	Medicaid	✓	✓
Medical Home PMPM enhanced payment with Shared Savings	Massachusetts Patient-Centered Medical Home Initiative [25]	Massachusetts	Thirteen public and private payers		

PROGRAM SUMMARY				EVIDENCE OF OUTCOMES	
Strategy	**Program Name**	**Context**	**Purchaser(s), population, services**	**Costs**	**Health**
Medical home enhanced payments with Shared Savings and Shared Risk	Medicare Comprehensive Primary Care Initiative (CPCI) [8, 105, 147]	Seven selected markets in eight states	Medicare and private payers		
Pay-for-performance and Medical Home PMPM	Michigan Physician Group Incentive Program [161, 162]	Michigan	Blue Cross Blue Shield of Michigan, voluntary program open to primary care providers and specialists	✓	
Pay-for-Performance	Integrated HealthCare Association Pay-for-Performance Program [11, 63, 163-165]	California	Commercial HMO members from eight health plans		
Pay-for-Performance	Local Initiative Rewarding Results program [63, 101, 166, 167]	California	Medicaid and Healthy Families	--	Mixed
Pay-for-Performance	Delivery System Reform Incentive Program (DSRIP) [71, 168, 169]	California	Medicaid, public hospitals only		
Pay-for-Performance	Indiana Health Information Exchange Quality Health First [170]	Indiana	Medicaid, state employee health benefit programs, major private insurers, and Medicare		
Pay-for-Performance	Maryland Hospital Acquired Conditions (MHAC) initiative [171]	Maryland	All payers and all hospitals	✓	
Pay-for-Performance	MassHealth hospital-based pay-for-performance program [63, 172]	Massachusetts	Medicaid	--	
Pay-for-Performance	Premier Hospital Quality Incentive Demonstration Project/Hospital Value-Based Purchasing Program [63, 71, 99, 173, 174]	National	Medicare, initially a voluntary program for hospitals in the Premier, Inc. alliance; expanded to all hospitals nation wide		--

PROGRAM SUMMARY				EVIDENCE OF OUTCOMES	
Strategy	**Program Name**	**Context**	**Purchaser(s), population, services**	**Costs**	**Health**
Pay-for-Performance	End-Stage Renal Disease Bundled-Payment and Quality Incentive Program (QIP) [175]	National	Medicare, dialysis facilities		
Pay-for-Performance	Medicare Physician Value-Based Payment Modifier [175]	National	Medicare, initially for select physicians; expanding nationally by 2017		
Pay-for-Performance	CMS Hospital-Acquired Conditions (Present on Admission Indicator) [71, 176]	National	Medicare		
Pay-for-Performance	Medicare Advantage Plan Bonus Demonstration [63, 177]	National	Medicare		
Pay-for-Performance	NovaHealth ACO [178]	Maine	Aetna Medicare beneficiaries	✓	✓
Pay-for-Reporting	Physician Quality Reporting Initiative/System [179, 180]	National	Medicare		
Pay-for-Reporting	Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program [181]	National	Medicare		
B. Provide decision makers with information to allow them to make decisions based on relative value					
Reference Pricing	Arkansas reference pricing program for PPIs [31, 105]	Arkansas	Arkansas State Employee Benefits Division (EBD) plan members	✓	
Reference Pricing	CalPERS Reference Pricing for Hip and Knee Replacements[31, 182]	California	CalPERS Anthem Blue Cross PPO members	✓	

PROGRAM SUMMARY				EVIDENCE OF OUTCOMES	
Strategy	**Program Name**	**Context**	**Purchaser(s), population, services**	**Costs**	**Health**
Reference Pricing	Safeway Reference Pricing Program [31, 37, 182, 183]	National	Safeway employees - 40,000 self-insured preferred provider organization plan, in addition to 150,000 unionized employees in separate health plans		
Reference Pricing /Rate Setting	Health Services Cost Review Commission Hospital Rate Setting Program [184, 185]	Maryland	Statewide program for all payers and all hospitals	✓	
Tiered/Limited Networks	Blue Shield of California Tiered Hospital Programs [186-188]	California	Blue Shield of California HMO members		
Tiered/Limited Networks	Massachusetts Tiered Network Products [65, 68]	Massachusetts	All health plans		
Tiered/Limited Networks	Minnesota Provider Peer Grouping System [67]	Minnesota	State employee health plan members, state public insurance programs, local government, and private health plans		
Tiered/Limited Networks	CalPERS Centers of Excellence Program for Hip and Knee Replacements [182]	California	CalPERS Blue Shield of California HMO members		
Tiered/Limited Networks	Lowe's Centers of Excellence Program for Nonemergency Cardiac Procedures [183]	National	Optional benefit for Lowes employees in HMO or self-insured PPO plans.		
Value-Based Insurance Design	MHealthy: Focus on Diabetes [189, 190]	Michigan	University of Michigan Employees	--	
Value-Based Insurance Design	Post-Myocardial Infarction Free Rx Event and Economic Evaluation (MI FREEE) [191, 192]	National	Aetna	Insig.	

PROGRAM SUMMARY				EVIDENCE OF OUTCOMES	
Strategy	**Program Name**	**Context**	**Purchaser(s), population, services**	**Costs**	**Health**
Technology Assessment	New England Comparative Effectiveness Public Advisory Council [193]	New England	General, provides information		
Technology Assessment	Washington State Health Technology Assessment Program [38, 40, 68, 194, 195]	Washington	All public payers		
Technology Assessment	Institute for Clinical and Economic Review (ICER) [196]	General	Contracted to states or purchasers		
Technology Assessment/Evidence-Based Purchasing	Washington Medicaid Evidence based purchasing policy [40, 68, 188]	Washington	Medicaid	✓	
Evidence-Based Purchasing	Washington Formulary Management Program [197, 198]	Washington	Medicaid		
Performance Reporting	Smart Buy Alliance (SBA) [67]	Minnesota	Purchaser Coalition including public and private purchasers		
Performance Reporting and Pay-for-performance	Minnesota Community Measurement (MNCM) and Bridges to Excellence [55, 67, 165]	Minnesota	Multi-stakeholder collaborative		

Source: Authors' review of the literature as of November 2012.

Appendix C Table 4. Descriptions of Selected Programs that Use Complementary Strategies to Adjust Incentives of the Base Payment Model

The **Health Care Delivery Systems Demonstration (HCDS) in Minnesota** is a shared savings/shared risk program beginning in 2012 for non-dually eligible adults and children in Medical Assistance and Medicaid FFS and managed care programs. Savings are determined against a risk-adjusted target total cost of care for all qualifying participants attributed to the system during the performance period. To be eligible to share savings, provider organizations must have a minimum of 1,000 attributed patients. Only integrated delivery systems with 2,000 or more patients are eligible to share risk. The total cost of care target is calculated using risk-adjusted claims and encounter data, and savings/risk determinations are made annually. Shared savings are contingent on performance on quality and patient experience outcomes. Providers continue to receive base FFS or capitated payments.[134-136]

The **Pioneer ACO** is a shared savings/shared risk program led by CMS for Medicare beneficiaries. Starting in 2011, the program was targeted to 32 organizations. Providers are initially reimbursed via partial capitation, with a shared savings/shared risk agreement. Providers can receive shared savings payments if they generate savings for Medicare based on a spending target, but they will pay financial penalties to Medicare if they accelerate growth in spending for the patient population. In the final demonstration year, successful provider organizations can shift to a fully capitated model for a portion of their patients.[81]

The **Physician Group Practice Demonstration (PGPD)** was a Medicare shared savings program that ran from 2005-2010. Providers 10 large physician group practices participated, accounting for 220,000 Medicare beneficiaries. The practices received bonuses if they slowed cost growth relative to local controls, contingent on meeting quality targets in several chronic conditions. Evaluation of the program demonstrated an improvement in quality but only a modest reduction in spending growth on average totaling approximately $121 per beneficiary over five years. There was significant variation in savings across practices, ranging from an overall mean per-capita annual saving of $866 (95% CI, $815-$918) to an increase in expenditures of $749 (95% CI, $698-$799). Much more uniform and larger cost reductions were achieved for beneficiaries who were dually eligible, averaging $532 per member per year.[63, 80]

Community Care of North Carolina (CCNC) is a statewide medical home initiative for Medicaid beneficiaries. The program seeks to link small practices in rural areas to care coordination resources. The program is made up of 14 regional networks that link primary care, safety net, and specialty providers in collaboration with hospitals and local health and social services departments. Provider enrollment is optional. Those who participate receive access to services including allied health professionals, and receive an enhanced payment of $2.50 PMPM. The regional

network receives an additional $3 PMPM to spend as needed. The program is moving toward enrollment of dually eligible and Medicare-only beneficiaries under a 646 waiver. Several independent evaluations of the program have demonstrated savings.[85, 104, 160]

Colorado's Multi-payer Patient-Centered Medical Home Pilot is a voluntary multi-payer medical home program that ran from May 2009 to April 2012. Approximately 100,000 patients with commercial insurance, Medicaid, Medicare, or employer self-insurance participated. Six health plans participated—United Healthcare; Anthem-WellPoint; Aetna; Cigna; Humana; and Cover-Colorado, the state's high-risk pool carrier. Providers received FFS payment, with an enhanced PMPM care management fee and P4P bonuses. Each plan had authority to set PMPM fee amounts, which ranged from $4 to $8 depending on medical home level attainment (using the National Committee for Quality Assurance (NCQA) standard). P4P bonuses were based on quality (60 percent) and costs (40 percent). Preliminary results show improvements in quality and reductions in acute care episodes particularly for patients with multiple chronic conditions. Anthem-WellPoint reported a return on its investment of 250 percent to 400 percent.[83-85]

Tiered and limited network strategies in the California Public Employee Retirement System (CalPERS) have been used to address price variation for members in their Blue Shield of California HMO plan. CalPERS excluded 38 hospitals from their HMO network based on tiers established by Blue Shield of California, which were created by comparing average cost and quality indicators across hospitals in regional and teaching status groups. This led to "virtual tiering" for CalPERS members, since beneficiaries that wanted to use higher cost hospitals could join the PPO option at a higher out of pocket cost. Similarly, CalPERS established a centers-of-excellence strategy for hip and knee replacements. For this service, the network is limited to a single hospital in each of nine regional markets, and beneficiaries receive travel expenses if they live more than 50 miles from a designated center of excellence.[182, 186-188]

Appendix C Table 5. List of Payment Reform Initiatives that Make Investments to Improve Population Health Outcomes

PROGRAM SUMMARY				OUTCOMES	
Strategy	**Program Name**	**Context**	**Purchaser(s), population, services**	**Costs**	**Health**
Wellness Trust	Massachusetts Prevention and Wellness Trust [86]	Massachusetts	General, community-based grants		
Wellness Trust	North Carolina Health and Wellness Fund [88-90]	North Carolina	General, community-based grants	✓	✓
Social Impact Bond	Adolescent Behavioral Learning Experience [46, 49, 50]	New York	Incarcerated youth at Rikers Island		

Source: Authors' review of the literature as of November 2012.

Appendix C Table 6. Descriptions of Selected Programs that Make Investments to Improve Health Outcomes at a Population Level

The **Massachusetts Prevention and Wellness Trust** will invest $60 million over 4 years in evidence-based community prevention activities starting in 2013, with the goal of reducing costly preventable health conditions. The majority of funds will be awarded through competitive grants to: municipalities or regional collaborations of municipalities; community organizations, health care providers, or health plans working in collaboration with one or more municipalities; and regional planning agencies.[86] The program is funded by a tax on insurers and an assessment on some larger hospitals.[87]

New York's Adolescent Behavioral Learning Experience is a social impact bond program that was designed to reduce recidivism among incarcerated youth at Riker's Island. Funded by private sector investors from Goldman Sachs and Bloomberg Philanthropies, the program was announced in 2012 and will run for four years. An independent evaluator will assess success of the program in reducing re-incarceration. The City will reimburse Goldman Sachs if the program is successful; at least a 10 percent reduction in re-incarceration is needed for the investors to be fully repaid, but investors may make a return on their investment if a greater reduction is achieved. [46, 49, 50]

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EMBARGOED FOR RELEASE
February 21, 2013, 12:01 a.m. ET

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LEADING MEDICAL SPECIALTY SOCIETIES IDENTIFY 90 TESTS AND TREATMENTS TO QUESTION

Choosing Wisely® *campaign releases an additional 18 lists of tests or procedures to question, highlighting potentially unnecessary —sometimes harmful — care provided in the United States*

More specialty societies to join Choosing Wisely *by year's end*

Washington, D.C. – Seventeen leading medical specialty societies have identified specific tests, procedures or medication therapies they say are commonly ordered, but which are not always necessary—and could cause undue harm. To date, more than 130 tests and procedures to question have been released as part of the ABIM Foundation's *Choosing Wisely*® campaign, which aims to spark conversations between patients and physicians about what care is really necessary.

Each specialty society participating in *Choosing Wisely* identified five specific tests or procedures that are commonly done in their profession, but whose use should be questioned. In April 2012, nine medical specialty societies each released *Choosing Wisely* lists.

The new lists, to be released Thursday at a Washington, D.C., press conference, include recommendations such as:

- **Don't schedule non-medically indicated inductions of labor or cesarean deliveries before 39 weeks, 0 days of pregnancy.** Delivery prior to 39 weeks is associated with increased risk of learning disabilities, respiratory problems and other potential risks. While sometimes induction prior to 39 weeks is medically necessary, the recommendation is clear that simply having a mature fetal lung test, in the absence of appropriate clinical criteria, is not an indication for delivery. *(American College of Obstetricians and Gynecologists; American Academy of Family Physicians)*

- **Don't use feeding tubes in patients with advanced dementia.** Studies show that percutaneous feeding tubes do not result in better outcomes for these patients. The recommendation states that assistance with oral feeding is a better, evidence-based approach. *(American Academy of Hospice and Palliative Medicine; American Geriatrics Society)*

- **Don't perform routine annual Pap tests in women 30 – 65 years of age.** In average-risk women, routine annual Pap tests (cervical cytology screenings) offer no advantage over screenings performed at three-year intervals. *(American College of Obstetricians and Gynecologists)*

- **Don't automatically use CT scans to evaluate children's minor head injuries.** Approximately 50 percent of children who visit hospital emergency departments with head injuries are given a CT scan. CT scanning is associated with radiation exposure that may escalate future cancer risk. The recommendation calls for clinical observation prior to making a decision about needing a CT. *(American Academy of Pediatrics)*

- **Avoid doing stress tests using echocardiographic images to assess cardiovascular risk in persons who have no symptoms and a low risk of having coronary disease.** The recommendation states that there is very little information on the benefit of using stress echocardiography in asymptomatic individuals for the purposes of cardiovascular risk assessment, as a stand-alone test or in addition to conventional risk factors. *(American Society of Echocardiography)*

- **When prescribing medication for most people age 65 and older with type 2 diabetes, avoid attempting to achieve tight glycemic control.** The recommendation states that there is no evidence that using medicine to tightly control blood sugar in older diabetics is beneficial. In fact, using medications to strictly achieve low blood sugar levels is associated with harms, including higher mortality rates. (*American Geriatrics Society*)

- **Don't perform EEGs (electroencephalography) on patients with recurrent headaches.** Recurrent headache is the most common pain problem, affecting up to 20 percent of people. The recommendation states that EEG has no advantage over clinical evaluation in diagnosing headache, does not improve outcomes, and increases costs. *(American Academy of Neurology)*

- **Don't routinely treat acid reflux in infants with acid suppression therapy.** Anti-reflux therapy, which is commonly prescribed in adults, has no demonstrated effect in reducing the symptoms of gastroesophageal reflux disease (GERD) in infants, and there is emerging evidence that it may in fact be harmful in certain situations. (*Society of Hospital Medicine*)

"Twenty-five of the nation's leading medical specialty societies have now spoken up and shown leadership by identifying what tests and treatments are common to their profession, but not always beneficial," said Christine K. Cassel, M.D., president and CEO of the ABIM Foundation. "Millions of Americans are increasingly realizing that when it comes to health care, more is not necessarily better. Through these lists of tests and procedures, we hope to encourage conversations between physicians and patients about what care they truly need."

The organizations releasing lists today represent more than 350,000 physicians:

- American Academy of Family Physicians*
- American Academy of Hospice and Palliative Medicine
- American Academy of Neurology
- American Academy of Ophthalmology
- American Academy of Otolaryngology—Head and Neck Surgery
- American Academy of Pediatrics
- American College of Obstetricians and Gynecologists
- American College of Rheumatology
- American Geriatrics Society
- American Society for Clinical Pathology
- American Society of Echocardiography
- American Urological Association
- Society for Vascular Medicine
- Society of Cardiovascular Computed Tomography
- Society of Hospital Medicine
- Society of Nuclear Medicine and Molecular Imaging
- Society of Thoracic Surgeons

**Releasing a second list.*

All of the recommendations were developed by the individual specialty societies after months of careful consideration and review. Using the most current evidence about management and treatment options within their specialty, the societies believe the recommendations can make a significant impact on patient care, safety and quality. The 25 specialty societies that have now released lists are undertaking considerable efforts to share the recommendations with their collective membership of more than 725,000 physicians. The campaign is also reaching millions of consumers nationwide through a stable of consumer and advocacy partners.

Consumer Reports—the world's largest independent product-testing organization—has used its website and magazine to amplify the campaign's key messages. Consumer Reports has also collaborated with specialty societies to publish more than 35 free easy-to-understand brochures and other online resources for dissemination to both English- and Spanish-speaking consumers. In a Consumer Reports survey of 2,669 consumers who received *Choosing Wisely* information, 72 percent agreed that it had changed their opinion of the topic, taught them new information, or prompted them to ask more questions of their health provider. Eighty-one percent of consumers reporting interest in a *Choosing Wisely* topic said they were likely to have a conversation with their physician about what they had read. The survey was fielded in December 2012.

Consumer Reports has worked with the ABIM Foundation to maximize the campaign's reach and impact through its network of consumer-facing partner organizations including:

- AARP
- Alliance Health Networks
- The Leapfrog Group
- Midwest Business Group on Health
- Minnesota Health Action Group
- National Business Coalition on Health
- National Business Group on Health
- National Center for Farmworker Health
- National Hospice and Palliative Care Organization
- National Partnership for Women & Families
- Pacific Business Group on Health
- SEIU
- Union Plus (reaching AFL-CIO members)
- Univision (with HolaDoctor)
- The Wikipedia Community

"In less than a year, more than 70 million consumers have received practical advice about medical tests and treatments that are often overused or inappropriate," said James A. Guest, J.D., president and CEO of Consumer Reports. It's a thrill to be working with the ABIM Foundation on *Choosing Wisely*. And we applaud the courage of the specialty societies for addressing overuse and encouraging informed patient-doctor dialogue."

In addition, the campaign announced that the Robert Wood Johnson Foundation has given a $2.5 million, 28-month grant to the ABIM Foundation to advance *Choosing Wisely*. The grant will fund medical specialty societies and regional health improvement collaboratives to work in specific communities to raise awareness of potential overuse of medical care, and stress the importance of conversations between physicians and patients about appropriate care. The grant will also strengthen Consumer Reports' efforts to produce and disseminate plain-language information about overuse.

"Reducing the overuse of health care resources is a critical part of improving quality of health care in America," said Risa Lavizzo-Mourey, M.D., president and CEO of the Robert Wood Johnson Foundation. "We want to see what can happen when this work is targeted in specific geographic regions and are pleased to help increase the tangible impact of the *Choosing Wisely* campaign."

The campaign also announced specialty societies who will release new lists later in 2013:

- American Academy of Dermatology
- American Academy of Family Physicians**
- American Academy of Orthopaedic Surgeons
- American College of Surgeons
- American College of Chest Physicians
- American College of Rheumatology*
- American Headache Society
- AMDA—Dedicated to Long Term Care Medicine
- American Society for Radiation Oncology
- American Society of Clinical Oncology*
- American Society of Hematology
- American Thoracic Society
- Heart Rhythm Society
- North American Spine Society
- Society of General Internal Medicine

**Releasing a second list.*
***Releasing a third list.*

The complete lists from the specialty societies, available at www.ChoosingWisely.org, include additional detail about the recommendations and evidence supporting them.

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About the ABIM Foundation
The mission of the ABIM Foundation is to advance medical professionalism to improve the health care system. We achieve this by collaborating with physicians and physician leaders, medical trainees, health care delivery systems, payers, policy makers, consumer organizations and patients to foster a shared understanding of professionalism and how they can adopt the tenets of professionalism in practice. To learn more about the ABIM Foundation, visit www.abimfoundation.org, read the Medical Professionalism Blog, connect with us on Facebook or follow us on Twitter.

About *Choosing Wisely*®
First announced in December 2011, Choosing Wisely *is part of a multi-year effort led by the ABIM Foundation to support and engage physicians in being better stewards of finite health care resources. Participating specialty societies are working with the ABIM Foundation and Consumer Reports to share the lists widely with their members and convene discussions about the physician's role in helping patients make wise choices. Learn more at www.ChoosingWisely.org.*

CONFRONTING COSTS

Stabilizing U.S. Health Spending While Moving Toward a High Performance Health Care System

The Commonwealth Fund Commission
on a High Performance Health System

January 2013

THE COMMONWEALTH FUND COMMISSION ON A HIGH PERFORMANCE HEALTH SYSTEM

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The Commonwealth Fund, among the first private foundations started by a woman philanthropist—Anna M. Harkness—was established in 1918 with the broad charge to enhance the common good.

The mission of The Commonwealth Fund is to promote a high performing health care system that achieves better access, improved quality, and greater efficiency, particularly for society's most vulnerable, including low-income people, the uninsured, minority Americans, young children, and elderly adults.

The Fund carries out this mandate by supporting independent research on health care issues and making grants to improve health care practice and policy. An international program in health policy is designed to stimulate innovative policies and practices in the United States and other industrialized countries.

CONFRONTING COSTS

Stabilizing U.S. Health Spending While Moving Toward a High Performance Health Care System

The Commonwealth Fund Commission on a High Performance Health System

January 2013

ABSTRACT: The Commonwealth Fund Commission on a High Performance Health System, to hold increases in national health expenditures to no more than long-term economic growth, recommends a set of synergistic provider payment reforms, consumer incentives, and system-wide reforms to confront costs while improving health system performance. This approach could slow spending by a cumulative $2 trillion by 2023—if begun now with public and private payers acting in concert. Payment reforms would: provide incentives to innovate and participate in accountable care systems; strengthen primary care and patient-centered teams; and spread reforms across Medicare, Medicaid, and private insurers. With better consumer information and incentives to choose wisely and lower provider administrative costs, incentives would be further aligned to improve population health at more affordable cost. Savings could be substantial for families, businesses, and government at all levels and would more than offset the costs of repealing scheduled Medicare cuts in physician fees.

This report was prepared for The Commonwealth Fund Commission on a High Performance Health System by Cathy Schoen, Stuart Guterman, Mark Zezza, and Melinda Abrams. Support for this research was provided by The Commonwealth Fund. The views presented here are those of the authors and not necessarily those of The Commonwealth Fund or its directors, officers, or staff. To learn more about new publications when they become available, visit the Fund's Web site and register to receive e-mail alerts. Commonwealth Fund pub. no. 1653.

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LIST OF EXHIBITS

ACKNOWLEDGMENTS

The Commonwealth Fund Commission on a High Performance Health System set the goal of stabilizing national health spending growth to no more than long-term economic growth and guided the framework, strategic approach, and key policies that could achieve this goal while also improving health system performance. The report was prepared for the Commission, with review and direction by Commission leadership and members, by Cathy Schoen, Commonwealth Fund senior vice president, Stuart Guterman, Fund vice president and Commission executive director, Mark Zezza, Fund senior program officer, and Melinda Abrams, Fund vice president.

On behalf of the Commission, the Fund contracted with the Actuarial Research Corporation (ARC) to model policy specifications that illustrate the potential of a synergistic approach to reducing cost growth. Jim Mays led the ARC team in preparing estimates.

Editorial and production support was provided by The Commonwealth Fund's Chris Hollander, Martha Hostetter, Paul Frame, and Suzanne Augustyn.

PREFACE

Growth in public and private health spending is putting increasing pressure not only on federal, state, and local budgets but on business and families as well. Moreover, the U.S. health system falls short of producing the quality and outcomes that should be possible given the current level of spending. To address these systemwide issues, The Commonwealth Fund Commission on a High Performance Health System presents *Confronting Costs: Stabilizing U.S. Health Spending While Moving Toward a High Performance Health Care System*. This report offers a comprehensive set of policies aimed at holding health spending growth to no more than the rate of long-term growth in the economy while improving health care quality and outcomes.

The Commission recommends a synergistic strategy that reflects the need to address health spending in both the public and private sectors, and to involve providers, consumers, and payers in improving system performance. To illustrate the potential of concerted action to accomplish these goals, we provide estimates of the impact of policies that follow this approach. This analysis indicates it would be possible to reduce projected spending by a cumulative $2 trillion over the next 10 years, with substantial savings accruing to the federal government, state and local governments, private employers, and households. These impacts are contingent on timely enactment of the policies, their effective implementation, and coordinated efforts across the public and private sectors to achieve the goals of better care, better health, and lower costs.

The Commission on a High Performance Health System offers these recommendations knowing that they will not be easy to enact and implement. Inaction, however, will only exacerbate the problems we currently face. Putting off difficult solutions, or pursuing policies that offer short-term solutions without addressing the underlying factors that drive health spending growth, will only make it more difficult to deal with these factors in the future and will threaten the viability of the health care system. The Commission therefore urges that policymakers act now to move toward a high performance health system.

David Blumenthal, M.D., M.P.P.
Chairman

Stuart Guterman
Executive Director

The Commonwealth Fund Commission on a High Performance Health System

EXECUTIVE SUMMARY

Health spending as a share of U.S. gross domestic product (GDP) has climbed steadily over the past half-century. Today, it constitutes 18 percent of GDP, up from 14 percent in 2000 and 5 percent in 1960, and we are well on our way to 21 percent by 2023, based on current projections. This increased dedication of economic resources to the health sector, however, is not yielding commensurate value in terms of improving population health or patients' experiences with care.

On average, the U.S. spends twice as much on health care per capita, and 50 percent more as a share of GDP, as other industrialized nations do. And yet we fail to reap the benefits of longer lives, lower infant mortality, universal access, and quality of care realized by many other high-income countries. There is broad evidence, as well, that much of that excess spending is wasteful. Stabilizing health spending and targeting it in ways that ensure access to care and improve health outcomes would free up billions of dollars annually for critically needed economic and social investments—both public and private—as well as higher wages for workers.

In this report, The Commonwealth Fund Commission on a High Performance Health System endorses the goal of holding future growth in total health spending to a rate no greater than that of long-term growth in GDP, while simultaneously moving toward a high performance health care system. This is an ambitious goal, to be sure, particularly given our aging population and the commitment to access for all. But with such a high proportion of our economic resources already devoted to health care, and with abundant evidence that we can do better, such a target should be achievable. It is also a key to enabling broader economic growth and a more affordable health care system for businesses, families, and federal, state, and local governments.

The policies described below should produce substantial reductions in health spending. But if spending growth targets are not met, further action should be taken to address areas in which spending growth is excessive. This should include more aggressive implementation of those policies, focusing particularly on both geographic areas and types of services that are found to be drivers of excessive spending and spending growth. The establishment of targets, then, can serve both as a metric to guide policy development and as an incentive for all involved parties to act to make them effective.

To show how future health spending growth could be held to a national target and stabilized while moving toward a high performance health care system, this report lays out a synergistic strategy relying on three broad thrusts:

- Provider payment reforms to promote value and accelerate health care delivery system innovation.
- Policies to expand options and encourage high-value choices by consumers armed with better information about the quality and cost of care.
- Systemwide action to improve how health care markets function, including reducing administrative costs and setting national and regional targets for spending growth.

The set of policies the Commission has identified in these three areas would interact with each other in mutually supportive ways to address market forces that contribute to high and rising costs but are failing to produce value. By applying these policies collectively—with the public and private sectors working in concert—the nation would be able to benefit from their synergy. Analysis of specific policies consistent with these approaches indicates that they could slow growth in national spending by a cumulative $2 trillion through 2023. Achieving

these potential savings depends on starting now and acting together.

Strategic Approach

This report translates these three broad thrusts into 10 policies to illustrate our comprehensive approach to stabilizing spending growth. The policies reinforce each other to address concerns about both public and private health care costs while also improving health outcomes and patients' care experiences.

Provider Payment Reforms to Promote Value and Accelerate Delivery System Innovation: Create incentives to coordinate care, lower costs, and improve outcomes.

1. *Revise Medicare physician fees and methods of updating payment so that we pay for value.* Replace Medicare's current system for determining physician fees (and the resulting reductions called for under current law) by holding fees constant at their current level, while adjusting relative payment rates for services that meet specified criteria as "overpriced." Provide increases in future payments only for providers that participate in payment and delivery system innovations that are accountable for the populations they serve. Institute competitive bidding for medical commodities such as drugs, equipment, and supplies.
2. *Strengthen primary care and support care teams for high-cost, complex patients.* Promote patient-centeredness and better outcomes by changing payment for primary care to reward care management, coordination, and a team-based, systemic approach to treating patients who are covered by Medicare, Medicaid, other public programs, and by private plans participating in the new health insurance exchanges.
3. *Bundle hospital payments to focus on total costs and patient outcomes.* Accelerate the implementation of provider reimbursement approaches in which a single payment is made for all services provided during an episode of care involving a hospital stay, including postacute services for specified procedures and conditions, for patients in Medicare, Medicaid, other public programs, and private plans participating in the new health insurance exchanges.
4. *Adopt payment reforms across markets, with public and private payers working in concert.* Align payment incentives across public and private payers to enable and support care systems that are more accountable for providing high-value care. Require private plans participating in health insurance exchanges to incorporate alternative payment approaches to support delivery system innovation, such as payment for primary care medical homes, care teams, bundled payment for episodes involving hospital care, and shared savings or global payment arrangements with networks of providers. Encourage private insurance plans in each state to negotiate health care prices that are consistent with value and efficiency—and not just pass on higher prices to consumers.

Policies to Expand Options and Encourage High-Value Choices by Consumers: Create incentives for consumers to choose high-value care and high-performing care systems based on comparative information about quality and costs.

5. *Offer Medicare beneficiaries a new "Medicare Essential" plan that provides more comprehensive benefits and better protection against catastrophic costs and includes provider and enrollee incentives to achieve better care, better health, and lower costs.* Develop a value-based benefit design that encourages beneficiaries to obtain care from

high-performing care systems. These incentives would be aligned with payment reforms that give providers incentives to develop and join innovative care systems that improve patient outcomes and care experiences.

6. *Provide positive incentives for Medicare and Medicaid beneficiaries to seek care from high-value, patient-centered medical homes, care teams, accountable care organizations, and integrated delivery systems.* Work with local employer coalitions to spread the same value-based approach, with positive incentives for patients in private plans.

7. *Enhance information on clinical outcomes of care and patient experiences to inform treatment decisions and choices of providers and care systems*. Accelerate the "meaningful use" of health information technology to assess and compare clinical outcomes over time from alternative treatment choices and, through use of patient registries, to enable post-marketing surveillance of safety and care outcomes. Provide consumers and clinicians with transparent information on costs and prices to further inform choices.

Systemwide Action to Improve How Health Care Markets Function: Reduce administrative costs, reform malpractice policy, and set targets for total spending growth nationally and at other geographic levels.

8. *Simplify and unify administrative policies and procedures across public and private health plans to reduce provider and plan administrative costs and complexity.*

9. *Reform medical malpractice policy and link to payment in order to provide fair compensation for injury while promoting patient safety and adoption of best practices.*

10. *Establish spending targets.* Target total combined public and private spending to grow at a rate no greater than economic growth per capita. Set targets for the nation (long-term GDP growth per capita), as well as for states, regions, or localities, and adjust policies as appropriate based on progress in meeting targets. Collect data to inform and enable state and local action to develop focused policies if growth exceeds targets.

Setting a target for overall spending growth—across all payers, public and private, and across all providers in all areas—of no greater than economic growth per capita would provide guidance for these policies and any further policy action that is needed. Collecting data on total spending and sources of spending growth at the national, state, and local levels would enable state and local governments to set their own targets and develop focused policies to meet them.

More consistent payment approaches across payers also could help counteract the concentration of market power among providers. Allowing multiple payers to negotiate jointly to employ similar payment methods and more consistent pricing under state or federal government auspices and aligning payment with efficient care and value, rather than simply passing on higher prices in consolidated markets, could lower private insurance premium costs for businesses and families. Joint negotiations among health care purchasers would need to take place under public auspices to ensure accountability.

Over time, the policies described in this report should generate evolutionary forces that lead to the formation of health care delivery organizations that are held accountable for the costs of care as well as health outcomes and care experiences. By assessing system performance continually relative to the spending target, flexible policies could be calibrated to address areas in which there is excessive cost growth.

Synergistic Policies

Our synergistic approach is intended to build on the substantial movement already afoot to improve health system performance. The policies would interact to accelerate and focus that momentum to achieve the goals of better health, better health care experiences, and lower costs.†

The need for action applies not only to the federal government, but also to state and local governments, businesses, and households—all of which are under increasing financial pressure from rapid health spending growth. The overarching goal should be moving the U.S. health system toward a higher level of performance, one marked by access to affordable care for all, improved quality and patient-centeredness, greater accountability for both health outcomes and treatment costs, and enhanced population health. A high performance health system is not only consistent with stability in health care spending, it is essential for it.

To examine the potential of our proposed synergistic policies, The Commonwealth Fund contracted with Actuarial Research Corporation (ARC) to estimate the cumulative impact on health care spending by 2023 if an illustrative set of policies were to take effect in 2014, assuming the policies are enacted in 2013. The analysis examined the net impact on spending by the federal government, state and local governments, private employers, and households as well as total health spending.‡

The estimates suggest the policies consistent with the strategic approach could reduce projected health spending by a cumulative $2.004 trillion over the first 10 years (2014–2023). The savings would accrue to the federal government ($1.036 trillion), state and local governments ($242 billion), employers ($189 billion), and households ($537 billion) (Exhibit ES-1).

For the federal government, the analysis indicates net savings well beyond the level necessary to offset the 10-year costs of replacing current Medicare policies that call for steep cuts in payments to physicians under the sustainable growth rate (SGR) formula. By instituting broader Medicare payment reforms and ensuring these spread to Medicaid as well, the pace of delivery system reform would be accelerated without resorting to across-the-board reductions in provider payments and would produce substantial net savings for federal programs. Targeted policies to lower administrative costs for providers could furthermore support growth in clinician incomes.

U.S. households would be the major winners over time from the strategic approach we describe here, with the potential for better care and health outcomes as well as an estimated $537 billion in direct savings over 10 years. These savings result from lower future insurance premium and out-of-pocket costs resulting from more efficient insurance markets serving Medicare beneficiaries, and from slower growth in the underlying costs of care as the delivery system responds to new incentives for enhanced, high-value care and care systems. In the end, reduced health spending by federal, state, and local governments and private employers also would accrue to households, which ultimately bear the burden of health spending through higher taxes, reduced wages, and direct out-of-pocket costs.

† D. Berwick, T. Nolan, and J. Whittington, "The Triple Aim: Care, Health, and Cost," *Health Affairs,* May/June 2008 27(3):759–69.

‡ For details regarding data used and modeling assumptions see J. Mays, D. Waldo, R. Socarras et al., *Technical Report: Modeling the Impact of Health Care Payment, Financing, and System Reforms* (prepared for The Commonwealth Fund by Actuarial Research Corporation, Jan. 2013).

Exhibit ES-1. Synergistic Strategy: Potential Cumulative Savings Compared with Current Baseline Projection, 2013–2023

Net impact in $ billions*

	Total NHE	Federal government	State and local government	Private employers	Households
2013–2018	–$686	–$345	–$84	–$66	–$192
2013–2023	–$2,004	–$1,036	–$242	–$189	–$537

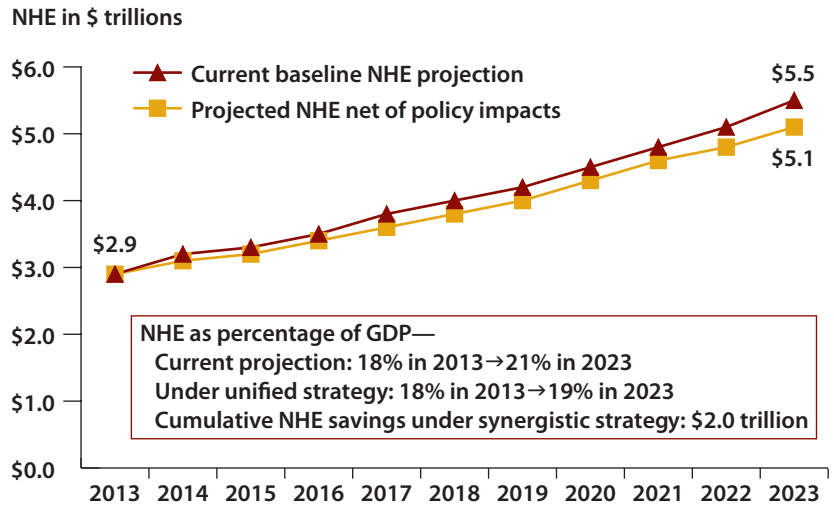
Note: NHE = national health expenditures.
* Net effect does NOT include potential impact of spending target policy.
Source: Estimates by Actuarial Research Corporation for The Commonwealth Fund. Current baseline projection assumes that the cuts to Medicare physician fees under the sustainable growth rate (SGR) formula are repealed and basic physician fees are instead increased by 1% in 2013 and held constant from 2014 through 2023.

It is important to note that, even with these savings, the health sector would continue to grow. This growth would provide resources to innovate and develop new medical breakthroughs, as well as allow us to meet the needs of an aging population (Exhibit ES-2).

Notably, the bulk of the estimated $2 trillion in savings comes from pay-for-value reforms that accelerate delivery system innovation and from lowering insurance-related administrative costs by simplifying and standardizing reporting and other policies (Exhibit ES-3). Administrative simplification savings would largely accrue to providers, freeing up physicians and their staff to spend more time on patient care.

The analysis indicates that such a comprehensive and synergistic approach, with all payers pulling together in the same direction, would stabilize health care spending and bring it more in line with growth of the economy. The percentage of GDP spent on health care by 2023 would be an estimated 19 percent—similar to the 18 percent projected in 2013 (before the policies begin to take

Exhibit ES-2. Projected National Health Expenditures (NHE), 2013–2023: Potential Impact of Synergistic Strategy



Note: GDP = gross domestic product.
Source: Estimates by Actuarial Research Corporation for The Commonwealth Fund. Current baseline projection assumes that the cuts to Medicare physician fees under the sustainable growth rate (SGR) formula are repealed and basic physician fees are instead increased by 1% in 2013 and held constant from 2014 through 2023.

Exhibit ES-3. Cumulative Net Impacts of Payment, Engaging Consumers, and Systemwide Policies, 2013–2023

Net savings in $ billions

	2013–2018	2019–2023	Total 2013–2023
Payment reforms to pay for value to accelerate delivery system innovation	–$442	–$891	–$1,333
Policies to expand and encourage high-value choices by consumers	–$41	–$148	–$189
Systemwide actions to improve how health care markets function*	–$203	–$279	–$481
Cumulative NHE impact**	–$686	–$1,318	–$2,004

Note: NHE = national health expenditures. Totals may not add because of rounding.
* Net savings do NOT include the potential impact of the spending target policy. Malpractice savings included in impact of provider payment reforms.
** Cumulative NHE impact adjusted for potential overlap of component policy impacts.
Source: Estimates by Actuarial Research Corporation for The Commonwealth Fund. Current baseline projection assumes that the cuts to Medicare physician fees under the sustainable growth rate (SGR) formula are repealed and basic physician fees are instead increased by 1% in 2013 and held constant from 2014 through 2023.

effect) and considerably lower than the 21 percent projected under current law.

The growth in Medicare spending per beneficiary would be below GDP growth for most of the decade, with substantial net savings compared with current projections. In contrast with Medicare, however, although private spending per enrollee would slow, it would continue to exceed GDP growth as it has in recent years. If focused policies at the local, state, regional, or national level slowed private per-person spending growth to bring it more in line with economic growth, the estimates indicate that national health expenditures (NHE) as a share of GDP by 2023 would be near the 2013 level.

Spending growth targets and data for assessing change will be instrumental to inform future action. At the state or local market level, it will be particularly important to have reliable information on baseline total spending and trends so that policies can be developed as needed, since patterns would likely vary in different parts of the country. Policies could be adjusted over time to achieve targets by the end of the decade.

To get these results, it will be necessary to act quickly and for major payers to pull together with a sense of urgency. As illustrated in Exhibit ES-1, the net impact of these policies accelerates over time as the health care delivery system and markets respond to new incentives and as the policies spread across the public and private sectors.

The Commonwealth Fund Commission on a High Performance Health System offers this synergistic set of policies as a way forward for federal and state policymakers and private-sector health care leaders confronting escalating health care costs. We also offer criteria to guide national discussions related to the federal deficit and federal health programs. Building on the three pillars of payment reform, high-value choices, and other market reforms, the United States has the potential to accelerate health care innovation while ensuring access for all.

CONFRONTING COSTS: STABILIZING U.S. HEALTH SPENDING WHILE MOVING TOWARD A HIGH PERFORMANCE HEALTH CARE SYSTEM

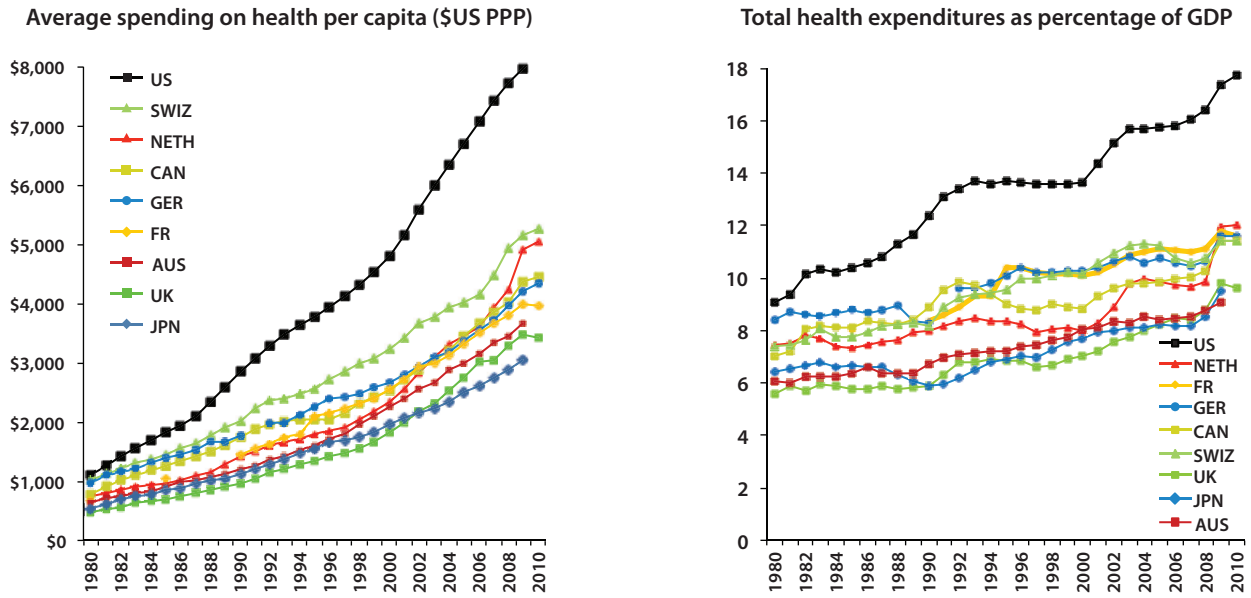
RISING HEALTH CARE COSTS: A NATIONAL CONCERN

Health spending as a share of the gross domestic product (GDP) has climbed steadily in the United States over the past half-century. Today, health care constitutes 18 percent of GDP, up from 14 percent in 2000 and 5 percent in 1960. On average, the U.S. spends twice as much per capita—and 50 percent more as a share of GDP—on health care as other industrialized nations do (Exhibit 1). But other wealthy nations achieve longer lives, lower infant mortality, better access to care, and higher care quality while spending far less.[1] Total U.S. spending on health care was $2.7 trillion at the end of 2011; under current policies, it is expected to more than double by 2023, rising to $5.5 trillion.

For decades, U.S. health care spending has grown far faster than incomes and consumed resources that might otherwise have been spent on other pressing needs. The high and rising portion of national resources spent on the health system means less for education, infrastructure (such as roads, updated electric power systems, and trains), non–health care jobs, wages, and investments necessary to compete in a global economy. Moreover, we have broad evidence that a substantial share of this spending is wasted on duplicative services, excessive administrative costs, and poorly coordinated, ineffective, or unsafe care. This excess spending has put pressure not only on federal, state, and local government budgets, but also on businesses and households across the country.

The growth of U.S. health spending also contributes to upward pressure on the federal budget. Our national commitment to providing health insurance to the elderly and disabled through Medicare and to low-income families, the disabled, long-term care residents, and children through Medicaid and the Children's Health Insurance Program—combined with our commitment to

Exhibit 1. International Comparison of Spending on Health, 1980–2010



Notes: PPP = purchasing power parity; GDP = gross domestic product.
Source: Commonwealth Fund, based on OECD Health Data 2012.

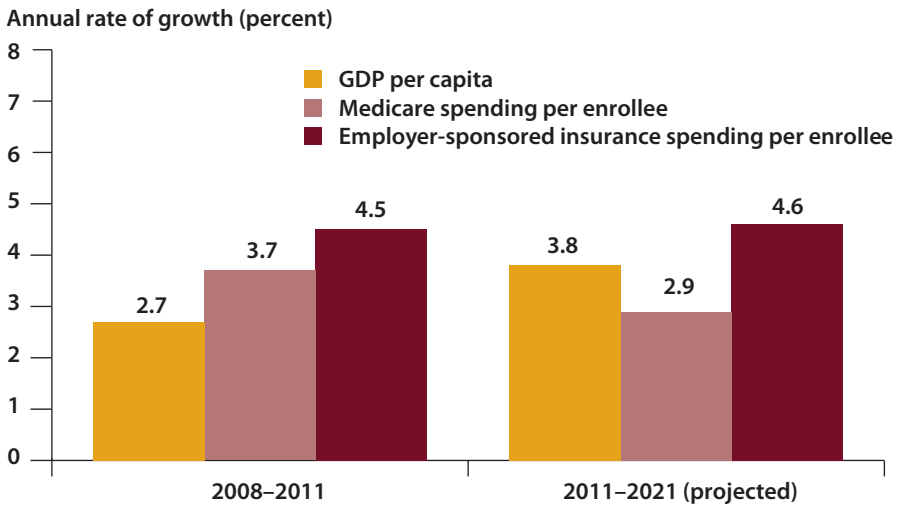
reaching near-universal coverage under the Affordable Care Act—means that a growing share of the population looks to government programs for help in ensuring affordable access to the health care system. This includes an increase in the number of Medicare beneficiaries from 48.7 million in 2011 to 65.8 million in 2021 as those born following World War II reach age 65.[2] The Congressional Budget Office (CBO) projects that, under current law, federal spending on Medicare, Medicaid, the Children's Health Insurance Program, and tax credits for low- and modest-income families to help offset the cost of private insurance in state exchanges will rise from 24 percent of the federal budget in 2012 to 32 percent in 2022 and 38 percent in 2037.[3]

Policies enacted as part of the Affordable Care Act helped ease the pressure somewhat by slowing the growth of Medicare spending per person—saving an estimated $716 billion from what Medicare would otherwise have spent over the next decade while improving benefits for beneficiaries.[4] This action extended the solvency of the Medicare Trust Fund for hospital care by seven years.[5]

While spending on publicly funded programs is currently a focal point of federal budget debates, for the past several years both Medicare and Medicaid spending per enrollee have been growing at rates well below spending for those who are privately insured.[6] And the slower rate of growth for public programs—particularly Medicare—is projected to continue over the next decade (Exhibit 2). On a per capita basis, Medicare spending is projected to increase at a rate of 2.9 percent per year between 2011 and 2021, compared with 4.6 percent for private employer-based insurance.[7] In fact, Medicare spending per enrollee is projected to grow more slowly than GDP per capita as a result of reforms put in place in recent years.[8]

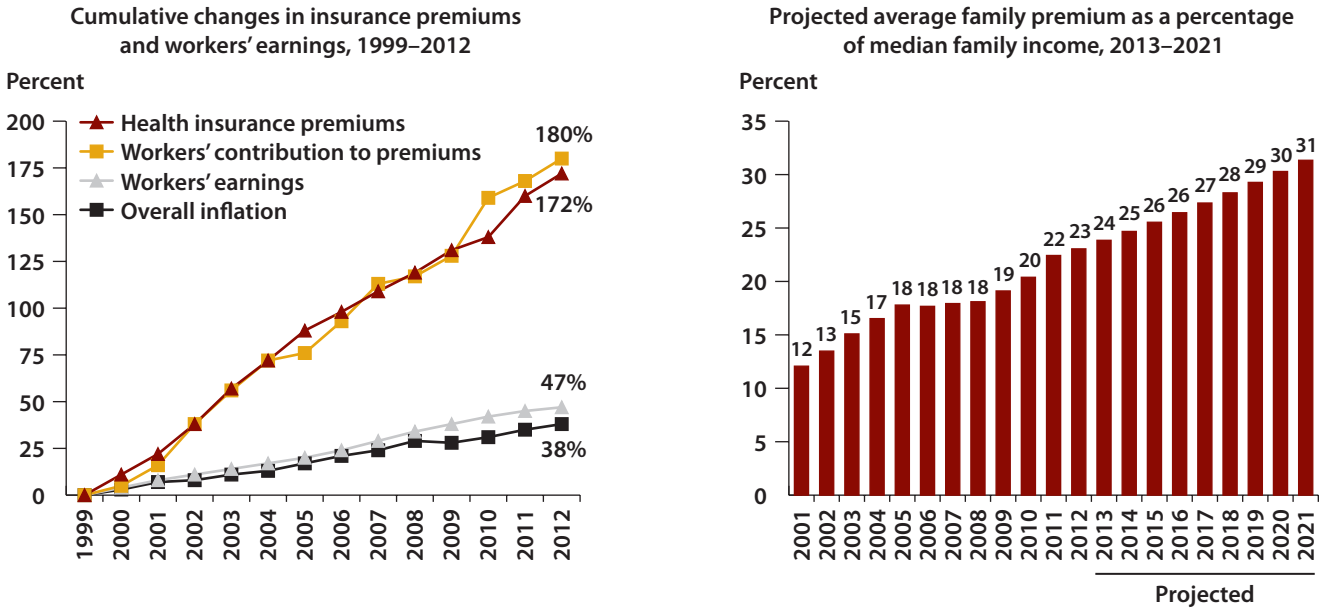
Indeed, businesses and families have faced rapid increases in private health insurance costs for more than a decade, with average premiums rising almost four times as fast as wages and general inflation since 1999. Total employer-based premiums are up by 172 percent and employee shares of premiums by 180 percent (Exhibit 3).[9] The full annual cost of

Exhibit 2. Medicare Spending per Enrollee Projected to Increase More Slowly Than Private Insurance Spending per Enrollee and GDP per Capita



Note: GDP = gross domestic product.
Source: CMS Office of the Actuary, National Health Expenditure Projections, 2011–2021, updated June 2012.

Exhibit 3. Premiums Rising Faster Than Inflation and Wages



Sources: (left) Kaiser Family Foundation/Health Research and Educational Trust, Employer Health Benefits Annual Surveys, 1999–2012; (right) authors' estimates based on CPS ASEC 2001–12, Kaiser/HRET 2001–12, CMS OACT 2012–21.

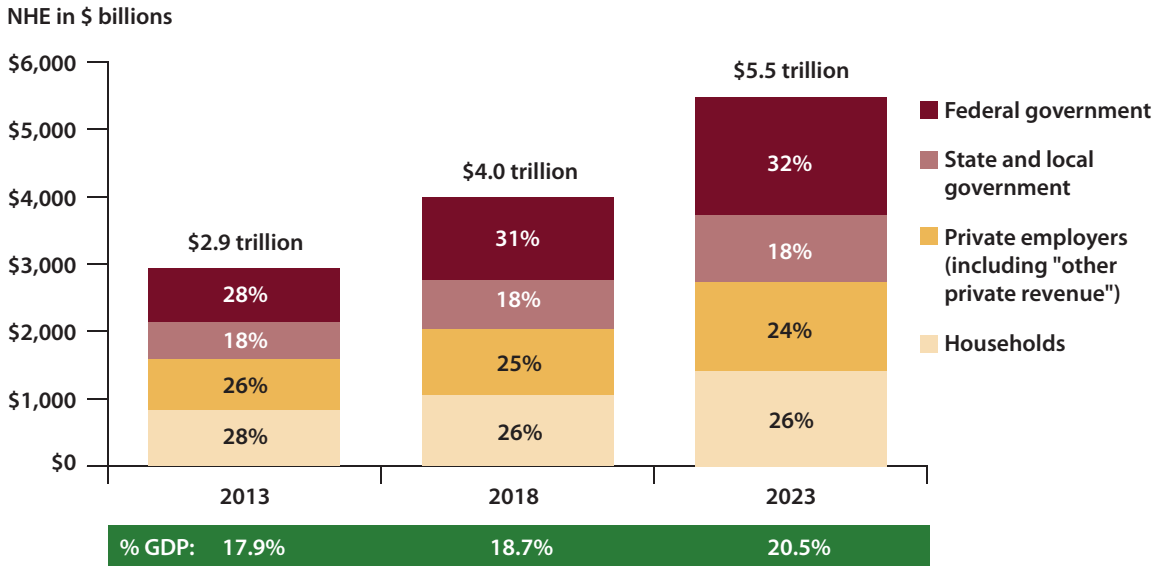
health insurance premiums already amounts to 23 percent of median family income, on average, for the working-age population. If projected trends continue, the average premium for a family plan would exceed $24,000 by 2021—the equivalent of 31 percent of median family income, intensifying pressure on family budgets across the country.[10] With deductibles up sharply and premiums already representing a high share of income for even middle-class households, affordability is of intense concern to working-age adults and their families.[11] If we could succeed in slowing the growth rate by 1 percent to 1.5 percent per year compared with historic trends while preserving coverage, it would mean $2,000 to $3,000 in premium savings by the end of the decade for families insured through employers—freeing up funds that could then be available for wages.[12]

Thus, the rising costs of health care are a shared concern. Total business and household spending on health, as well as federal health spending, are projected to increase sharply between 2013 and 2023 as national health expenditures increase from $2.9 trillion to $5.5 trillion (Exhibit 4). Businesses and households are projected to pay half of total national health care costs in 2023, while the federal government will pay 32 percent and state and local governments will pay 18 percent. Although the business share will be somewhat smaller in 2023 than in 2013 as a result of the aging of the population, total business spending on health benefits is projected to increase by 60 percent over the decade.

The challenge for national policy leaders and the federal government, then, is how to further stabilize and slow the increase in Medicare and Medicaid spending per enrollee, given already relatively low projected rates of growth. To secure further reductions in the growth rates, federal programs will need to work in concert with private payers to address the underlying factors that are driving up the costs of care across the health system.

At the same time, as pressure mounts to address the federal deficit and puts greater focus on federal health spending, it is imperative to act in ways that are consistent with the goals of a high

Exhibit 4. Projected U.S. National Health Expenditures (NHE) by Source, 2013–2023



Note: GDP = gross domestic product.
Source: Estimates by Actuarial Research Corporation for The Commonwealth Fund.

performance health system. The current situation presents both a crisis and an opportunity to accelerate movement to a high-quality, innovative system that is accessible for all—while stabilizing health care costs.

With the goal of informing national policy, this report provides a framework, sets criteria, and outlines actions that could reduce future federal health care spending primarily by accelerating delivery system reform and innovation. If implemented soon and effectively, the policies described here have the potential to produce significant savings for state and local governments, businesses, and households as well as the federal government, while improving health system performance.

These policies target the underlying factors contributing to rising health care costs while continuing to support the overarching goal of a high-performing health system. As background for these policies, the following two sections: 1) summarize key factors contributing to rising costs for private and public payers; and 2) present a framework and criteria to guide and inform policy choices.

The policy section of the report then describes a set of actions that address factors driving up costs while adhering to the proposed criteria. These synergistic policies combine payment reforms, incentives and information for engaging consumers in high-value choices, and other reforms to improve the way markets function. We estimate the potential impact over the next 10 years using illustrative policies consistent with such a strategic approach.

The concluding section of the report discusses the need to act soon and the importance of all payers pulling together to bring cost growth in line with economic growth in ways that also secure access to care and improve health system performance.

FACTORS DRIVING UP HEALTH CARE SPENDING

Health spending, by definition, is the product of the price paid for health services and the volume and intensity of services used. Both prices and utilization

have contributed to high levels of and increases in health spending in the public and private sectors. Moreover, there is considerable overlap between key factors influencing prices and volume.[13] Although the specific contribution of each factor to total costs is debatable, most are amenable to policies that address high or rising costs and the gap between costs and value.[14]

Prices

The U.S. pays much higher prices for health services than do other countries, whether for drugs, medical devices, diagnostic tests, or other services.[15] There is also wide variation in the prices paid by different payers for the same services. Even more striking, a single insurer in the private sector may pay widely different prices for the same service, depending on the provider, and different insurers pay very different prices for the same service from the same provider.[16] Such incoherence appears to be the norm rather than the exception.[17] Studies indicate that prices tend to be highest for services delivered by providers that dominate the market or that are regarded as "must have" by insurers, and thus have market power.

In recent years, higher prices paid by private insurers have accounted for most of the increase in health insurance premiums.[18] Yet a lack of transparency makes it difficult to see, much less address, price concerns.[19] Critical factors contributing to high and rising prices include:

- *Concentration of market power.* Both the private health insurance industry and the health care delivery system have become more concentrated over time, although the degree of concentration varies across geographic areas. As a result, the relative market power of some providers to charge more, and payers to pass on these costs to business and households, have emerged as central concerns.[20]
- *Administrative costs.* Administrative costs in the U.S. are considerably higher than in other countries.[21] Monitoring and complying with the myriad regulations promulgated as a result of the fragmentation of the health care financing and delivery systems adds substantial overhead costs to private insurers and public payers as well as internal costs to providers. The costs to providers include the time that physicians and their staff members spend interacting with health plans that could otherwise have been devoted to patient care.[22] Higher administrative costs drive up prices in the health care market with minimal contribution to quality or access to care.

Volume and Intensity

Current fee-for-service payment in both the public and private sectors rewards the provision of more health services and procedure-based treatments, regardless of their contribution to better patient outcomes.[23] Although volume and intensity vary across geographic areas and category of service, the overall trend has been one of upward pressure on total health spending.[24] This trend is driven by several key factors:

- *Fragmented care and care systems.* Health care is too often fragmented as a result of failures to share information and develop a treatment plan among the various clinicians who may care for a particular patient, especially for patients with multiple or complex conditions. Several studies indicate the potential benefits of primary care teams that include nurses and other clinicians in addition to doctors, especially for care for high-risk patients.[25] These gains are enhanced by more integrated care systems, in which specialists and primary care clinicians work together supported by systems that provide key information across

sites of care, including during transitions from a hospital to community or home care.

- *Medical technology.* Unlike in most industries, in health care the availability of new technology has tended to add to costs rather than lowering them.[26] Although new technology may contribute to better health in specific applications, the frequent lack of connection between the value and the price of new drugs, devices, and treatments is a symptom of market failure.[27] Conversely, technology with the potential to yield social benefits that accrue beyond an individual practice or facility—such as health information technology—is slow to spread without targeted policies that provide incentives for adoption and use across markets.[28]
- *Malpractice liability.* Estimates of the impact of the current malpractice system on excessive screening and other tests in reaction to fear of lawsuits range from minimal to more substantial.[29] But whatever the contribution to costs, malpractice reforms that reward best practices, provide fair compensation for injury, and encourage patient safety would be more effective in mitigating incentives to do more tests and promoting a culture of safety than the current system.[30]
- *Increasing prevalence of chronic medical conditions.* Estimates of the contributions of obesity and other chronic conditions to rising health care costs vary.[31] Still, chronic conditions certainly account for a large and growing proportion of U.S. health spending, especially among the elderly.[32] Initiatives that encourage healthier aging and the use of teams to support and manage care for people with multiple chronic conditions offer the potential to slow decline in health or prevent complications, improve care, and reduce cost growth.[33]
- *Changing demographics.* The U.S. population is growing older, as are the populations of most high-income countries. In fact, many countries already have much older populations than the U.S.[34] The aging of the population has important implications for health spending because the elderly tend to have greater health care needs. Without innovation in the way we deliver care, it will be difficult to meet the needs of our aging population and hold the line on health spending.[35]

Although their impact may differ by geographic area or sector, all of these factors contribute to both public and private health spending, and most are directly amenable to policy. However, policies that target federal programs alone or simply shift costs to states, businesses, or households potentially destabilize the health care system and ignore the underlying market realities. A successful strategy to stabilize health spending will require a multipronged approach, guided by a strategic framework to improve performance across the health system.

CRITERIA FOR STABILIZING HEALTH SPENDING GROWTH AND IMPROVING SYSTEM PERFORMANCE

As national policy leaders consider approaches to slow and stabilize the growth of federal health spending in ways that also benefit all payers (state and local governments, businesses, and households), it is crucial that these approaches be developed and applied to adhere to and further the goals of a high performance health system. These goals include providing affordable access across the nation to high-quality, well-coordinated and patient-centered care with continuous delivery system innovation.[36] Achieving the goals of a high performance health system, while stabilizing cost growth, requires a

focus on the total health system and health care markets, not just federal programs.

There is an urgent need to act and to do so strategically within a framework and guided by criteria that promote these overall goals. Otherwise, we risk producing unintended consequences (including harm to vulnerable populations) and/or pursuing self-defeating and ineffective action. For example, approaches that focus only on cutting eligibility and benefits, or slashing payments to providers, may reduce the projected growth of federal spending, but only by shifting costs to individuals and employers while undermining access to care.[37] By contrast, innovative federal actions, such as payment reforms through Medicare and Medicaid, as well as those that establish partnerships with private payers, providers, and consumers, have the potential to accelerate the pace of change across communities. Indeed, in the past, private payers have often followed Medicare's lead in implementing innovative payment reform—such as with the introduction of more bundled payments for hospitals using diagnosis-related groups (DRGs) and the implementation of the resource-based relative value scale for determining physician fees. And Medicare has implemented approaches that have been developed in the private sector as well, such as value-based purchasing.

A framework that considers the potential for federal policies to spread through collaboration with states and private payers—and that takes the best of what private or public sectors have to offer—could align incentives across markets to accelerate delivery system reform. Further, having public and private payers work in concert is critical for sending consistent market signals to hold care systems accountable for innovating to improve population health and add value.

Ensuring that patients have access to high-quality care is fundamental to a high performance health system and to improving population health. Thus, any action addressing costs must preserve access and enhance equity. At the same time, value-based insurance benefit designs that lower or eliminate costs for essential care and provide incentives and information to guide choices of care and care systems—and to choose wisely—could augment and support provider incentives to focus on outcomes and value.

With the aim of making continued progress toward a high performance health system—one that is high-quality, innovative, accessible, and affordable for all—the Commission developed the following criteria to guide the selection and design of policies to control health spending. These criteria adhere to the goals of a high performance health system and guide the selection of policies that have the potential to make a positive difference (Exhibit 5).

Exhibit 5. High Performance Health System Criteria for Developing Options to Stabilize Spending Growth

- Set targets for total spending growth
- Pay for value to accelerate delivery system reform for better outcomes, better care, at lower costs
- Address the systemwide causes of health spending growth—not just federal health costs
- Align incentives for providers and consumers across public and private payers
- Protect access and enhance equity, but also engage and inform consumers
- Invest in information systems to guide action

- **Set spending targets.** Set national and regional targets for health spending growth that limit increases in health spending to the rate of growth of the economy as a whole. Such targets would focus attention on growth rates, create accountability for excessive growth and provide a benchmark against which to judge the success of policies. Setting targets and tracking cost trends would inform future actions aimed at addressing problem areas, while allowing sufficient growth to capture the benefits of advances in biomedical science.
- **Pay for value to accelerate delivery system reform.** Hold providers accountable for population health outcomes and high-value care. Changing the way care is delivered, managed, and coordinated is critical to stabilizing health spending and improving outcomes.
- **Focus systemwide.** Policies to control health spending growth should address its systemwide causes and effects, not just federal costs. Federal spending is an imminent concern, but health spending growth also puts pressure on state and local governments, businesses, and households. It will be important to stabilize spending for everyone, not shift costs from one stakeholder to another.
- **Align incentives.** Public and private payers should act in concert, adopting similar payment reforms to send consistent signals and provide support for innovative care teams and accountable care systems. It is essential to align incentives for providers and consumers across public and private payers to advance the "triple aim" of better care, better health, and lower costs.[38]
- **Protect access to care and enhance equity while engaging consumers.** Access to care and equity must be protected and enhanced, but consumers also should be engaged in the process of improving health and choosing high-value care.
- **Invest in information to guide action.** Invest in better information and information systems on clinical outcomes and costs of care to drive and guide consumer choices, providers' health care decisions, and policy.

In devising policies to confront health care costs, we can draw on the authority to innovate and the tools that are already available as a result of recent health reform legislation, thus building on the momentum of promising efforts under way across the country. As a result of congressional action and efforts of multiple groups around the country, the nation is investing in the spread and use of health information technology, better information to inform patients about the risks and benefits of treatment choices, and an array of payment and delivery system reforms intended to reduce long-term health spending and improve health system performance.[39] (See box on next page, Initiatives and Provisions Currently in Place to Support Health System Reform.)

Federal, state, and private-sector concerns about costs have stimulated joint Medicare and Medicaid initiatives, as well as partnerships among federal and state governments and private payers. We are also seeing new collaboration among providers and between providers and payers around the joint

goals of better quality and lower costs.[40] This momentum includes several physician specialty groups' actions to identify treatments and care that are potentially inappropriate or ineffective through the Choosing Wisely campaign to engage and inform patients.[41]

As policymakers and the nation confront the urgent need to stabilize health spending, these activities provide a foundation on which to build. However, we need to accelerate the pace of change by implementing policies that can help create a more affordable, better health care system for all.

INITIATIVES AND PROVISIONS CURRENTLY IN PLACE TO SUPPORT HEALTH SYSTEM REFORM

- Insurance market reforms: will provide choice, establish essential benefit designs that include preventive care, and create market rules that ensure access, increase transparency, and focus competition among insurers on improving value for their enrollees.
- Health information technology: Policies and funding to encourage physicians, hospitals, and other providers to use electronic health records and exchange information to improve the efficiency and quality of the care they provide.
- Value-based purchasing: Public and private efforts to use financial incentives to improve quality, safety, and outcomes, including reducing hospital infection and readmission rates.
- Medicare Advantage: Revised payment for private Medicare Advantage plans with incentives for efficient provision of care and rewards for high performance.
- Primary care: Enhanced Medicare and Medicaid payment for primary care and new ways of paying for primary care that support medical homes and similar models.
- Bundled payment: Public and private bundled payment initiatives for hospitals to encourage better care in the hospital, better transitions between care settings, and coordination with postacute settings.
- Medicare Shared Savings Program: to foster the development of accountable care organizations, with groups of providers taking broad responsibility for the quality, outcomes, and costs of care and earning rewards for high performance. Multiple initiatives include Medicare as part of multipayer efforts.
- Federal/state Medicaid initiatives: teams and "health homes" to coordinate and provide care for those with multiple chronic conditions, and advanced care teams for ongoing care for high-risk patients.
- Private initiatives: Multiple private insurer initiatives to support patient-centered primary care homes, accountable networks, bundled payments for care, and shared savings agreements.
- Center for Medicare and Medicaid Innovation: authority to develop, implement, assess, and spread promising models of care payment and delivery. The authorization allows the HHS Secretary to extend and expand successful innovations if they reduce costs and/or improve outcomes. Medicare also is provided with authority to partner with state and private-payer initiatives.
- Patient-Centered Outcomes Research Institute: public/private partnership to encourage research on diagnosis and treatment options as well as ways to improve health care systems and accelerate patient-centered outcomes research and methodological research.
- Administrative reforms: more standardized reporting and electronic submissions and standards to lower overhead costs for private insurance.

GETTING AHEAD OF THE CURVE: POLICIES TO STABILIZE HEALTH CARE SPENDING WHILE IMPROVING SYSTEM PERFORMANCE

To address federal and broader national concerns about affordability and health care costs, it is imperative to act, but do so in ways that are consistent with the goals of a high performance health system. Guided by the criteria described above, the Commission set the goal of holding future growth in health spending to no greater than the long-term growth of the economy, and to do so primarily by reforming the way health care is paid for and delivered.

The initiatives described below seek to harness provider incentives, consumer incentives, and market interactions so that all pull in the same direction of better care and care experiences at lower cost. The policies also would allow flexibility for local innovation and provide better, more transparent information for consumers and health system leaders to choose and act wisely. Using a three-pronged approach, these policies would: 1) use payment reform to reward value and accelerate delivery system innovation; 2) engage consumers with information and positive incentives to choose high-value care and care systems; and 3) implement other systemwide reforms to address market forces driving costs, including administrative complexity, malpractice costs, and consolidation of market power. Improving the way markets function also includes setting a target for total spending growth at no more than economic growth to hold care systems and insurers accountable for the overall costs of care in ways that meet the needs of the population.

Provider Payment Reform to Promote Value and Accelerate Delivery System Innovation: Create incentives to coordinate care, lower costs, and improve outcomes.

As a result of an aging population and insurance expansions, over the next decade Medicare, Medicaid, and the Children's Health Insurance Program (CHIP) together will be paying for care for more than 40 percent of the population (150 million people).[42] It is possible, then, to implement widespread reform by starting with these programs. The following payment policies would use payment reform to accelerate the pace of delivery system innovation and care integration and coordination, while increasing accountability for improving outcomes and reducing cost growth per beneficiary over time. To maximize the impact and ensure consistent signals, the policies would coordinate public programs' payment policies (Medicare, Medicaid, and other public programs) and facilitate spread to private payers to align incentives and reduce administrative complexity for providers.

The net effect of these policies would be to move from our current unfettered fee-for-service payment system into one that pays for value, including more bundled payment approaches that reward efficient care and better population outcomes. These payment changes would accelerate delivery system transformation to improve population health at lower cost, and would promote diverse organizational models that enable providers to better manage the quality and cost of care for their patient populations.

In addition, these policies would strengthen primary care by providing funds for better practice infrastructure (such as health information technology and teams to manage high-cost patients and coordinate care). Policies focused on primary care would include incentives and expanded resources

(including nurses and other clinicians) to improve outcomes, while maintaining or enhancing primary care physicians' income.

Finally, the set of payment reform policies would replace the current Medicare sustainable growth rate (SGR) formula that calls for an across-the-board reduction in payment to physicians. A new Medicare physician payment policy would include incentives to join and develop high-value care networks and care systems while eliminating the scheduled cuts.

The following four illustrative payment reform policies would move away from paying fees for services to paying for value to accelerate delivery system reform while incentivizing and supporting providers to lower costs and improve care.

1. **Medicare physician fees: pay for value.**
   Replace Medicare's current system for determining physician fees (and the resulting reductions called for under current law) by holding fees constant at their current level, while adjusting relative payment rates that meet specified criteria as "overpriced." Provide increases in future prices only for providers participating in payment and delivery system innovations with accountability for the populations they serve. Institute competitive bidding for medical commodities (drugs, equipment, and supplies).

One impediment to using payment policy to accelerate delivery system innovation with a focus on paying for value is the sustainable growth rate (SGR) formula used to set Medicare physician fees.[43] This formula was intended to counteract the incentive to increase volume and intensity by imposing across-the-board reductions in fees if Medicare physician spending growth exceeded a predetermined target. Since 2003, however, Congress has intervened to supersede the scheduled reductions temporarily, without changing the formula. Medicare physician fees were scheduled to be cut by 27 percent across the board—for every service—on January 1, 2013.[44] Congress postponed the cuts for a year. There is broad consensus on the need to replace the SGR policies.

This policy would repeal and replace the SGR with a Medicare physician payment policy that provides incentives to improve health outcomes and participate in care system innovation. The policy would restructure the Medicare fee schedule to reduce payment rates for services meeting specified criteria as overpriced, and institute a system for future increases tied to performance.[45] To move more quickly to models of coordinated care with accountability for outcomes, the policy would provide future increases in fees only for providers participating in innovative payment or delivery systems such as patient-centered medical homes (see below), bundled payment, and accountable care organizations. Fees would otherwise remain at 2013 levels. To use the market to drive down costs, Medicare could institute competitive bidding for medical commodities.[46]

2. **Strengthen patient-centered primary care and support care teams for high-cost, complex patients.**
   Change payment of primary care to reward care management, coordination, and a team-based systemic approach to caring for patients under Medicare, Medicaid, other public programs, and private plans participating in health insurance exchanges.

Strengthening the primary care foundation of the nation's health system is critical to providing timely access to care, preventive care, and better outcomes for those with chronic disease. Rich evidence from within the U.S. and abroad attests to the potential of redesigned primary care and care teams to improve care and patient experiences—and to lower costs over time by preventing complications

and reducing avoidable use of hospitals and more specialized care.[47] By enhancing primary care payment tied to the capacity to serve as patient-centered medical homes with teams for managing care for chronic conditions across sites of care, payment reform would strengthen primary care and overall systems of care. This policy would augment fee-for-service payments with additional payment for care coordination, 24/7 access, and the use of teams for care delivery under Medicare, Medicaid, other federal programs, and private plans. It would include incentives for providers to improve patient outcomes. The policy would complement new Medicare beneficiary incentives that include reduced cost-sharing for those who select patient-centered medical homes and chronic care teams (discussed below).

In addition to providing core support for medical homes, the policy would invest in the development and more intensive use of teams to manage care and improve care coordination by providing enhanced payment to providers that have the team-based capacity to care for high-cost patients with multiple chronic diseases or disability. Such teams would include nurses and other clinicians working with primary care physicians and would provide and coordinate after-hours or at-home care. Care teams responsible for high-risk, high-cost patients would work interactively with hospitals and specialists to ensure patients make smooth transitions across care settings and receive follow-up care after hospitalizations. Such teams would be held accountable for patients receiving timely, safe, and effective care.

New payment incentives and support for comprehensive primary care teams through Medicare and Medicaid would spread efforts already under way that include the use of multidisciplinary teams of doctors, nurses, and others to support and engage patients.[48] This policy would focus on the highest-cost Medicare and Medicaid patients and extend to the Federal Employees Health Benefits Program, the military health coverage programs (TRICARE and the Civilian Health and Medical Program of the Uniformed Services), the Veterans Health Administration, and other federal programs. Public programs would partner with private payers where possible to enhance community-wide access to more effective, patient-centered care teams and networks.

3. **Bundle hospital payment to focus on total costs and patient outcomes.**
   Accelerate bundled payment approaches for hospital and postacute care under Medicare, Medicaid, other public programs (including the Federal Employees Health Benefits Program) and private plans participating in insurance exchanges.

Currently, Medicare, Medicaid, and private insurer payments for hospital care typically do not include physician services and do not hold hospitals accountable for readmissions or follow-up care. More-inclusive bundled payments in which a single payment is made for all care provided during an episode of care involving a hospital stay—including physician services—would provide incentives for teamwork and accountability for the total costs of care and outcomes associated with hospital episodes of care. Medicare has begun a pilot to test alternative approaches to bundled payment. One model being tested bundles physicians' services and postacute transition care for selected procedures. Several bundled payment initiatives have been implemented in the private sector as well.[49] Accelerating bundled payment for hospital and posthospital care under Medicare, Medicaid, the Federal Employees Health Benefits Program, and other public programs and private plans in insurance exchanges would support movement toward high performance, and provide incentives for hospitals to make transitions and follow-up care a priority. Greater use of bundled

payment for hospital care and postacute care also would make it easier for patients as well as payers to compare and assess the total costs of care and quality for certain procedures and conditions such as hip replacement surgery, appendectomy, or heart bypass surgery.

4. **Adopt payment reforms across markets, with public and private payers working in concert.** Align payment incentives across public and private payers to enable and support more accountable care systems. Require private plans participating in health insurance exchanges to incorporate alternative payment approaches to support delivery system innovation such as primary care medical homes, care teams, bundled payment for hospital episodes, and shared savings or global payment arrangements with provider systems. Encourage private plans in each state to negotiate prices consistent with efficient care and value and not to just pass on higher prices to consumers.

With federal and state health care programs insuring over 40 percent of the population, including those 65 and older, the disabled, and patients with long-term, complex health conditions, the acceleration of payment policy innovations across federal and state public programs would stimulate change across the country, supporting local care system innovation to achieve the triple aim of better care, better health, and lower costs. This effect would be amplified and benefit private as well as publicly insured families if similar payment methods applied to private as well as public payers. Ensuring that public and private payers employ the same or similar payment methods and reporting requirements would also reduce complexity for physicians and strengthen incentives to transform their practices in ways that improve the value of care. Requiring plans participating in health insurance exchanges to incorporate alternative payment approaches, such as bundled payment and support for medical homes and high-cost care teams, would further accelerate practice innovation.

More consistent payment approaches across payers could also help counteract the concentration of provider market power. Under state or federal government auspices, allowing multiple payers to negotiate jointly to employ similar payment methods and more consistent pricing that promotes efficient care and value—rather than passing on higher prices in consolidated markets—could lower private insurance premium costs for businesses and families and counteract concentration of market power in some areas of the country. However, such negotiations would likely need to be under some type of public authority to avoid violation of antitrust statutes and to ensure that joint payer action converts savings into lower premiums rather than surplus for dominant private insurers. Antitrust oversight could also enable integration of care systems, as long as the net effect is to lower costs and improve quality. Improving the way private insurance markets function and pay providers for care is of paramount interest to families as well as employers that sponsor and pay for employee health benefits. With the federal government providing premium tax credits for modest- and lower-income families enrolled through health insurance exchanges, stabilizing private health insurance costs would also mean lower federal outlays in the future.

Policies to Expand Options and Encourage High-Value Choices by Consumers: Create incentives for consumers to choose high-value care and high-performing health care systems, armed with comparative information about quality and costs. Currently, patients and consumers have very little information to guide their care decisions or to choose care or care systems wisely.[50] The lack of information about different treatment choices, clinical outcomes, prices, total costs, and quality of care

has discouraged efforts to develop insurance benefit designs that provide positive incentives to seek care from high-value care teams or networks. In all communities, annual health spending is highly concentrated among the sickest 10 percent of the population, who account for 65 percent of total health spending.[51] This population includes those with cancer, heart attacks, major injuries, and multiple chronic illnesses. In contrast, the healthiest half of the population accounts for just 5 percent of total spending each year. Given that the bulk of health spending is for the sickest patients, it is important that efforts to engage consumers do not increase the substantial costs already borne by these vulnerable patients. To improve care outcomes and lower costs, policies should instead focus on providing better information and positive incentives to choose wisely based on value.

Engaging consumers requires providing better information on alternative care choices, as well as incentives to choose care systems that provide better patient outcomes and more patient-centered care. With advances in communication and health information technology (HIT), we have the potential to track, assess, and use information about clinical outcomes over time to inform and guide treatment decisions. As HIT spreads, following investments made possible by the 2009 economic stimulus bill, meaningful use and exchange capacity have the potential to provide more timely and longitudinal information on clinical outcomes resulting from different care decisions.

A consumer-friendly, patient-centered approach to providing information and positive incentives to choose wisely would complement payment policies that give providers incentives to innovate and collaborate while being held accountable for population outcomes and the total costs of care. Positive consumer incentives include reducing cost-sharing or eliminating cost-sharing altogether for essential, highly effective care, and providing patients with comparative cost information for equivalent care choices. To enable such informed choice, there is also a critical need to expand scientific information about the comparative risks and benefits of alternative treatment choices, with assessment of outcomes for existing as well as new medical technologies and practice.

The following three illustrative policies would promote consumer engagement in making informed, high-value choices about providers and treatments.

5. **Offer Medicare beneficiaries a new "Medicare Essential" plan that provides more comprehensive benefits and better protection against catastrophic costs, with provider and enrollee incentives to achieve better care, better health, and lower costs.**
   Use a value-based benefit design that provides positive incentives for Medicare beneficiaries to seek care from high-performing care systems, such as patient-centered medical homes, health care teams, accountable care organizations, integrated delivery systems, and other organized systems of care. These incentives would be aligned with payment reforms that give providers incentives to develop and join innovative care systems that improve patient outcomes and care experiences.

Currently, Medicare beneficiaries who decide to stay in traditional Medicare face a benefit structure that exposes them to unlimited risk for high costs of care unless they buy supplemental "Medigap" coverage and Part D plans to cover prescription medications. The current core benefits also include separate deductibles for hospital care, physicians, and prescription medications. The need for three insurance policies is confusing to beneficiaries and generates high administrative costs and high annual premium costs. Having multiple policies also

makes it more difficult to obtain the data needed to coordinate care effectively and complicates efforts to incorporate appropriate incentives that benefit the patient and ensure essential care (e.g., reduce hospitalizations through improved medication adherence.)

Offering Medicare beneficiaries a competitive Medicare Essential plan with integrated benefits that limit out-of-pocket costs while providing positive incentives to seek care from high-value care networks and teams would engage Medicare beneficiaries while protecting access and affordability. These positive incentives would work in tandem with the provider payment policies described above to encourage physician participation in high-performing health care organizations and payment innovations, including the formation of patient-centered medical homes, high-cost care teams, and high-value provider networks. Beneficiaries could enroll in a modernized Medicare Essential benefit option with deductibles or copayments lowered or eliminated for those who register with a medical home or receive care from a care team. This would involve the designation of a set of essential benefits, including integrated Part A (Hospital Insurance, which covers facility-based care), Part B (Supplementary Medical Insurance, which covers physician services), and Part D (the Prescription Drug Benefit) services and an overall out-of-pocket spending limit for covered services. This option could be designed as self-financing, with beneficiaries paying a premium directly to Medicare.

In estimating the potential premium cost for such a Medicare Essential plan we find it would generally be lower than the amount seniors typically pay for current Medicare Supplements (Medigap policies), in part because of lower administrative costs.[52] This confirms earlier analyses that similarly found that the resulting premium could be less than the current premiums paid by beneficiaries with private Medigap policies that provide supplemental coverage.[53]

The benefit package of a Medicare Essential plan would more closely correspond to that provided by private plans in Medicare Advantage and those available through public and private employers. This would provide beneficiaries with real choices among health plan options. Recalibrating payments to Medicare Advantage plans based on the costs of the new Medicare option, with shared savings for lower-cost, high-quality plans and their enrollees, would encourage plans to operate more efficiently and encourage beneficiaries to select the best plan for them. High-quality plans would be those that perform well (4 or more stars out of the maximum of 5) according to the rating system used by Medicare.[54]

6. **Provide positive incentives for Medicare and Medicaid beneficiaries to seek care from high-value, patient-centered medical homes, care teams, accountable care organizations, and integrated delivery systems.**
   Work with local employer coalitions to spread the same value-based approach with positive incentives for patients in private plans.

To complement provider incentives to strengthen primary care and participate in accountable care networks, both Medicare and Medicaid would offer beneficiaries positive incentives to select care from practices and networks with proven track records of better outcomes. In Medicare, the deductible would be waived for primary care for beneficiaries who register with a practice that is a medical home or for care teams with the capacity to care for high-cost, high-risk patients. Cost-sharing also could be reduced for those patients who agree to receive care from networks that participate in the Medicare

Shared Savings Program or the Pioneer ACO initiative. To spread this approach in Medicaid, high-cost and chronically ill patients who elect to receive care provided by teams would be provided with access to enhanced services. Private plans participating in Medicare Advantage, Medicaid, and insurance exchanges would be encouraged to follow a similar approach and to align incentives across markets to support high-value care teams and care systems. Efforts to align information and provide positive incentives would be particularly important for networks participating as ACOs with multiple payers, including public and private payers.

7. Inform choice.
Enhance clinical information on outcomes of care and patient experiences to inform choice of care and care systems by accelerating "meaningful use" of health information technology to assess and compare clinical outcomes over time from alternative treatment choices and use registries to enable post-market surveillance of safety and outcomes. Promote transparency about health care costs and prices to further inform choices.

Providing better information on the benefits, safety, and cost of alternative high-cost medical treatment choices or technologies would inform decisions by patients and providers. As use of electronic medical records spreads, with enhanced capacity to exchange information across providers, the nation has the potential to reap benefits from its investment in smarter information systems and clinical support. Meaningful use of such systems, however, will require a concerted effort across care systems to pool information on outcomes to track and assess patient experience. The potential to learn from experience would be further enhanced with registries that track experience with medical devices or other high-tech procedures, such as the registry for total joint replacement maintained by Kaiser Permanente.[55] Developing a national approach, rather than relying on private systems, would provide information about the safety of devices and other technologies as well as their comparative benefits for patients and doctors.

Having all-payer information on prices, quality, patient experiences, and outcomes of care, at both the state and community levels, would inform consumer choice. It also would inform efforts by providers to improve care by setting benchmarks and targets, and would enable payers (both public and private) to develop more value-based insurance benefit designs.

Policy leaders also may want to consider a ban on direct-to-consumer advertising for medical devices and prescription drugs in favor of providing information from unbiased, scientific sources. This would represent a return to policies in force in the United States before 1997.[56] Having trusted third-party sources that compare alternatives would further enhance the ability of consumers and physicians to make informed choices. Alternatively, there could be tightened oversight of claims in advertising.

Systemwide Action to Improve How Health Care Markets Function: Reduce administrative costs, reform malpractice policy, and set targets for total spending growth nationally and at other geographic levels.

Currently, health care markets do not function well. Fragmented payment policies and reporting requirements have given rise to an incoherent range of prices paid for the same service and same provider, and added layers of administrative costs for providers and health plans. At the same time, current malpractice liability laws provide incentives to do more testing while failing to address safety concerns.

Within local markets, consolidation of providers that may result in higher-quality and more-integrated care also has the potential to increase

prices, irrespective of value, if a relative imbalance of market power results from the consolidation. In recent years, increasing concentration has been an important factor in driving up costs for care systems and for health insurance. Indeed, increases in prices paid for care by private insurers for "must have" providers or dominant systems have accounted for much of the rise in private insurance premium costs as insurers pass on the higher costs, taking the path of least resistance.[57] This dynamic puts pressure on public programs to pay more, adding up to a recipe for increases in total spending in excess of economic growth.

As described above, transparency about health care prices, quality, and outcomes would inform consumer choice as well as providers' efforts to improve. However, transparency alone will do little to address rising prices. Indeed, there is the potential for lower-cost providers to aim for the high end of the range once this is made public. And in communities where markets are concentrated, with few alternative sources of care available, consolidated market power could overwhelm and undermine any incentives for consumers to compare costs.

Given the reality of the current health insurance and delivery system market dynamics and concentration, systemwide efforts will be needed to complement payment reforms and incentives for consumers. This includes systemic efforts to lower the administrative costs that result from having multiple payers and failure to coordinate or standardize insurers' policies.

To support payment reforms and incentives for consumers to choose wisely, the following policies seek to further improve the functioning of health care markets by reducing excessive administrative costs, reforming malpractice to promote safety and fair compensation, and enabling multipayer approaches.

Establishing a spending target and providing data on total spending (by both public and private payers) at national, state, and local levels would further inform policies over time and hold health care markets accountable. The targets, shaped by information on sources of cost increases and comparative data, would enable adjustment of policies to focus on what further action might be needed to achieve the goal of holding health spending increases to no more than the growth of the economy.

8. **Simplify and unify administrative policies and procedures across public and private plans to reduce administrative costs and complexity.**

Currently, private insurers employ different payment methods, reporting requirements, benefit designs, and regulatory policies. As a result, physicians and hospitals face complex insurance payment, regulatory, and reporting policies with consequently high administrative costs. This complexity also results in insurance administrative costs in the United States that are well above those in other countries, including those with multiple payers and private insurance markets. Recent forums of insurers and providers, and the policy papers they produced, have concurred that the multiple variations add cost without value, and that there is the potential for substantial savings with simplification.[58] But with variation seen as a potential market niche, each insurer alone has had little incentive to act.

Policies that simplify and require more uniform administrative policies and procedures across public and private plans would reduce an expensive layer of paperwork and make it easier for providers to focus on providing more effective, coordinated, and efficient care. Integrating administrative records systems, electronic submission of claims, shared

provider enrollment and credentialing systems, and common quality reporting would reduce redundancy and complexity that add time and staffing costs for practices and hospitals. The reduced administrative cost burden would largely accrue to physicians and hospitals. Streamlined enrollment processes for Medicaid and new insurance exchanges would also reduce health plan and insurance system administrative costs and promote more continuous enrollment.[59] Such efforts would build on beginning steps for administrative simplification embedded in the Affordable Care Act.[60]

9. **Reform medical malpractice policy.** Malpractice reforms should be linked to payment reforms and should provide fair compensation for injury while promoting patient safety and adoption of best practices.

Like administrative burdens, high premiums for professional liability insurance add to practice costs, especially for some specialties. Yet, despite its expense, the current malpractice system fails to create effective incentives to provide safe or evidence-based care, or to encourage admissions of mistakes or errors to inform corrective action. Reforming the malpractice system to include provisions for fair compensation for injury and medical costs, policies to encourage disclosure of errors, and protection for those adopting evidence-based practice could curb incentives to provide excessive or inappropriate care. Creating an environment that encourages the medical profession to police itself—with information shared across state borders for licensure—would further protect patients. Such an approach would also promote patient safety and evidence-based practice.

Although system savings would likely be modest, coupling such malpractice reform with Medicare payment reform would further focus incentives on value, and avoid liability incentives that could lead to or be cited as the reason for excessive care.

10. **Establish spending targets.** Target total public and private spending (combined) to grow at a rate no greater than economic growth per capita. Set targets at national and other geographic levels and adjust policies as appropriate based on progress toward meeting those targets. Collect data to inform and enable state and local action and allow for focused policy responses if growth exceeds targets.

Starting in 2014, the federal government will be providing tax credits to low- and modest-income families to help them buy insurance through state exchanges. As noted above, private costs per capita (per enrollee) are rising faster than Medicare costs per capita, and they are projected to continue to increase faster through the coming decade. In many markets, private insurers pay more than Medicare for specialized services and hospital care, especially in markets with more provider concentration or "must have" providers. To the extent that Medicare incentives to form ACOs speed up market consolidation across a continuum of care, more integrated care systems could further shift the balance of market power in favor of higher prices.

Rising costs and higher private market prices increase costs to businesses and working families and threaten access for beneficiaries of public programs. Policies that require transparent information on prices, quality, patient experiences, and outcomes of care would inform efforts to reduce excess increases. Enabling multipayer initiatives, including joint negotiations, under public auspices, could further curb increases. With the above strategic payment, consumer, and market policies, it should be possible to make significant progress toward stabilizing health care spending growth to no greater than the growth in the economy.

Establishing such a spending target, and adjusting policies as needed if the target is exceeded, would focus attention on identifying the sources of excessive cost increases. For example, certain geographic regions, more consolidated markets, or specific service areas may be the heart of the problem. Data would be collected to enable state or local communities to establish baselines, set targets, and adjust policies as needed. A spending target would also guide any multipayer negotiations of payment methods and rates.

A policy that includes provisions for adjustment of policies over time and allows for focusing on specific geographic areas or services if trends exceed the target would provide impetus to act and collaborate. A well-designed policy could enable targeted action at the geographic or service area or within local markets, with flexibility to refocus over time as needed.

ESTIMATING THE IMPACT OF THE POLICY OPTIONS

To estimate the potential impact of combining payment reform, positive consumer incentives to make high-value choices, and marketwide policies, we detailed illustrative policies that correspond to the strategies described above. Since the spending target actions would allow for adjustment pending the impact of the other policies, we did not delineate a specific policy to achieve the target of holding health care spending growth to no more than economic growth. In other words, the spending target policy was not scored.

The Commonwealth Fund contracted with the Actuarial Research Corporation (ARC) to estimate the potential cumulative effects if all policies were in place starting in 2013, with first-year impacts in 2014. ARC estimated the incremental and cumulative spending impact over the 10-year period 2014 through 2023, compared with baseline projections under current policies. To estimate the potential of the combined policies, ARC adjusted estimates for each to reflect potential overlap.

For the baseline projections, ARC started with projections of national health expenditures, including spending and enrollment by major payer categories, from the Centers for Medicare and Medicaid Services Office of the Actuary. In recognition of the fact that Congress has consistently postponed the scheduled SGR cuts in Medicare physician fees, ARC used an alternative baseline that increases fees by 1 percent in 2013 and then holds base physician fees at their 2013 level under the assumption that Congress will continue to postpone the cuts throughout the decade. This would have the cumulative impact of raising total Medicare spending by some $334 billion dollars from 2014 through 2023, compared with current law. This alternative baseline is similar in concept to the "extended alternative fiscal scenario" presented by the Congressional Budget Office in their annual *Long-Term Budget Outlook*.[61]

The ARC estimates draw on existing evidence regarding likely responses to policy changes. As always with estimates of projected changes, actual impacts would depend on the specifics of policy proposals, how rapidly and well policies could be implemented, and behavioral responses across markets.

All estimates assume policies are enacted in 2013 and in place starting in 2014, with accelerating impact over time as they take hold and spread across public and private payers. A separate technical document provides assumptions and data used to model the potential impact and studies used to inform the specifications.[62]

THE POTENTIAL IMPACT OF THE COMMISSION'S POLICY OPTIONS

Analysis indicates that the policies consistent with the reforms discussed above offer the potential to slow and stabilize health spending, with significant savings across payers compared with projected spending over the next decade. By combining payment reform to accelerate delivery system innovation, initiatives to engage consumers to make high-value choices, and policies to lower administrative costs and improve the way health care markets function, total national spending could be reduced by a cumulative $2.0 trillion from 2014 through 2023, if all were enacted together as part of a unified, synergistic strategy (Exhibit 6).

Looking at potential savings by major payer category, the analysis indicates there would be substantial savings for both public and private payers compared with baseline projections as policies spread across markets. The federal government would save an estimated $1.036 trillion over the decade as a result of slower growth in spending per beneficiary for Medicare ($528 billion) and Medicaid (federal share: $369 billion). Households would save an estimated $537 billion as a result of lower premium and out-of-pocket costs for medical care. State and local governments would save $242 billion, primarily as a result of slower growth in their share of Medicaid costs (state share: $236 billion), but also because of slower growth in public employee health care costs. And private employers would save an estimated $189 billion as a result of lower costs per person for their employees and retirees.

Analysis by strategic area indicates that the bulk of potential savings would result from payment reform and the resulting delivery system change (Exhibit 7). Together, these policies account for $1.333 trillion of the estimated $2 trillion in potential cumulative savings. Engaging consumers to make high-value choices about their care and giving them better information and positive incentives to receive care through high-value care systems and care teams could achieve an additional net savings of $189 billion over the decade. Enabling consumers to make informed choices would also align incentives with payment reform to provide support and synergy for the development of higher-value care networks.

Focused efforts to improve the way health care markets function would reduce excessive administrative costs and ensure that care systems are held accountable for costs as well as health outcomes across all payers. Enacting strong measures to simplify and reduce administrative costs could potentially reduce net spending by $481 billion. Although malpractice savings would likely be small, reforms could reduce costs for providers and improve the signals they receive from health care markets.

Exhibit 6. Synergistic Strategy: Potential Cumulative Savings Compared with Current Baseline Projection, 2013–2023

Net impact in $ billions*

	Total NHE	Federal government	State and local government	Private employers	Households
2013–2018	–$686	–$345	–$84	–$66	–$192
2013–2023	–$2,004	–$1,036	–$242	–$189	–$537

Note: NHE = national health expenditures.
* Net effect does NOT include potential impact of spending target policy.
Source: Estimates by Actuarial Research Corporation for The Commonwealth Fund. Current baseline projection assumes that the cuts to Medicare physician fees under the sustainable growth rate (SGR) formula are repealed and basic physician fees are instead increased by 1% in 2013 and held constant from 2014 through 2023.

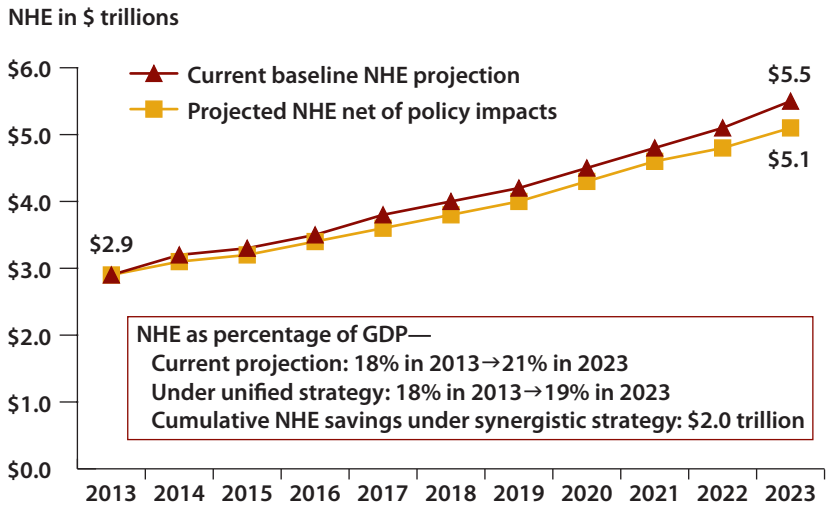
Exhibit 7. Synergistic Strategy: Cumulative Savings, 2013–2023

Payment reforms to accelerate delivery system innovation ($1,333 billion)
Pay for value: replace the SGR with provider payment incentives to improve care
Strengthen patient-centered primary care and support care teams
Bundle hospital payments to focus on total cost and outcomes
Align payment incentives across public and private payers
Policies to expand and encourage high-value choices ($189 billion)
Offer new Medicare Essential plan with integrated benefits through Medicare, offering positive incentives for use of high-value care and care systems
Provide positive incentives to seek care from patient-centered medical homes, care teams, and accountable care networks (Medicare, Medicaid, private plans)
Enhance clinical information to inform choice
Systemwide actions to improve how health care markets function ($481 billion)
Simplify and unify administrative policies and procedures
Reform malpractice policy and link to payment*
Target total public and private payment (combined) to grow at rate no greater than GDP per capita**

Notes: SGR = sustainable growth rate formula; GDP = gross domestic product.
* Malpractice policy savings included with provider payment policies.
** Target policy was not scored.

The above estimates of potential savings indicate that systemwide payment reforms, positive incentives for consumers to make high-value choices, and concerted efforts to reduce administrative costs could potentially hold spending growth to no more than GDP growth per capita for most of the decade, without resorting to additional policies implemented specifically to achieve the spending growth target. Together, the policies described above would reduce total national spending by a cumulative $2 trillion, with health spending amounting to an estimated 19 percent of GDP by 2023 compared with the current projection of 21 percent (Exhibit 8).

Exhibit 8. Projected National Health Expenditures (NHE), 2013–2023: Potential Impact of Synergistic Strategy



Note: GDP = gross domestic product.
Source: Estimates by Actuarial Research Corporation for The Commonwealth Fund. Current baseline projection assumes that the cuts to Medicare physician fees under the sustainable growth rate (SGR) formula are repealed and basic physician fees are instead increased by 1% in 2013 and held constant from 2014 through 2023.

The nation is projected to spend about 18 percent of GDP on health care in 2013, the year before these policies are assumed to be implemented. Thus, the synergistic policy approach comes close to the goal of stabilizing spending growth to no more than the growth of the economy, with a significant reduction in the currently projected rate of growth. Analysis indicates there would not be a need for further action to enforce the spending growth and share of GDP target until near the end of the decade (2021) if policies were implemented quickly and effectively.

In other words, all estimates in the exhibits represent the net impact of the specified payment, consumer incentives, malpractice, and administrative-cost reforms without resorting to additional actions to reach the spending target. Examining the potential impact by year, the analysis indicates that the combined impact of payment reforms, incentives for consumers, and market reforms would potentially hold the line on national spending as a share of GDP at 18 percent up to 2021. And throughout most of the decade, the growth in Medicare spending per beneficiary would be below GDP growth per capita, with substantial net savings compared with current projections. However, at the end of the decade an aging population would lead to increases in Medicare and Medicaid spending above projected GDP growth without further health system innovation.

Notably, although private spending per insured enrollee would slow, it would continue to exceed GDP annual growth and Medicare per beneficiary growth throughout the decade as it has in recent years. In specifying policies, none of the illustrative policies explicitly aimed at controlling the prices private payers pay for care or limiting the rate of increase. Instead, the policies focused on private payers adopting similar payments through insurance exchanges. The analysis does not examine what could happen to private payer trends if dominant private payers were better able to leverage their purchasing power by paying for value or through multipayer initiatives.

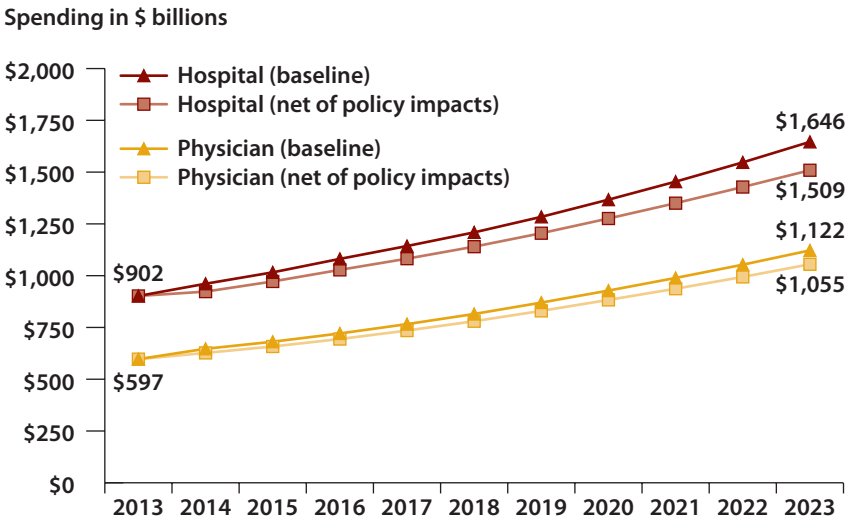
If the pace of delivery system change accelerated and private-payer payment policies spread to slow private per-person spending growth and bring it more in line with economic growth, the estimates here indicate that national health expenditures as a share of GDP by 2023 would be held near the 2013 level of 18 percent.

The analysis further suggests that policies would need to be adjusted or expanded over time to achieve the target at the end of the decade—but the nation would be within reach of the goal. In other words, it should be possible to achieve the target if all sectors pull together and are accountable for the total costs of care, further enhancing the effectiveness of these policies.

It is important to note that despite the substantial savings produced by these policies over 10 years, the health sector would still grow—with adequate resources to adopt innovations in care delivery, introduce new medical breakthroughs, and ensure care for an aging population. Even under these policies, health spending is projected to increase from $2.9 trillion in 2013 to $5.1 trillion in 2023—an increase of more than 75 percent over the decade. In particular, national spending on both hospitals' and physicians' services would continue to grow, with the potential for net revenue growth as administrative costs decline (Exhibit 9). This would also be true if total national spending stabilized to a constant share of GDP, as long as the economy continued to grow.

With an aging population, there will be a need in the future for community-based care teams that include nurses and medical assistants to ensure timely access to care. By eliminating duplication,

Exhibit 9. Impact of Synergistic Strategy on Projected Annual Hospital and Physician Spending, 2013–2023



Projected growth of hospital spending, 2013–2023:
- **Baseline projection: 82% (6.2% annual)**
- **Net of policy impact: 67% (5.3% annual)**

Projected growth of physician spending, 2013–2023:
- **Baseline projection: 88% (6.5% annual)**
- **Net of policy impact: 77% (5.9% annual)**

Source: Estimates by Actuarial Research Corporation for The Commonwealth Fund. Current baseline projection assumes that the cuts to Medicare physician fees under the sustainable growth rate (SGR) formula are repealed and basic physician fees are instead increased by 1% in 2013 and held constant from 2014 through 2023.

inappropriate care, and excessive administrative costs, and by providing safer care, it should be possible to organize the care system around patients' needs and redirect resources away from waste to essential, high-value care.

The substantial—but slower, more stable, and better targeted—growth in health spending would continue to allow for expansion of services to those who are now uninsured and underinsured, the ongoing adoption of information technology, the introduction of new prescription drugs and medical breakthroughs, and an increase in compassionate care for the most vulnerable, including low-income individuals, the elderly, and the disabled. It also provides for jobs in the health sector, stable incomes for health care professionals, and fiscal viability for efficient hospitals providing essential services.

CONCLUSIONS

The analysis described above indicates that it should be possible to stabilize health care spending growth in ways that achieve substantial savings in federal spending as well as savings for households, businesses, and state and local governments—all the while adhering to the principles and goals of a high performance health care system that is accessible to all. Analysis of potential policy action in the key strategic areas identified by the Commission indicates there is potential to substantially reduce spending growth through a combination of reforming provider payment, engaging consumers to make high-value choices, improving the way health care markets function, and holding markets accountable.

In combination, these policies could lead to wiser and more efficient expenditures of health care dollars, while also enhancing the benefits of health care. Further, the projected savings could be redirected to other essential sectors of the economy. By stabilizing growth, health care would no longer deprive other essential sectors of the economy of the resources required to invest in education, research,

innovation, and infrastructure development, all of which are needed for a thriving economy in the future.

Freeing up $2 trillion that would otherwise have been spent on the health sector over the next 10 years because of the rising costs of care could also result in positive reverberations across the economy. It would ease burdens on U.S. businesses and potentially raise incomes for the working population through a return to economic growth, while better meeting the needs of an aging population.

Notably, the policies could achieve substantial federal budget savings compared with projected trends while at the same time preserving access to care and affordability and avoiding shifting costs to households, business, or state and local governments. The analysis further indicates that potential federal savings could more than offset the $334 billion 10-year costs of repealing scheduled Medicare cuts to physicians—yielding substantial net federal savings—while aligning payment more closely with system goals. Achieving these savings, however, requires reforms of current payment policies, with future increases dependent on development of more accountable care systems and high-value care teams. The analysis also assumes that Medicare policy would recalibrate payment rates as appropriate, depending on market trends, especially where prices paid by private payers have moved lower than historic Medicare rates. This would require enabling more flexible payment authority to respond to market changes.

The analysis indicates that families would be the major winners over time from such a strategic approach, with potential for better care outcomes and experiences as well as an estimated $537 billion in direct savings over 10 years, compared with projected trends. These savings are the result of lower future premium costs as well as lower out-of-pocket costs, including gains from more efficient insurance coverage of Medicare beneficiaries. The slower growth of medical care costs would reduce out-of-pocket costs as the delivery system responds with enhanced high-value care and care systems. The substantial net savings for Medicare's elderly and disabled beneficiaries depend on the provision of a Medicare Essential option for beneficiaries that would complement provider payment policies and reduce costs for beneficiaries. In the end, reduced health spending by federal, state, and local governments and private employers also would accrue to households, which ultimately bear the burden of rising health spending through higher taxes, reduced wages, or direct out-of-pocket costs.

Overall, the analysis indicates the potential of aiming policy efforts at the forces driving up medical care costs for the nation, rather than a narrow short-term focus on federal programs only. The policy set outlined by the Commission in this report, with its three-pronged strategic approach, would interact synergistically to address the forces that are driving up costs without adding value across the health system and would accelerate progress to a more patient-centered, high-quality, innovative health care delivery system.

The fact that private insurance costs per enrollee have been rising more rapidly than public per-enrollee costs, and that Medicare costs per beneficiary are growing more slowly than GDP per capita, further highlights the need for joint public- and private-payer action. Integrated care systems, which produce better health outcomes at lower costs, have as yet failed to spread because health care markets do not support movement in that direction. With the advent of promising payment initiatives in the private sector, as well as in some states, there is an

opportunity to accelerate this trend by having Medicare, Medicaid, and private payers collaborate to align provider incentives and address market dynamics that are barriers to moving forward.

In summary, analysis of the set of policies identified by the Commission indicates the potential to achieve the goal of stabilizing health care spending growth if policies are applied broadly and effectively and public and private payers act in concert—and if payment reforms accelerate delivery system changes and address market forces that drive up costs without increasing value.

Moving from concept to action, however, will require that national policy leaders reach consensus that health care cost growth is a national concern, not just a federal budget concern. The need for action applies not only to the federal government, but also to state and local governments, businesses, and households, all of which are under increasing financial pressure as a result of the growth in health spending. Ideally, all of these stakeholders would work together toward the same goals: simplifying the health system; reducing administrative waste; changing the way we pay for care to hold care systems accountable for population health while providing flexibility to innovate; and leveraging the impact of policy changes across payers. By pulling together to stabilize health spending, we have the opportunity to reduce the federal deficit, free up resources for state and local governments, and make care and high-value health insurance more affordable for families and employers.

Further, the overarching goal should be moving the U.S. health system toward a higher level of performance, with access to affordable care for all, improved quality and patient-centeredness, greater accountability for both health outcomes and treatment costs, and enhanced population health. A high performance health system is not only consistent with, but also necessary for, stabilizing health care spending into the future.

As looming federal deficits intensify the call for action, it will be critical that health care spending decisions are guided by the goal of creating a high performance health system. To achieve this goal, policymakers will need to come together to act on behalf of the nation. The federal government is in a unique position to partner with states and private payers. In addition, through Medicare, it plays a critical role for all families across the United States. The analysis of the potential yield to the federal government and the nation if policies that aim to address systemic concerns and accelerate care system innovation are enacted indicates that federal health programs could achieve substantial savings with a unified strategy.

There is the opportunity to act now, spurred by concerns of future federal deficits. But it is essential to act wisely. The Commission offers this unified strategy and exemplary policies as a framework pointing a way forward for federal, state, and private policy leaders as they confront health care costs. Building on the three pillars of payment reform, high-value consumer choice, and improved market function, the nation has the potential to accelerate health care innovation, ensure access for all, and at the same time achieve not only a more affordable, but also a better and higher-performing health system.

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6 J. Holahan and S. McMorrow, "Medicare and Medicaid Spending Trends and the Deficit Debate," *New England Journal of Medicine*, Aug. 2, 2012 367(5):393–95.

7 Note that all three of these rates are below the projected rate of increase for overall national health expenditures. This is because the proportions of the population covered by Medicare and Medicaid—who are considerably more expensive than people covered by private employer-based insurance—are expected to rise, increasing overall per capita spending more rapidly than any of its components.

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[60] These include: electronic submission standards and streamlined rules for consistent format and data content to comply with HIPAA. Examples include eligibility verification and electronic funds transfers. The adoption of standards are expected to save providers billions over the next 10 years. Since most of the benefits accrue to providers rather than plans, however, these may be difficult to enforce without further action. The Affordable Care Act also limits the administrative overhead for health insurance plans with provisions for thresholds for medical loss ratios, requiring plans to rebate excess overhead charges. The thresholds have provided strong incentives for plans to reduce overhead costs to ensure profit margins.

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FEBRUARY 2013

Realizing Health Reform's Potential

Implementing the Affordable Care Act: State Action on the 2014 Market Reforms

Katie Keith, Kevin W. Lucia, and Sabrina Corlette

Abstract: The Affordable Care Act includes numerous consumer protections designed to improve the accessibility, adequacy, and affordability of private health insurance. Because states are the primary regulators of health insurance, this issue brief examines new state action on a subset of protections—such as guaranteed access to coverage and a ban on pre-existing condition exclusions—that go into effect in 2014. The analysis finds that, to date, only one state passed new legislation on all of these protections, and an additional 10 states and the District of Columbia passed new legislation or issued a new regulation on at least one protection. The analysis also finds that—without new legislation—some states face limitations in fully enforcing these reforms. These findings suggest an acute need for states to take action in 2013 to help ensure that consumers are fully protected by and benefit from the Affordable Care Act's most significant reforms.

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OVERVIEW

The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010, ushers in significant reforms designed to improve the accessibility, affordability, and adequacy of private health insurance. These reforms will phase in over time, with the most dramatic changes scheduled to take effect for health insurance plans or policy years beginning on or after January 1, 2014. These changes—known as the "2014 market reforms"—include guaranteed access to coverage, a ban on preexisting condition exclusions, restrictions on the use of health status and other factors when setting premium rates, and the coverage of a minimum set of essential health benefits, among other critical consumer protections.[1]

The Affordable Care Act significantly strengthens standards for private health insurance under federal law and protects consumers across the nation.

The mission of The Commonwealth Fund is to promote a high performance health care system. The Fund carries out this mandate by supporting independent research on health care issues and making grants to improve health care practice and policy. Support for this research was provided by The Commonwealth Fund. The views presented here are those of the authors and not necessarily those of The Commonwealth Fund or its directors, officers, or staff.

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Commonwealth Fund pub. 1662
Vol. 8

States continue to be the primary regulators of health insurance and thus are key players in enforcing federal laws and ensuring that consumers receive the benefits of federal protections. Although states have the primary responsibility to enforce federal health insurance law, federal regulators will enforce the Affordable Care Act if a state fails to "substantially enforce" it. Federal enforcement could subject insurers to significant fines for failure to comply with the law's requirements.[2]

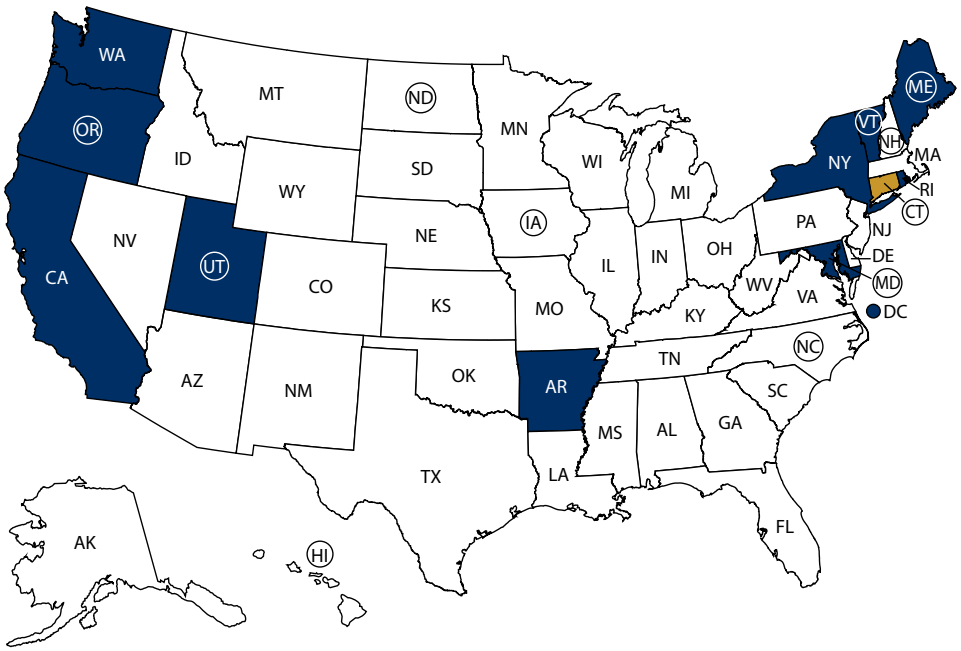
To understand states' progress in implementing the Affordable Care Act, this issue brief examines new actions states took from January 1, 2010, to October 1, 2012, on seven of the most critical 2014 market reforms. Our analysis shows that only one state took new legislative or regulatory action on all of these protections while an additional 10 states and the District of Columbia passed new legislation or issued a new regulation on at least one protection (Exhibit 1). The binding nature of new legislation and new regulations means a state has full authority to enforce and write new rules on these consumer protections. With this enforcement and rulemaking authority, states have the flexibility to provide additional guidance on how reform should be implemented and use a broad array of regulatory tools to ensure compliance with the Affordable Care Act.

The majority—39 states—have yet to take new legislative or regulatory action to implement the 2014 market reforms. To understand whether states did not take action because regulators have existing authority to enforce federal law (through, for example, a broad provision that allows the insurance department to enforce federal insurance protections), we also surveyed state regulators about their legal authority to enforce and write new rules regarding the 2014 market reforms. We found that 11 states passed new legislation that explicitly requires (or allows) state regulators to enforce or issue regulations regarding some or all of the 2014 market reforms (Exhibit 1). But, of the remaining states, only eight reported that they already have

Exhibit 1. State Action on 2014 Market Reforms Under the Affordable Care Act, as of October 2012

- Passed new law or issued new regulation on all seven 2014 market reforms
- Passed new law or issued new regulation on at least one 2014 market reform
- Took no action on 2014 market reforms

- Passed new law on enforcement or rulemaking authority regarding 2014 market reforms



Notes: Maine, Massachusetts, New Jersey, New York, and Vermont required insurers to provide coverage to individuals on a guaranteed basis prior to the Affordable Care Act. Utah has explicit authority to enforce some, but not all, of the 2014 market reforms. Hawaii has explicit authority to enforce the 2014 market reforms but does not have explicit authority to write new regulations regarding these requirements. In contrast, Iowa has the authority to issue new regulations regarding the 2014 market reforms but does not have explicit authority to enforce these requirements. New Hampshire has explicit authority to enforce and issue regulations on the 2014 market reforms, but this authority is conditioned upon approval by a legislative oversight committee.
Source: Authors' analysis.

full enforcement or rulemaking authority regarding the 2014 market reforms while 22 states reported that there could be some limits on their authority to do so, although state authority varied significantly. Ten states did not respond to the survey.

These findings suggest that many states may need to take action in 2013 to ensure that consumers receive the full benefits promised under the Affordable Care Act. Because states are expected to be the primary enforcers, most will need to implement the new protections so they are reflected in state law or—at a minimum—give the insurance department the authority to enforce and write new rules on the 2014 market reforms.

Even though states can use existing authority to promote compliance with many of the Affordable Care Act's requirements, questions remain about how effectively states can enforce the 2014 market reforms without new or expanded legal authority. These open questions suggest that states may need to take new state action to help ensure compliance with the law and to limit or preclude federal enforcement of these reforms. Because states can decide whether to take new action to ensure that state laws are consistent with the 2014 market reforms, much may depend on the enforcement standard set by the federal government and whether states can rely on their existing authority to meet this standard. For these reasons—and to ensure that state regulators have the requisite authority needed to fully protect consumers—state policymakers should consider taking action on the 2014 market reforms during their 2013 legislative sessions.

BACKGROUND

States have historically been the primary regulators of private health insurance.[3] Although states continue to play this role, the Affordable Care Act sets a minimum federal standard for consumer protections such as the 2014 market reforms, and allows—but does not require—states to enforce these protections.[4]

The Affordable Care Act largely uses the regulatory framework that Congress adopted in 1996 with the Health Insurance Portability and Accountability Act (HIPAA), which improved access to insurance as well as its renewability and portability.[5] Under HIPAA, federal regulators will step in to enforce federal law only after a state informs the federal government that it is not enforcing or if federal regulators determine that a state has failed to "substantially enforce" a provision following an investigation.[6] In response to HIPAA, nearly all states passed new laws or issued new regulations implementing the federal requirements.[7]

Because the Affordable Care Act uses the same enforcement standard as HIPAA, federal officials may step in to enforce some or all of the law's provisions if a state substantially fails to do so.[8] In states where federal regulators are directly enforcing the Affordable Care Act, federal regulators can impose significant fines on insurers that fail to comply with the law's requirements.[9]

The federal standard established by the Affordable Care Act includes significant reforms that—depending on the reform at issue—apply to insurers in the individual, small-group, or large-group markets in all 50 states and the District of Columbia (Exhibit 2). Under the law's regulatory framework, states have considerable discretion regarding whether to substantially enforce these and other requirements.

ABOUT THIS STUDY

This analysis is based on a review of new actions taken by all 50 states and the District of Columbia between January 1, 2010, and October 1, 2012, to implement or enforce seven of the Affordable Care Act's most critical consumer protections that go into effect for health insurance plan or policy years beginning on or after January 1, 2014. We refer to these provisions as the Affordable Care Act's 2014 market reforms. Our review included new state laws, regulations, and subregulatory guidance. The resulting assessments of state action were confirmed by state regulators.

We also surveyed state regulators about their authority to enforce or write new regulations regarding the 2014 market reforms. In presenting these results, we only identify the 11 states that took new action regarding the Affordable Care Act. We do

Exhibit 2. Seven 2014 Market Reforms Under the Affordable Care Act, Effective January 1, 2014

2014 market reform	Description
Accessibility	
Guaranteed issue	Requires insurers to accept every individual and employer that applies for coverage.[c]
Waiting periods	Prohibits insurers from imposing waiting periods (i.e., the period that must pass before an employee is eligible to be covered for benefits) that exceed 90 days.[a]
Affordability	
Rating requirements	Requires insurers to vary rates based solely on four factors: family composition, geographic area, age, and tobacco use; prohibits insurers from charging an older adult in the oldest age band more than three times the rate of a younger person in the youngest rate band; prohibits insurers from charging tobacco users more than 1.5 times the rate of a non–tobacco user's rate.[b,c]
Adequacy	
Preexisting condition exclusions	Prohibits insurers from imposing preexisting condition exclusions with respect to plans or coverage.
Essential health benefits	Requires coverage of specified benefits that include 10 categories of defined benefits: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.[b,c]
Out-of-pocket costs	Requires insurers to limit annual out-of-pocket costs, including copayments, coinsurance, and deductibles, to the level established for high-deductible health plans that qualify as health savings accounts; indexes this level to the change in the cost of health insurance after 2014.[c]
Actuarial value	Requires insurers to cover at least 60 percent of total costs under each plan; requires plans to meet one of four actuarial value tiers (bronze, silver, gold, or platinum) as a measure of how much costs are covered by the plan.[b,c]

Note: Unless otherwise noted, the provisions apply to new plans in the individual market as well as new and grandfathered plans (those in existence before the Affordable Care Act that have not made significant changes since March 23, 2010) in the small-group and large-group markets.

[a] Does not apply to plans in the individual market.

[b] Does not apply to plans in the large-group market.

[c] Does not apply to grandfathered plans. Note that guaranteed issue in the small-group market was already required under HIPAA and thus applies to grandfathered plans in the small-group market.

not identify the states that may rely on their existing enforcement and rulemaking authority to enforce the Affordable Care Act; these findings are presented only in aggregate.

This issue brief is limited to state action on the Affordable Care Act's private market reforms that apply both inside and outside of the law's new health insurance exchanges and does not include a review of state action on exchange development. We also do not address the considerable efforts that states undertook to select an essential health benefits benchmark plan. Preliminary analysis by the authors suggests that many states have taken new action in these areas. Although further research on these issues is forthcoming, it is separate from the analysis presented here on the 2014 market reforms.

A state may not have taken action on the 2014 market reforms if existing state law is consistent with the Affordable Care Act, or if the state already has authority to enforce federal law.[10] For example, several states—including Maine, Massachusetts, New Jersey, New York, and Vermont—required insurers to provide coverage to individuals on a guaranteed basis prior to the Affordable Care Act and may not need to take new state action on this 2014 market reform. Because our findings are limited to new state action since January 1, 2010, we did not analyze whether existing state laws are consistent with federal requirements.

FINDINGS

Only one state has taken new legislative or regulatory action on all seven 2014 market reforms examined in this brief, while an additional 10 states and the District of Columbia passed new legislation or issued a new regulation on at least one of these protections. The majority—39 states—have yet to take new legislative or regulatory action to implement the 2014 market reforms. Because some states may be able to enforce the Affordable Care Act without new action, we also surveyed the states and found that state enforcement and rulemaking authority vary significantly. Eleven states passed new legislation that explicitly requires (or allows) state regulators to enforce or issue regulations regarding some or all of the 2014 market reforms. But, of the states that have not yet passed new legislation, a minority—only eight states—reported full enforcement and rulemaking authority regarding the 2014 market reforms. Below we discuss trends in state action and describe the variation in state enforcement and rulemaking authority regarding the 2014 market reforms.

Few States Took Action on the 2014 Market Reforms

Eleven states and the District of Columbia passed new legislation or issued a new regulation on at least one of the 2014 market reforms (Exhibit 3). Of these, only one state took new action on all seven of the reforms studied. Most—39 states—have yet to take new legislative or regulatory action to implement the 2014 market reforms.

Only Connecticut Took New Legislative or Regulatory Action on All 2014 Market Reforms

Only Connecticut took action on all seven of the 2014 market reforms studied in this brief. In 2011, Connecticut passed legislation establishing a new section in its insurance code entitled "Compliance with the Patient Protection and Affordable Care Act—Regulations."[11] This section requires insurers to comply with specified sections of the Public Health Service Act, as amended by the Affordable Care Act, and authorized the insurance commissioner to adopt regulations to implement these provisions.

According to Connecticut regulators, many of the Affordable Care Act's requirements are already reflected in state law and regulators would have had the authority to enforce the 2014 market reforms even without new legislation.[12] However—similar to the state's approach in implementing HIPAA—the legislature passed new legislation to make it explicit to insurers and the federal government that the insurance department (DOI) has the authority to enforce the Affordable Care Act. Consistent with reports from other states, Connecticut chose to enact broad enforcement authority—rather than amending specific provisions of existing state law—to retain flexibility ahead of federal guidance on the 2014 market reforms.[13]

California addressed all but one of the 2014 market reforms studied and, in contrast to Connecticut, did so by amending or enacting specific provisions in state law.[14] Although California addressed all of the 2014 market reforms except limits on out-of-pocket costs, the state did not impose these requirements in all markets or for all types of plans. For example, legislators enacted all reforms except limits on out-of-pocket costs in the small-group market but legislation that would have extended some of these requirements to the individual market was ultimately vetoed by the governor.[15] Future legislation is expected to be considered during the state's special legislative session to address the remaining requirements necessary to implement the 2014 market reforms.[16]

Ten States and D.C. Took Action on at Least One 2014 Market Reform

Ten states and the District of Columbia passed new legislation or issued a new regulation on at least one of the 2014 market reforms (Exhibit 3). In addition to the District of Columbia, these states are Arkansas, California, Maine, Maryland, New York, Oregon, Rhode Island, Utah, Vermont, and Washington. With the exception of Arkansas, these states and the District of Columbia passed new legislation to address the 2014 market reforms. Following the passage of new legislation, Utah and Washington also issued a new regulation on some of the reforms. The binding nature of legislative and regulatory action means that a state has full authority to enforce those consumer protections.

Exhibit 3. State Action on the 2014 Market Reforms, Provision by Provision, as of October 1, 2012

State	Accessibility		Affordability	Adequacy			
	Guaranteed issue	Waiting periods	Rating requirements	Preexisting condition exclusions	Essential health benefits	Out-of-pocket costs	Actuarial value
State legislative or regulatory action on all seven 2014 market reforms							
Connecticut	L	L	L	L	L	L	L
State legislative or regulatory action on at least one 2014 market reform							
Arkansas	—	—	—	—	R	—	—
California	L[a]	L	L[a]	L	L	—	L
District of Columbia	—	—	—[c]	—	L[b]	L[b,d]	L[b]
Maine	—	—	L	L	L	L	L
Maryland	—	L	L	L	L	L[b,d]	L
New York	—	—	—	L	—	—	—
Oregon	—	—	—	—	L	—	L
Rhode Island	—	—	—	L	—	—	—
Utah	—	L	—	—	L, R	—	—
Vermont	—	—	—	—	L	L	L
Washington	—	—	—	—	L, R	L, R	L

Key	Definition
L	The state passed a new law on the 2014 market reform.
R	The state issued a new regulation on the 2014 market reform.
—	The state has taken no official action on the 2014 market reform.

Note: States may have decided not to address a particular reform because state law is already consistent with it or because the state has the authority to enforce federal law. For example, Maine, Massachusetts, New Jersey, New York, and Vermont already required insurers to provide coverage to individuals on a guaranteed basis. The exhibit does not take into account such existing laws or authority.

[a] State action only applies in the small-group market. In 2012, California passed new legislation that prohibits plans in the small-group market—both health care service plans and commercial carriers—from varying rates using any factors other than age, geographic area, and family composition.

[b] State action applies only to qualified health plans sold through the exchange.

[c] In 2010, the District of Columbia passed new legislation that prohibits rating based on gender and establishes age bands that cannot vary by more than a ratio of three-to-one.

[d] State action applies only to coverage in the individual and small-group markets and does not extend to the large-group market.

The majority of these 10 states and the District of Columbia took action on two or more 2014 market reforms, while Arkansas, New York, and Rhode Island addressed only one reform. States were most likely to take action on the requirements designed to improve adequacy: all states either prohibited preexisting condition exclusions or required insurers to cover essential health benefits, limit out-of-pocket costs, or meet actuarial value requirements (Exhibit 4). With the exception of the ban on preexisting condition exclusions, these "adequacy" requirements are part of the Affordable Care Act's "essential health benefits package" that must be covered by all insurers in the individual and small-group markets, both inside and outside the exchange.[17]

States may have taken action on the adequacy reforms because most do not have an existing similar standard or because states addressed these reforms in exchange legislation or in selecting an essential health benefits benchmark plan. For example, the District of Columbia adopted this requirement in new legislation, but the new rules are limited to qualified health plans sold within the exchange and do not apply to plans offered outside the exchange. Thus policymakers may need to take additional legislative or regulatory action to apply these requirements to plans offered outside the exchange.[18]

Exhibit 4. State Action on the 2014 Market Reforms, by Type of Provision, as of October 1, 2012

Type of provision	2014 market reform	State
Accessibility	Guaranteed issue Waiting periods	California, Connecticut, Maryland, Utah
Affordability	Rating requirements	California, Connecticut, Maine, Maryland
Adequacy	Preexisting condition exclusions Essential health benefits Out-of-pocket costs Actuarial value	Arkansas, California, Connecticut, District of Columbia, Maine, Maryland, New York, Oregon, Rhode Island, Utah, Vermont, Washington

Note: States may have decided not to address a particular reform because state law is already consistent with it or because the state has the authority to enforce federal law. For example, Maine, Massachusetts, New Jersey, New York, and Vermont already required insurers to provide coverage to individuals on a guaranteed basis. The exhibit does not take into account such existing laws or authority.

States chose to take action on only some reforms for a number of reasons. Some states reported that existing state law is consistent with the Affordable Care Act and, thus, no new state action is required. For example, a handful of states have long required insurers to make coverage available on a guaranteed basis while other states pointed to existing requirements that insurers make coverage available to small employers on a guaranteed basis, as required under HIPAA. Because of these existing laws, states may not have taken action in response to the requirements of the Affordable Care Act.

Other states reported that they acted only where existing state law conflicted with federal law, either directly or where clarification of state law was needed. Still other states may have taken action on only certain reforms to promote a level playing field between plans sold inside and outside the exchange. Oregon, for example, passed new legislation on essential health benefits and actuarial value requirements, motivated by the need to limit adverse selection against standardized health plans sold through the exchange.[19] Some states noted they did not need to take action on all the 2014 market reforms because they already have the authority to enforce federal law. Although the reasons vary for why states acted on only some 2014 market reforms, such variation raises the question of potential regulatory or enforcement gaps.

In addition, some states implemented only certain components of the 2014 market reforms. The District of Columbia, for example, passed legislation in 2010 that prohibits the use of gender in rating and establishes age bands that cannot vary by more than a ratio of three-to-one.[20] Two other states—Delaware and New Mexico—did not take new action on the 2014 market reforms but, like the District of Columbia, amended their rating requirements to phase out or prohibit gender rating, among other requirements.[21] These provisions are consistent with some—but not all—of the Affordable Care Act's new rating requirements, which require insurers to vary rates based solely on family composition, geographic area, age, and tobacco use.[22] While the new legislation moved these states' rating rules closer to the federal standard, state policymakers may decide to take additional action on the remaining requirements by, for example, prohibiting rating based on health status.

Thirty-Nine States Took No Action on the 2014 Market Reforms

The vast majority of states—39 states—have yet to take action on the 2014 market reforms. States may not have acted because of political opposition to the Affordable Care Act, the need for additional guidance from federal regulators, or uncertainty in light of legal challenges to the law and the outcome of the 2012 presidential and congressional elections.

Despite this inaction, states continue to consider issues related to implementation of the Affordable Care Act. For example, four states—Maine, Massachusetts, Maryland, and Washington—passed new legislation (and, in Washington, issued new regulations) regarding the state's desire to administer a reinsurance program, a risk-adjustment program, or both.

Other states are making decisions in the context of exchange planning that affect their markets both inside and outside the exchange. Arizona, for example, has identified how it will divide up the state into different geographic rating areas in which insurers can vary premiums.[23] These actions suggest that state policymakers continue to consider critical issues ahead of 2014, even if states have not taken official legislative or regulatory action.

States that pass new legislation or issue new regulations have the authority to enforce and write rules regarding the new requirements. However, states that do not take such action may be limited in their ability to do so unless regulators have existing authority to enforce federal law. If a state already has this authority, state policymakers may not have taken action on the 2014 market reforms. In the next section, we explore the extent of states' existing authority to enforce federal law and what it could mean for state implementation of the 2014 market reforms.

States May Face Enforcement Gaps Without New Legislation

State enforcement and rulemaking authority vary significantly across states, particularly in regard to the 2014 market reforms. Since January 1, 2010, 11 states passed new legislation that explicitly requires (or allows) state regulators to enforce or issue regulations regarding some or all of the 2014 market reforms. In the absence of new legislation, only eight of the remaining states reported full authority to enforce or issue new regulations on the 2014 market reforms (Exhibit 5).

Eleven States Amended Their Authority on the 2014 Market Reforms

Eleven states—Connecticut, Hawaii, Iowa, Maine, Maryland, New Hampshire, North Carolina, North Dakota, Oregon, Utah, and Vermont—passed new legislation to enforce or issue new regulations on the Affordable Care Act, including the 2014 market reforms. Although state action varied considerably among these states, regulators with enforcement and rulemaking authority are able to use a broad array of regulatory tools—such as market conduct exams, sanctions, and license revocation—to ensure compliance with the Affordable Care Act (Exhibit 6).

Of these 11 states, most passed new legislation to both enforce and issue new regulations regarding the 2014 market reforms. Some states combined this authority in a single provision while others amended separate parts of their code to adopt both enforcement and rulemaking authority. For example, North Dakota passed new legislation containing a single provision that directs its insurance commissioner to "administer and enforce" the Affordable Care Act while Oregon adopted separate provisions for enforcement and rulemaking authority.[24]

Some of these states addressed only one type of authority. Hawaii, for example, passed legislation that gives the DOI enforcement authority, but not rulemaking authority.[25] In contrast, Iowa passed legislation allowing its insurance commissioner to issue new regulations pursuant to the Affordable Care Act but it neither requires the commissioner to enforce the Affordable Care Act's requirements nor requires insurers to comply with the reforms.[26]

Exhibit 5. State Authority to Enforce and Issue New Regulations on the 2014 Market Reforms

Authority	Number of states
State passed new legislation that includes the explicit authority to enforce or issue new regulations on the 2014 market reforms.	11 states
State has full authority to enforce or issue new regulations on the 2014 market reforms without new legislation.	8 states
State has limited authority to enforce or issue new regulations on the 2014 market reforms without new legislation.	22 states
State did not respond to the survey.	10 states

Source: Survey responses from state regulators in all 50 states and the District of Columbia (referred to as a "state" for purposes of Exhibit 5). Assessments of state authority were confirmed by state regulators.

Exhibit 6. Select Regulatory Tools Used by State Health Insurance Regulators

Regulatory tool	Definition
Form review	Review, approval, or disapproval of insurer policy forms to ensure that insurers offer policies that comply with state requirements, including mandatory benefits and appropriate appeals procedures.
Rate review	Review, approval, or disapproval of insurer rates to ensure that insurers set premiums in accordance with state requirements.
Market conduct examinations	Periodic or targeted audits of insurers in response to specific practices or suspected issues designed to identify noncompliance with state requirements.
Sanctions	Fines levied against insurers for violating state requirements.
License revocation	Revocation of a license to engage in the insurance business in the state.

Source: M. Kofman and K. Pollitz, *Health Insurance Regulation by States and the Federal Government: A Review of Current Approaches and Proposals for Change* (Washington, D.C.: Georgetown University Health Policy Institute, 2006).

Of the 11 states that amended their authority, most states passed new legislation that included broad authority to cover all provisions of the Affordable Care Act, including the 2014 market reforms. But two states—New Hampshire and Utah—face some limitations on the extent of their authority. Utah, for example, passed a provision to allow enforcement of only select provisions of the Affordable Care Act, such as essential health benefits and waiting periods.[27] New Hampshire passed legislation that allows its DOI to both enforce and write new rules regarding the Affordable Care Act but only after prior approval from a legislative oversight committee.[28] New Hampshire regulators are currently reviewing their ability to enforce the Affordable Care Act, including the 2014 market reforms, to help ensure that consumers receive the benefits of the law.[29]

State regulators reported that explicit authority regarding the Affordable Care Act was motivated by the desire to ensure that the states would continue their role as the primary regulator of health insurance and to limit or preclude the need for enforcement by the federal government. Regulators pointed to the benefit of broad enforcement and rulemaking authority as a way to meet the Affordable Care Act's requirements while retaining the flexibility a state needs to monitor and regulate a unique marketplace. Another state noted that broad authority met the state's needs to preserve statutory requirements for grandfathered plans, especially in light of uncertainty about how to develop parallel requirements for grandfathered and non-grandfathered coverage. For the reasons above, states that have not yet done so might consider passing similar legislation giving regulators the broad authority to enforce and issue new regulations regarding the Affordable Care Act, including the 2014 market reforms.

Although broad authority can serve many needs, regulators in a number of states—even those with broad enforcement and rulemaking authority—anticipate the need to take additional legislative or regulatory action to reflect the 2014 market reforms in state law or amend existing state laws that conflict with these requirements. A number of these states indicated that they had or were preparing such legislation for the 2013 legislative session.

Some States Have Limited Existing Authority to Address the 2014 Market Reforms

Eight states reported full authority to enforce the 2014 market reforms without passing new legislation (Exhibit 5). We refer to "full authority" as the ability to require full compliance with and issue new regulations on the 2014 market reforms. While most states indicated that their authority is derived from provisions giving the DOI the ability to broadly enforce insurance laws, there was significant variation across states. In one state, for example, regulators have long been able to issue new rules to minimally meet federal standards. Other states have general authority to execute all laws that relate to insurance and the DOIs interpret these provisions to apply to both state and federal law. Another state has the authority to

coordinate regulatory activities with the federal government in regulating insurance, which the state relies on to enforce federal law.

Not all state DOIs, however, have such broad enforcement or rulemaking authority regarding federal law. In the absence of new legislation, 22 states reported that they had no enforcement and rulemaking authority regarding the 2014 market reforms or that this authority was limited. We refer to "limited authority" as 1) the ability to require compliance with and/or issue new regulations on some, but not all, of the 2014 market reforms, or 2) the ability to take some actions—such as review policy forms or rates—to ensure that insurers comply with the 2014 market reforms, but unable to issue guidance on these requirements or use the state's full suite of regulatory powers, like market conduct exams, sanctions, and license revocation, to enforce the 2014 market reforms.

Enforcement Authority. In response to our survey, regulators in a number of states cited general authority to regulate the sale of insurance or prevent unfair trade practices as their source of authority to enforce the 2014 market reforms. Although these provisions do not explicitly reference federal law, at least some regulators have adopted the position that a policy that fails to comply with federal law also fails to meet these standards, which allows regulators to take enforcement action if necessary.

Other states noted that they have inherent authority to enforce federal law based on their ability to regulate insurance and prevent illegal or unfair trade practices. However, regulators in some states raised concerns about past state court rulings that could undermine this authority. Regulators in another state indicated that they would use their authority to regulate insurer solvency to help enforce the 2014 market reforms. According to regulators, the state could use this authority to enforce the 2014 market reforms because of concerns that an insurer might face large federal fines for failure to comply with the Affordable Care Act. Some regulators noted that reliance on this type of general or inherent enforcement authority can be a powerful tool, but—without additional statutory authority to enforce the Affordable Care Act's most dramatic changes in 2014—may be valuable only to the extent that insurers do not challenge the state's interpretation of its authority.

Many states noted that they would rely heavily on their authority to review and approve policy forms and rate filings to enforce the 2014 market reforms in the absence of new legislation. In many states, regulators have the authority to approve or disapprove policy forms and can require insurers to amend their policy forms to ensure that they comply, or do not conflict, with the Affordable Care Act.[30] Regulators could, for example, disapprove any policy that includes preexisting condition exclusions or does not include the state's essential health benefits package. And, once a policy is approved for use, regulators can typically enforce the provisions of the policy should an insurer violate one of these requirements.

Regulators in one state, for example, noted their plans to require insurers to file an attestation of compliance with the Affordable Care Act and state law under the state's broad authority to review and approve policy forms. During this form review process, regulators would ensure that insurers filed the attestation and that the policy contained a provision incorporating the attestation, which would give regulators the ability to enforce the Affordable Care Act's requirements, including the 2014 market reforms.

Yet, regulators in some states reported that reliance on form review alone is likely to be an imperfect solution to enforcing the 2014 market reforms and thus ensuring that consumers receive the benefits promised under the Affordable Care Act. As one regulator put it, the use of form and rate review authority is a "reasonably good enforcement tool" but regulators could be limited if this is their sole source of authority to enforce the 2014 market reforms. For example, regulators questioned how a state would use form review to determine whether an insurer is complying with guaranteed issue requirements, which is related more to an insurer's marketing practices than the content of a policy. Another regulator asked how a state relying solely

on form and rate review would address noncompliance in previously approved products.

Even though regulators expect few problems with ensuring that forms comply with the 2014 market reforms, some raised concerns about whether they could enforce federal requirements that had no corresponding requirement reflected in state law. Indeed, some regulators raised concerns about their ability to respond to consumer complaints, require an insurer to change its practices, or impose sanctions without express authority to enforce federal law. Others noted that a major limitation of using form and rate review authority alone is that most states would be unable to issue interpretive guidance on what the Affordable Care Act means and how the DOI will interpret a particular provision.

Rulemaking Authority. Most states have broad authority to issue new regulations or guidance, but this authority typically only extends to requirements that are reflected in state law. Because the 2014 market reforms are likely not reflected in state law in the 39 states that have yet to take action on these requirements, these states may be unable to issue regulations on all the reforms.

Some states face additional hurdles in issuing new regulations, even if they have incorporated the 2014 market reforms. This is because a number of DOIs can only issue "legislative rules" where members of the legislature—either a committee or the full legislature—must approve (or can disapprove) new insurance regulations before they become effective. Some states with this requirement noted that it would not be problematic in implementing the Affordable Care Act because they expect to have a supportive legislature. However, in states where legislators are opposed to the Affordable Care Act, obtaining legislative approval may prove difficult.

These limitations notwithstanding, some states reported they would be able to use existing regulatory authority to address certain 2014 market reforms. For example, a number of states noted the possibility of enforcing the Affordable Care Act's rating requirements by incorporating this standard into the state's existing rate review process. Other states have passed exchange legislation that includes the authority to issue new regulations and noted the possibility of issuing regulations that extend federal exchange requirements—including at least some of the 2014 market reforms—to plans sold outside of the exchange.

POLICY IMPLICATIONS

Our findings reveal that few states have taken formal legislative or regulatory action on the 2014 market reforms, with only one state addressing all of the protections. States may have chosen not to act for a number of reasons. First, states may have waited until closer to 2014 when the reforms become effective. Indeed, our prior research shows that more states took action to implement the Affordable Care Act's early market reforms, which went into effect on September 23, 2010.[31] Second, states may not have acted on the 2014 market reforms because of uncertainty surrounding the law, including a challenge of the law's constitutionality before the Supreme Court of the United States, political opposition, and the results of the 2012 presidential and congressional elections. Third, states may have been waiting on key regulations from the federal government before taking new action.

Because so few states have taken formal action to address the 2014 market reforms, 2013 will be a critical time period for state policymakers who wish to limit direct federal enforcement of the reforms and for consumers expecting to benefit from these new protections. State legislators and regulators should consider whether new legislation or regulations—either to amend existing state law or give the DOI the authority to enforce or write new rules—may be appropriate to ensure that consumers in their state receive the full benefits promised under the Affordable Care Act. Indeed, a number of regulators reported that they had or were preparing legislation on the 2014 market reforms for the 2013 legislative session.

The need for state action is acute because some states may face enforcement gaps if relying solely on existing authority to enforce the 2014 market reforms. Indeed, regulators raised concerns about how a state

could respond to a consumer complaint regarding the 2014 market reforms without explicit authority to enforce federal law. Will state regulators merely monitor for violations of federal law and then refer complaints to the federal government? Or will states be expected to try to resolve complaints before referring consumers to federal regulators? How will the process compare to states' current lack of authority to enforce consumer protections in self-funded plans, which are regulated by the federal government?

Despite these gaps, most regulators have the authority to use at least some of the regulatory tools needed to successfully enforce the market reforms, even without new legislation. The benefits of using existing authority to enforce the 2014 market reforms include avoiding the need for new legislation and using regulatory mechanisms that regulators are already familiar with, such as form and rate review.

However, regulators also reported that—without additional authority—they cannot use all the regulatory tools they might need. For example, states may be limited in their ability to regulate insurers' marketing practices, which cannot be easily tracked by reviewing policy forms and rate filings and because some DOIs may not initiate market conduct exams until after regulators have received a sufficient number of consumer complaints. And, unlike new legislative or regulatory action, form and rate review are unable to address ambiguities when the 2014 market reforms do not exist in state law or conflict with existing state standards. In light of these limitations, state policymakers may decide to take new action to ensure that state laws are consistent with federal laws, to avoid confusion and the need for coordination between the state and federal governments, and to address regulatory gaps.

The extent of state action on the 2014 market reforms—and thus expanded state authority—may ultimately be influenced by the enforcement standard that federal regulators adopt. Federal regulators can define what it means for a state to "substantially enforce" the 2014 market reforms and whether explicit legal authority will be required to meet this standard. If existing authority—such as form and rate review authority—is considered sufficient (without requiring new legislative or regulatory authority), states may decide not to enhance their existing authority. As a result, some states reported that they could be limited in their ability to fully enforce the Affordable Care Act and federal regulators may need to undertake at least partial or full enforcement of these reforms in some states.

However, if federal regulators set a standard that demands explicit authority to enforce federal law, states may choose to enhance their existing enforcement and rulemaking authority regarding the 2014 market reforms. Regulators in some states indicated they would favor such legislation to limit federal enforcement of insurance laws and ensure that their consumers are protected. To assist states in making important decisions about enforcement, federal regulators should consider soon establishing an enforcement standard; doing so would provide state policymakers with a clear indication of how much time, energy, and political capital should be used to pass new legislation or issue new regulations in 2013, a critical time period for implementing the Affordable Care Act.

CONCLUSION

Eleven states and the District of Columbia took new legislative or regulatory action on at least one of the 2014 market reforms; one state took action on all seven reforms studied. Most—39 states—have yet to take new legislative or regulatory action to implement the 2014 market reforms. Many could face enforcement gaps if relying solely on existing authority to enforce the 2014 market reforms. These findings suggest that states may need to take new action in 2013 to protect consumers and limit federal enforcement of the reforms. Although states can use some regulatory tools to promote compliance with the 2014 market reforms, questions remain about how effectively states can enforce these requirements in the absence of new legislation and additional state action may depend on the enforcement standard set by the federal government. Our findings also suggest that policymakers will benefit from continued analysis of the actions states take to enforce and implement the Affordable Care Act.

Notes

1 Pub. L. 111-148, 124 Stat. 782 (2010) §§ 1201, 1302; Pub. L. 111-152, 124 Stat. 1029 (2010).

2 Public Health Services Act § 2723 (codified at 42 U.S.C. § 300gg-22); 45 C.F.R. § 150.203.

3 T. S. Jost, "The Regulation of Private Health Insurance" (Washington, D.C.: National Academy of Social Insurance, National Academy of Public Administration; Princeton, N.J.: Robert Wood Johnson Foundation, Jan. 2009). Congress reaffirmed this role in 1945, when it passed the McCarran–Ferguson Act, which recognized state authority over private health insurance unless Congress expressed its intent to regulate coverage. See 15 U.S.C. §§ 1011, 1012 (2006).

4 See, for example, "Request for Comments Regarding Section 2718 of the Public Health Services Act (Medical Loss Ratios)" (Washington, D.C.: Departments of Health and Human Services and Labor, and the Internal Revenue Service, April 8, 2010), which notes that "the Secretaries of HHS, Labor, and Treasury have shared interpretive and enforcement authority under Title XXVII of the PHS Act, Part 7 of ERISA, and Chapter 100 of the Code."

5 Public Law 104–191, 110 Stat. 1936 (1996) (codified at 42 U.S.C. §§ 300gg, 1320d et seq. and 29 U.S.C. § 1181 et seq.).

6 Public Health Services Act § 2723(a)(2); 45 C.F.R. §§ 150.203, 150.303.

7 U.S. Government Accountability Office, "Private Health Insurance: Federal Role in Enforcing New Standards Continues to Evolve," letter to Sen. Jeffords (Washington, D.C., May 7, 2001), http://www.gao.gov/assets/100/90726.pdf.

8 Public Health Services Act § 2723(a)(2).

9 Ibid. § 2723(b)(2).

10 See National Association of Insurance Commissioners, "Survey on State Authority to Enforce PPACA Immediate Implementation Provisions" (Washington, D.C., 2010), http://www.naic.org/documents/index_health_reform_section_ppaca_state_enforcement_authority.pdf.

11 Conn. Gen. Stat. Ann. § 38a-591(b) (2011) ("Each insurance company, fraternal benefit society, hospital service corporation, medical service corporation and health care center licensed to do business in the state shall comply with Sections 1251, 1252 and 1304 of the Affordable Care Act and the following Sections of the Public Health Service Act, as amended by the Affordable Care Act: (1) 2701 to 2709, inclusive, 42 USC 300gg et seq.; (2) 2711 to 2719A, inclusive, 42 USC 300gg-11 et seq.; and (3) 2794, 42 USC 300gg-94.").

12 Personal correspondence with health insurance regulator, Connecticut Insurance Department (Oct. 24, 2012) (on file with authors).

13 Ibid.

14 2011 Ca. A.B. 1083.

15 2012 Ca. A.B. 961; 2012 Ca. A.B. 1461.

16 Personal correspondence with health insurance regulator, California Department of Managed Health Care (Oct. 25, 2012) (on file with authors). In December 2012, California legislators introduced two bills, 2013 Ca. A.B. 18 and 2013 Ca. S.B. 18, that state the intent of the legislature "to enact legislation to reform the individual health care coverage market consistent with the federal Patient Protection and Affordable Care Act."

17 Pub. L. 111-148, 124 Stat. 782 (2010) §§ 1201, 1302 (codified at 42 U.S.C. §§ 300gg-6, 18022 (2006)).

18 The D.C. Health Insurance Exchange recently adopted a recommendation to require all health insurance to be sold through the Exchange; in this case, all health insurance would be considered a qualified health plan and thus new legislation may not be necessary to extend these requirements to plans offered outside the Exchange.

19 2011 Or. S.B. 91.

20 2010 D.C. Laws 18-360 (Act 18-710).

21 2010 Del. H.B. 85; 2010 N.M. S.B. 148. Delaware's law also limits rating based on age.

22 42 U.S.C. § 300gg (2006).

23 Personal correspondence with health insurance regulator, Arizona Department of Insurance (Oct. 15, 2012) (on file with authors).

24 N.D.C.C. § 26.1-02-29; O.R.S. §§ 743.731, 743.758.

25 H.R.S. §§ 431:10A-105.5, 432:2-611, 432:1-107, 432D-28; Utah St. § 31A-2-212; MD Ins. Code § 15-137.1.

26 Iowa Code § 505.8(19) (2011).

27 U.C.A. 1953 § 31A-2-212; MD Code, Insurance, § 15-137.1

28 N.H. Rev. Stat. § 420-N:5.

29 Personal correspondence with health insurance regulator, New Hampshire Insurance Department (Nov. 8, 2012) (on file with authors).

30 National Association of Insurance Commissioners, *Compendium of State Laws on Insurance Topics*, "Filing Requirements: Health Insurance Forms and Rates" (Washington, D.C.: Nov. 2011).

31 K. Keith, K. W. Lucia, and S. Corlette, *Implementing the Affordable Care Act: State Action on Early Market Reforms* (New York: The Commonwealth Fund, March 2012).

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Editorial support was provided by Deborah Lorber.

THE COMMONWEALTH FUND

Health Insurance Exchanges Under the Patient Protection and Affordable Care Act (ACA)

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January 31, 2013

Congressional Research Service
7-5700
www.crs.gov
R42663

CRS Report for Congress
Prepared for Members and Committees of Congress

Summary

The fundamental purpose of a health insurance exchange is to provide a structured marketplace for the sale and purchase of health insurance. The authority and responsibilities of an exchange may vary, depending on statutory or other requirements for its establishment and structure. The Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) requires health insurance exchanges to be established in every state by January 1, 2014. ACA provides certain requirements for the establishment of exchanges, while leaving other choices to be made by the states.

Qualified individuals and small businesses will be able to purchase private health insurance through exchanges. Issuers selling health insurance plans through an exchange will have to follow certain rules, such as meeting the private market reform requirements in ACA. While the fundamental purpose of the exchanges will be to facilitate the offer and purchase of health insurance, nothing in the law prohibits qualified individuals, qualified employers, and insurance carriers from participating in the health insurance market outside of exchanges. Moreover, ACA explicitly states that enrollment in exchanges is voluntary and no individual may be compelled to enroll in exchange coverage.

Exchanges may be established either by the state itself as a "state exchange" or by the Secretary of Health and Human Services (HHS) as a "federally-facilitated exchange." A federally-facilitated exchange may be operated solely by the federal government, or it may be operated by the federal government in conjunction with the state, as a "partnership" exchange. All exchanges are required to carry out many of the same functions and adhere to many of the same standards, although there are important differences between the types of exchanges. States had to declare their intentions to establish their own exchange no later than December 14, 2012; to date, 17 states and D.C. have received conditional approval from HHS to operate a state exchange. States interested in pursuing a partnership exchange must declare their intentions no later than February 15, 2013.

ACA and regulations require exchanges to carry out a number of different functions. The primary functions relate to determining eligibility and enrolling individuals in appropriate plans, plan management, consumer assistance and accountability, and financial management. ACA gives various federal agencies, primarily HHS, responsibilities relating to the general operation of exchanges. Federal agencies are generally responsible for promulgating regulations, creating criteria and systems, and awarding grants to states to help them create and implement exchanges.

A state that is approved to operate its own exchange has a number of operational decisions to make, including decisions related to organizational structure (governmental agency or a nonprofit entity); types of exchanges (separate individual and Small Business Health Options Program (SHOP) exchanges, or a merged exchange); collaboration (a state may independently operate an exchange or enter into contracts with other states); service area (a state may establish one or more subsidiary exchanges in the state if each exchange serves a geographically distinct area and meets certain size requirements); contracted services (an exchange may contract with certain entities to carry out one or more responsibilities of the exchange); and governance (governing board and standards of conduct).

In general, health plans offered through exchanges will provide comprehensive coverage and meet all applicable private market reforms specified in ACA. Most exchange plans will provide coverage for "essential health benefits," at minimum; be subject to certain limits on cost-sharing,

including out-of-pocket costs; and meet one of four levels of plan generosity based on actuarial value. To make exchange coverage more affordable, certain individuals will receive premium assistance in the form of federal tax credits. Moreover, some recipients of premium credits may also receive subsidies toward cost-sharing expenses.

This report outlines the required minimum functions of exchanges, and explains how exchanges are expected to be established and administered under ACA. The coverage offered through exchanges is discussed, and the report concludes with a discussion of how exchanges will interact with selected other ACA provisions.

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Introduction

A health insurance exchange is a structured marketplace for the sale and purchase of health insurance. "Customers" can include individuals and businesses. The insurance companies ("issuers") that choose to sell their products through an exchange may be required to comply with consumer protections, such as offering insurance to every qualified applicant. Exchanges, however, are not issuers; rather, exchanges contract with issuers who will make insurance products available for purchase through exchanges. Essentially, exchanges are designed to bring together buyers and sellers of insurance, with the goal of increasing access to coverage.

This rather broad definition allows for a great deal of latitude, and therefore variance, in the number and scope of responsibilities covered in a particular exchange. For example, the role of an exchange may be more or less administrative: facilitating the sale and purchase of health insurance. An administrative-only exchange may function similar to websites that allow individuals to find airline travel options and purchase tickets (e.g., Kayak). Such an approach does not necessarily change or establish standards for the products being sold (whether they are health plans or airline tickets), or limit the types of buyers and sellers participating in the exchange, beyond what already exists in the private market. An example of a minimalist health insurance exchange is the Utah Health Exchange. Essentially, Utah's exchange is an Internet portal that is "designed to connect consumers to the information they need to make informed health care choices, and in the case of health insurance, to execute that choice electronically."[1]

At the other end of the spectrum, an exchange may have multiple functions beyond the role of insurance marketplace. For instance, an exchange may be responsible for implementing regulatory standards, such as requiring standardization of all products offered through it or imposing requirements on exchange participants. An exchange may be responsible for determining eligibility for exchange plans and government-provided subsidies. An example of a more regulatory-oriented exchange is the Health Connector ("Connector") in Massachusetts. Similar to Utah's exchange, the Connector provides an online tool to allow consumers and others to find commercial health insurance options available to them. In addition, the Connector also manages a publicly subsidized coverage program for low-income state residents, and offers certificates to exempt individuals from the state's individual mandate, among other duties.[2]

An exchange may occupy a physical location and/or be virtual (i.e., performing its functions on the Internet). It may be governed by a public agency, a private entity, or a hybrid organization. The insurance options offered through an exchange may also vary across insurance markets[3] and plan types. Nonetheless, while the authority and responsibilities of an exchange may vary, its fundamental purpose is to provide a venue where insurance companies may sell their insurance products and purchasers can compare and choose from multiple options available to them. Thus an exchange allows for "one-stop shopping" with respect to health insurance.

[1] "Utah Health Exchange," http://www.exchange.utah.gov/about-the-exchange.

[2] "Health Connector," https://www.mahealthconnector.org/portal/site/connector.

[3] The private health insurance market is made up of three segments—the large group, small group and nongroup (individual) markets. The nongroup market refers to insurance policies offered to individuals and families buying insurance on their own. Group insurance refers to health plans offered through a plan sponsor, typically an employer.

The exchange concept was included in the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended), as a means to increase access to health insurance. While ACA places many restrictions on the design and function of exchanges, the law also leaves many operational decisions to the states. Such flexibility will likely lead to variation in exchange models across the states. For example, a state may decide to operate an exchange by itself, establish an exchange in partnership with the federal government, or leave this work entirely to the federal government. States had to declare whether they will have a state exchange by December 14, 2012. By February 15, 2013, states must declare whether they will operate an exchange in partnership with the federal government. The initial open enrollment period for all exchanges will begin on October 1, 2013, and all exchanges are to be operational and offering coverage on January 1, 2014.

This report looks at the requirements for exchanges established in ACA and provides information on the requirements and choices available to states for the establishment, functions, financial responsibilities, and coverage of the ACA exchanges. It also includes a brief discussion of the interactions between exchanges and other provisions in the law.

ACA Exchanges

ACA intends exchanges to be marketplaces where qualified individuals and small businesses can "shop" for private health insurance coverage.[4] The coverage offered through exchanges will be comprehensive[5] and meet all applicable private market reforms[6] specified in ACA. Such plans offered through the exchanges will be certified as "qualified health plans" or QHPs.[7]

ACA explicitly states that enrollment in exchanges is voluntary and no individual may be compelled to enroll in exchange coverage.[8] While the main purpose of the exchanges will be to facilitate the offer and purchase of health insurance, nothing in the ACA prohibits qualified individuals, qualified small businesses, and insurance carriers from participating in the health insurance market outside of exchanges.[9]

[4] Before 2016, states will have the option to define "small employers" either as those with 100 or fewer employees or 50 or fewer employees. Beginning in 2016, small employers will be defined as those with 100 or fewer employees. Beginning in 2017, states may allow large employers to obtain coverage through an exchange (but will not be required to do so).

[5] With the exception of stand-alone dental plans that are allowed to be offered in the exchanges.

[6] For additional information about ACA's private market reforms, see CRS Report R42069, *Private Health Insurance Market Reforms in the Patient Protection and Affordable Care Act (ACA)*, by Annie L. Mach and Bernadette Fernandez.

[7] As discussed in the "Plan Management Responsibilities" section of this report, a plan has to meet certain statutory requirements to be certified as a QHP. Certain plans offered through exchanges (e.g., stand-alone dental plans) do not necessarily meet all of the criteria to be certified as a QHP; however, the plans are required to meet some criteria and are considered QHPs for the purpose of how the exchange interacts with the plan. For example, while a stand-alone dental plan cannot meet criteria related to benefits to qualify as a QHP (because the plan only offers dental benefits), a stand-alone dental plan is still required to meet the QHP standard to annually provide benefit and rate information to the exchange.

[8] §1312(d)(3)(B) of ACA.

[9] §1312(d)(1) of ACA.

For individuals seeking coverage, exchanges will not only create marketplaces where qualified individuals can purchase QHPs in the nongroup (individual) market, but exchanges will also assist individuals with obtaining federally subsidized premium and cost-sharing assistance to help low to middle income individuals offset the cost of both purchasing and using health insurance. Exchanges will also screen individuals for eligibility for certain public insurance programs (e.g., Medicaid) and connect them with appropriate agencies.

Small businesses seeking coverage for their employees will be able to use the small business health options program (SHOP) exchange. The SHOP exchange is designed to assist qualified small employers and their employees with the purchase of QHPs offered in the small group market. Qualified small employers will be able to select QHPs available in the SHOP to offer to their employees, and they will be able to set the amount they will contribute to QHP premiums.

ACA requires exchanges to be established in every state by January 1, 2014. Exchanges must be established by the state itself or by the Secretary of HHS,[10] and they must carry out the general functions described above for both individuals and small businesses. Additionally, exchanges will be expected to perform a number of other functions relating to managing the QHPs offered through the exchanges and assisting individuals and small businesses in accessing and obtaining coverage.

Establishment of ACA Exchanges

ACA provides general direction regarding the establishment and administration of an exchange. ACA is supplemented by the final regulation on the establishment of exchanges and other guidance produced by federal agencies, particularly HHS.[11] Taken together, these documents set forth some requirements and minimum standards that various stakeholders—including consumers, states, issuers, and employers—must meet to be part of or to participate in an exchange.

One factor that could influence a number of determinations related to how an exchange is implemented is whether the exchange is established by a state or HHS. States have the option of establishing their own exchanges ("state exchange") as a governmental agency or a non-profit entity. If a state wants to operate its own exchange beginning January 1, 2014, it had to submit a "Declaration Letter" and an "Exchange Blueprint" application[12] to HHS by December 14, 2012. Eighteen states and D.C. submitted letters and applications prior to the deadline; to date, HHS has conditionally approved applications from 17 states and D.C.[13]

[10] §§1311(b) and 1321(c) of ACA.

[11] 77 *Federal Register* 18310, March 27, 2012.

[12] §1311(b) of ACA. Instructions for submitting the Declaration Letter and the Exchange Blueprint application are available at http://cciio.cms.gov/resources/files/hie-blueprint-081312.pdf.

[13] Seventeen states and D.C. have received conditional approval to operate a state exchange: CA, CO, CT, HI, ID, KY, MD, MA, MN, NV, NM, NY, OR, RI, UT, VT, and WA. Mississippi is the only other state that submitted an application to operate a state-based exchange; HHS is withholding a decision on the state's application until state officials settle an internal dispute regarding who has the authority to act on behalf of Mississippi to establish an exchange.

If a state's exchange is not approved, or if a state chooses not to establish its own exchange, the HHS Secretary has the authority to establish and operate an exchange in that state directly, or through an agreement with a non-profit entity.[14] In a "federally-facilitated exchange," HHS will carry out all functions of the exchange and have authority over the exchange. HHS gives states the option to enter into a hybrid type of exchange—somewhere between a state exchange and a federally-facilitated exchange. This option is referred to as a "partnership" with a federally-facilitated exchange, whereby certain state-designed and operated functions are combined with federally designed and operated functions. While HHS and states share responsibility for carrying out functions in partnerships within federally-facilitated exchanges, HHS retains authority over these exchanges.[15] If a state wants to have a partnership exchange, it must submit to HHS a Declaration Letter and an Exchange Blueprint application by February 15, 2013.

Regardless of whether an exchange is established by a state or the federal government, the initial open enrollment period for an exchange will be October 1, 2013, through March 31, 2014. Exchanges must begin offering coverage to qualified individuals and small businesses on January 1, 2014.[16]

State Exchanges

The HHS Secretary must approve the operation of a state exchange if it meets the following standards:

- the exchange is able to carry out the required functions of the exchange as established in the law and regulation, which include making QHPs available to qualified individuals and qualified employers;
- the exchange is capable of carrying out the information reporting requirements related to sharing information with the federal government in order to determine an individual's eligibility for a premium tax credit;[17] and
- either the entire geographic area of the state is covered in the exchange or the state has established multiple exchanges that cover the entire geographic area of the state.[18]

A state exchange is responsible for creating and implementing its structure and governing system according to the guidelines outlined in the statute and regulations, as discussed below.

[14] §1321(c) of ACA.

[15] 77 *Federal Register* 18310, March 27, 2012. The law also requires that the HHS Secretary creates a process whereby states that were operating exchanges before January 1, 2010, can receive assistance from federal agencies to bring their exchanges into compliance with the requirements under ACA (§1322(e) of ACA).

[16] Selected exchange implementation dates are shown in **Table A-1**. It should be noted that the final rule on exchange establishment (77 *Federal Register* 18310, March 27, 2012) provides for ways in which states can change the type of exchange established in the state. For example, if a state chooses not to establish an exchange for 2014, it still may elect to do so in the future.

[17] For a comprehensive discussion of the premium tax credits, see CRS Report R41137, *Health Insurance Premium Credits in the Patient Protection and Affordable Care Act (ACA)*, by Bernadette Fernandez and Thomas Gabe.

[18] 77 *Federal Register* 18310, March 27, 2012.

Operational Structure of a State Exchange

A state that is approved to establish its own exchange has a number of decisions to make regarding the exchange's operational structure. A state must determine whether its exchange will be a governmental agency or a non-profit established by the state. The terms "governmental" and "non-profit established by the state" have not been defined; instead, it seems these terms are subject to state interpretation.[19]

A state can choose to independently operate an exchange, or a state can enter into contracts with other states (regardless of whether the states are contiguous) to operate a regional exchange.[20] States can also establish one or more subsidiary exchanges in the state if each exchange serves a geographically distinct area and if the area served by each exchange meets the geographic size requirement established in the law.[21] In other words, while states have a great deal of leeway in establishing how the exchange is divided up geographically, they must serve the entire population in their state. Furthermore, regional exchanges and subsidiary exchanges must meet all exchange requirements.

A state exchange must operate both the individual and SHOP exchanges, but a state can either merge the exchanges and operate both under the same administrative and governance structures, or elect to create separate administrative and governance structures for the individual and SHOP exchanges.[22] Additionally, regional and subsidiary exchanges must perform the functions of a SHOP exchange. If an exchange chooses to operate an individual exchange and a SHOP exchange under two different governance and administrative structures, a SHOP exchange must cover the same geographic area as the regional or subsidiary individual exchange.[23]

States also have the authority to allow a state exchange to contract with the entities described below to carry out one or more responsibilities of the exchange.[24] States can grant this authority to state exchanges independent of whether an exchange is a governmental agency or a non-profit established by the state. For example, a state exchange that is a non-profit established by the state could contract with a state agency that meets the criteria below to carry out certain consumer assistance functions for the exchange.

A state exchange may contract with

- an entity, including a state agency other than a Medicaid agency, incorporated under and subject to the laws of at least one state, that has demonstrated

[19] In responding to requests for clarification regarding what would be considered "governmental," HHS has said that it will not offer further clarification of "governmental" in deference to existing state classifications. HHS has not commented on the definition of a non-profit established by a state.

[20] §1311(f)(1) of ACA. Each state participating in the regional exchange must permit the operation of the regional exchange, and the HHS Secretary has to approve the regional exchange before it can begin operation.

[21] §1311(f)(2) of ACA. The area served by a subsidiary exchange must be at least as large as a rating area approved by the HHS Secretary for purposes described in §2701 of the Public Health Service Act (PHSA).

[22] §1311(b)(2) of ACA.

[23] 77 *Federal Register* 18310, March 27, 2012.

[24] §1311(f)(3) of ACA and 77 *Federal Register* 18310, March 27, 2012. If an exchange contracts out any function of the exchange, the exchange is responsible for ensuring that the contracted entity meets all federal requirements related to the function.

experience on a state or regional basis in the individual and small group health insurance markets and in benefits coverage, but is not an issuer; and/or

- a state Medicaid agency.

Governance of a State Exchange

Generally, a state exchange must have a governing board that meets certain requirements; the board must[25]

- be administered under a publicly adopted operating charter or by-laws;
- hold regular meetings that are open to the public and announced in advance;
- ensure that the board's membership includes at least one voting member who is a consumer representative and is not made up of a majority of voting representatives with conflicts of interest (e.g., representatives of issuers); and
- ensure that a majority of the voting members on its governing board have relevant experience in the health care field (e.g., in health benefits administration, or in public health).

In addition, a state exchange is required to have in place and make publicly available a set of governance principles that include ethics, conflict of interest standards, transparency and accounting standards, and standards related to disclosure of financial interests. A state exchange must also implement procedures as to how members of the governing board will disclose any financial interests. The state exchange's governance principles are subject to periodic review by HHS.[26]

Federally-Facilitated Exchange

If a state chooses not to operate its own exchange or if a state does not have approval to operate its own exchange, the HHS Secretary is required to establish a "federally-facilitated exchange" in the state.[27] A federally-facilitated exchange can be implemented by HHS alone, or a state can enter into a "partnership" with a federally-facilitated exchange, combining state-designed and operated functions with federally designed and operated functions.[28] Partnerships are considered a subset of federally-facilitated exchanges, indicating that HHS has authority over partnerships in federally-facilitated exchanges.[29] States interested in pursuing a partnership exchange effective in

[25] 77 *Federal Register* 18310, March 27, 2012.

[26] Ibid.

[27] §1321(c) of ACA.

[28] The partnership model is discussed in an HHS fact sheet published September 19, 2011, available at http://www.healthcare.gov/news/factsheets/2011/09/exchanges09192011a.html. The partnership model and the federally-facilitated exchange model are both discussed in the final rule on establishment of exchanges (77 *Federal Register* 18310, March 27, 2012). Finally, more information is provided about federally-facilitated exchanges, including partnerships, in guidance released May 16, 2012, available at http://cciio.cms.gov/resources/files/FFE_Guidance_FINAL_VERSION_051612.pdf.

[29] 77 *Federal Register* 18310, March 27, 2012.

2014 must submit to HHS a Declaration Letter and an Exchange Blueprint application by February 15, 2013.[30]

The final rule on the establishment of exchanges does not include provisions specific to federally-facilitated exchanges (instead saying that information for these exchanges will be provided in future guidance). However, the final rule does indicate that federally-facilitated exchanges are required to carry out many of the same functions as state exchanges. Additionally, federally-facilitated exchanges and state exchanges must adhere to many of the same standards outlined in ACA and the final rule. For example, state exchanges and federally-facilitated exchanges are both required to offer the same tools to help consumers access an exchange and assess their plan options through an exchange.

HHS has published some guidance that generally describes how a non-partnership federally-facilitated exchange will operate within the framework established by ACA and the final rule.[31] A detailed analysis of the guidance is beyond the scope of this report; however, the guidance generally describes how a non-partnership federally-facilitated exchange will determine which plans will be offered through an exchange, how it will conduct eligibility and enrollment activities, and how it will operate the SHOP exchange. The guidance also indicates that further guidance on non-partnership federally-facilitated exchanges is forthcoming.

With regard to the partnership exchange, HHS retains authority over the exchange, but it expects states to assume responsibility for certain exchange activities.[32] To enter into a partnership exchange, a state must either manage activities related to plan management or consumer assistance or both. If a state elects to administer plan management activities, the state will be responsible for recommending plans for certification to be offered through an exchange and managing day-to-day administration and oversight of exchange plans. If a state elects to perform consumer assistance activities in a partnership exchange, then the state will be responsible for providing in-person assistance to individuals applying for or enrolled in coverage offered through the exchange and can choose to be responsible for outreach and educational activities. If a state elects to administer both the plan management and consumer assistance activities within the partnership, then the state will carry out all of the activities described above.[33]

What Exchanges Do

Exchanges are required to carry out a number of different functions, including determining eligibility and enrolling individuals in appropriate plans; conducting plan management activities; assisting consumers; ensuring plan accountability; and providing financial management.[34] These

[30] Instructions for submitting the Declaration Letter and the Exchange Blueprint application are available at http://cciio.cms.gov/resources/files/hie-blueprint-081312.pdf.

[31] Center for Consumer Information and Insurance Oversight, *General Guidance on Federally-facilitated Exchanges*, May 16, 2012, http://cciio.cms.gov/resources/files/FFE_Guidance_FINAL_VERSION_051612.pdf.

[32] Ibid.

[33] On January 3, 2012, HHS published guidance on partnership exchanges, available at http://cciio.cms.gov/resources/files/partnership-guidance-01-03-2013.pdf.

[34] The framework for this section is adapted from a report co-authored by Deborah Bachrach and Patricia Boozang, titled, "Federally-Facilitated Exchanges and the Continuum of State Options," available at http://www.nasi.org/research/2011/federally-facilitated-exchanges-continuum-state-options.

functions are not necessarily exhaustive of exchange responsibilities; rather, this section is intended to provide a general overview of an exchange's responsibilities. Unless otherwise noted, both state and federally-facilitated exchanges are required to carry out the functions described in this section. Additionally, some responsibilities may be different for individual exchanges and SHOP exchanges, so the following discussion provides information for both.

Eligibility and Enrollment

Exchanges are responsible for a variety of functions related to determining an applicant's eligibility (whether an individual's or an employer's) for various plans/programs and for enrolling eligible applicants into those plans/programs. Exchanges must verify the information received from applicants and re-determine eligibility as necessary. Exchanges are expected to have secure electronic databases in place that support exchanges' eligibility and enrollment responsibilities by allowing information to be shared among state and federal agencies.[35] An exchange's responsibilities to determine eligibility and to enroll eligible individuals are different, but related, for the individual exchange and the SHOP exchange (for small business employees).

Flexibility Related to Eligibility and Enrollment Systems

ACA intends to create a seamless eligibility and enrollment system for individuals seeking health insurance coverage in the nongroup market and/or through public programs (e.g., Medicaid). The system would allow individuals to fill out a single application that collects the information necessary to screen the individual for multiple types of coverage and financial assistance. The system would then facilitate the enrollment of the individual in the appropriate plan/program.

States have some flexibility in designing and implementing this streamlined system. The flexibility is related to how eligibility and enrollment responsibilities will be shared among entities, including individual exchanges. ACA requires that the system is able to determine an applicant's eligibility for enrollment in a QHP[36] and for insurance affordability programs (IAP),[37] which include Medicaid, the State Children's Health Insurance Program (CHIP), the Basic Health Program (BHP),[38] advanced payment of premium tax credits, and cost-sharing reductions.

ACA and regulations allow different entities to participate in the eligibility and enrollment system. For example, the system can be designed to enable one entity (e.g., the individual exchange) to determine eligibility for and effectuate enrollment in QHPs and all IAPs. Alternatively, the system can be designed so that one state agency determines eligibility for one IAP (i.e., the state's Medicaid agency determines Medicaid eligibility) while another entity or other entities determine eligibility for other plans/programs.

Descriptions of the potential variations in eligibility and enrollment systems that may occur as a result of this flexibility are beyond the scope of this report. However, it is important to note that this section generally describes how an individual exchange would handle its eligibility and enrollment functions *if it were to carry out the functions*. The summaries of eligibility requirements for enrollment in plans/programs described in **Table 1**, **Table 2**, **Table 3**, and **Table 4** are the same regardless of which entity determines eligibility.

[35] §§1413 and 1561 of ACA. The most recent guidance (May 2011) produced by Centers for Medicare & Medicaid Services (CMS) addressing the electronic databases is available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/Downloads/exchangemedicaiditguidance.pdf.

[36] For more information about QHPs offered through an exchange, see the "Qualified Health Plans" section of this report.

[37] The term and definition of "insurance affordability programs" is adopted from a definition in the final rule on exchange establishment (77 *Federal Register* 18310, March 27, 2012).

[38] §1331 of ACA requires the HHS Secretary to create a basic health program (BHP), which is a health insurance program for low-income individuals who are not eligible for Medicaid, and is offered in lieu of eligible individuals obtaining coverage through an exchange. States have the option to implement the BHP, and therefore, exchanges will interact with BHPs in only those states that choose to implement a BHP.

Individual Exchange

To determine eligibility, an individual exchange must use a single, streamlined application to collect information from an applicant and verify that information according to procedures identified in regulation. For example, an individual exchange is expected to verify an applicant's social security number by transmitting the number to HHS, which will consult the Social Security Administration and the Department of Homeland Security, as needed, to verify the number.[39]

An individual exchange is expected to re-determine an enrollee's eligibility if the individual exchange receives and verifies new information relating to the enrollee. This information can come from the enrollee, as enrollees are required to report any change with respect to eligibility standards within 30 days of the change, or it can come from information the individual exchange finds through its required periodic examination of available information that might affect eligibility (e.g., whether an enrollee has died). An individual exchange is also expected to re-determine or re-assess the eligibility of all enrollees on an annual basis. However, re-determinations and re-assessments due to changes in status do not fully satisfy the requirement for annual re-determinations and re-assessments.[40]

Eligibility for Enrollment in a QHP

An individual exchange is required to *determine* an applicant's eligibility for enrollment in a QHP. If an applicant is determined eligible for a QHP, the individual exchange is expected to facilitate the applicant's enrollment into the QHP selected by the individual. **Table 1** shows the criteria an individual exchange must use to determine eligibility for enrollment in a QHP.

Table 1. Criteria for Determining Eligibility for Enrollment in a QHP

	An individual exchange must determine an applicant eligible for a QHP if the applicant meets the following criteria:
Enrollment in a QHP	• Citizen, national, or noncitizen who is lawfully present in the United States[a] • Not incarcerated, other than pending the disposition of charges • Meets applicable state residency standards

Source: CRS analysis of ACA (as amended) and 77 *Federal Register* 18310, March 27, 2012.

a. Only lawful residents may obtain exchange coverage; unauthorized aliens will be prohibited from obtaining coverage through an exchange, even if they could pay the entire premium without a subsidy.

Eligibility for Premium Tax Credits and Cost-Sharing Subsidies

Certain individuals who purchase a QHP through an individual exchange will be eligible for financial assistance to help them off-set the cost of the coverage and to defray some costs associated with using health services. ACA provides assistance, for the purchase of exchange coverage, in the form of premium tax credits. (A tax credit is a reduction that is applied to the amount an individual (or family) owes, if any, when filing income taxes.) Premium tax credits are advanceable, meaning instead of having to wait until after the end of the tax year to receive the

[39] 77 *Federal Register* 18310, March 27, 2012.

[40] Ibid.

credit, the individual may receive the payments in advance to coincide with when insurance premiums are due (usually on a monthly basis).

In addition to the premium tax credits, ACA provides cost-sharing subsides to certain individuals to help them pay costs related to the use of health services. (Cost-sharing generally refers to costs that an individual must pay when using services that are covered under the health plan that the person is enrolled in; common forms of cost-sharing include copayments and deductibles.) Both premium tax credits and cost-sharing subsidies are discussed later in this report under the section "Cost Assistance."

Because the premium tax credits are advanceable, it will be necessary to determine an individual's eligibility for the credits at the time the individual applies for coverage through an exchange. In regard to advanced payment of premium tax credits, an individual exchange may either *determine* an applicant's eligibility directly or *implement a determination* of eligibility made by HHS.[41] Determining eligibility directly is similar to determining eligibility for QHPs; the individual exchange reviews an applicant's information and makes a determination of eligibility. If an individual exchange chooses to determine an applicant's eligibility for advance payment of premium tax credits, the exchange must calculate the amount of the advance payment in accordance with Section 36B of the Internal Revenue Code. An individual exchange may only provide the advance payment if the applicant meets the eligibility criteria (see **Table 2**).

Similarly, an individual exchange may either directly determine eligibility for cost-sharing subsidies, or it may implement a determination made by HHS. If an individual exchange chooses to determine an applicant's eligibility for cost-sharing subsidies, the exchange must do so according to the criteria outlined in **Table 2**.

If an individual exchange decides *not* to directly determine eligibility for advanced payment of premium tax credits or *not* to directly determine eligibility for cost-sharing subsidies but rather implements HHS determinations, then an individual exchange is expected to transmit all collected and verified information to HHS. The individual exchange does not make a recommendation in this process; rather, the individual exchange shares information with HHS and then is expected to adhere to the determination of eligibility made by HHS.[42]

[41] These provisions were included as "interim final" rather than in the final rule on exchange establishment (77 *Federal Register* 18310, March 27, 2012), and comments were accepted on both provisions through May 11, 2012. The preamble of the final rule indicates that further guidance on these provisions is forthcoming.

[42] The eligibility criteria for advance payment of premium tax credits and cost-sharing subsidies are the same regardless of whether an individual exchange makes the determination or HHS makes the determination.

Table 2. Criteria for Determining Eligibility for Subsidies Through an Exchange

An exchange or HHS may determine an applicant eligible for the subsidies below according to the following criteria:	

Advanced payment of premium tax credits	• Meets the criteria for eligibility for enrollment in a QHP through an exchange[a]
	• Not eligible for minimum essential coverage[b] other than
	  • through the individual health insurance market; or
	  • employer-sponsored insurance that is "unaffordable" or does not provide "minimum value"[c]
	• Is part of a tax-filing unit
	• Is enrolled in a QHP offered through an exchange
	• Has household income that either
	  • is between 100% and 400% FPL; or
	  • is not greater than 100% FPL and is an alien lawfully present (but not eligible for Medicaid because of duration of U.S. residency)[d]

Cost-sharing subsidies[e]	• Meets the criteria for eligibility for enrollment in a QHP through an exchange • Meets the criteria for eligibility for advance payment of premium tax credits • Is enrolled in a silver plan through an exchange[f] • Has household income between 100% and 400% FPL[g]

Source: CRS analysis of ACA (as amended) and 77 Federal Register 18310, March 27, 2012.

a. These criteria are detailed in **Table 1**.

b. The definition of minimum essential coverage is discussed in CRS Report R41331, *Individual Mandate and Related Information Requirements under ACA*, by Janemarie Mulvey and Hinda Chaikind.

c. For the purpose of this provision, ACA considers an employer-sponsored plan "unaffordable" if the employee's premium contribution to the employer's self-only plan exceeds 9.5% of household income. An employer-sponsored plan does not provide "minimum value" if it covers less than 60% of total allowed costs (on average).

d. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193) determined that most individuals who are not citizens but are lawfully present in the United States are barred from Medicaid for the first five years that they are in the United States.

e. ACA establishes different eligibility criteria for cost-sharing subsidies for certain American Indians and Alaska Natives. For more information, see CRS Report R41152, *Indian Health Care: Impact of the Affordable Care Act (ACA)*, by Elayne J. Heisler.

f. A description of the different tiers of coverage offered through an exchange is included in the "Coverage Levels and Benefits" section of this report.

g. The cost-sharing subsidies reduce the annual caps on out-of-pocket expenses for individuals with income between 100% and 400% FPL. Additionally, ACA requires QHP issuers to further reduce cost-sharing requirements for individuals with income between 100% and 250% FPL. For more information, see CRS Report R41137, *Health Insurance Premium Credits in the Patient Protection and Affordable Care Act (ACA)*, by Bernadette Fernandez and Thomas Gabe.

Eligibility for Medicaid and CHIP

An individual exchange may either *determine* or *assess* an applicant's eligibility for enrollment in Medicaid and/or CHIP. If an individual exchange *determines* eligibility for Medicaid and/or

CHIP, then the individual exchange is also responsible for the enrollment of eligible applicants. Once an applicant has been determined eligible, the individual exchange must transmit the applicant's information to the state Medicaid or CHIP agency, thus effectuating enrollment.

An individual exchange may only *assess* eligibility for Medicaid/CHIP. If an applicant is assessed eligible for a program the individual exchange is required to transmit all collected and verified information to the state Medicaid or CHIP agency to enable the agency to make a final determination of the applicant's eligibility. In this case, the exchange is only making a recommendation and sharing information with the appropriate agency; it is not responsible for making a final determination of eligibility. The individual exchange is expected to adhere to the final determination made by the agency.

The final rule on Medicaid eligibility changes under ACA indicates that the state Medicaid and/or CHIP agency will decide whether an individual exchange will determine or assess eligibility for its program(s).[43] Additionally, the rule clarifies that some individuals have financial eligibility for Medicaid based on modified adjusted gross income (MAGI), while others do not have financial eligibility based on MAGI.[44] The rule provides that a state's Medicaid agency can separately decide on the individual exchange's role in determining or assessing Medicaid eligibility for MAGI and non-MAGI populations. **Table 3** shows criteria an individual exchange must use to determine or assess eligibility for individuals whose financial eligibility is based on MAGI. It is beyond the scope of this report to detail the criteria used to determine or assess eligibility for individuals whose financial eligibility is not based on MAGI.

[43] 77 *Federal Register* 17144, March 23, 2012.

[44] On June 28, 2012, the United States Supreme Court issued its decision in *National Federation of Independent Business v. Sebelius*. The Court held that the federal government cannot terminate current Medicaid program federal matching funds if a state refuses to expand its Medicaid program to include non-elderly, non-pregnant adults under 133% of the federal poverty level. If a state accepts the new ACA Medicaid expansion funds, it must abide by the new expansion coverage rules, but, based on the Court's opinion, it appears that a state can refuse to participate in the expansion without losing any of its current federal Medicaid matching funds. This decision did not affect the ACA requirement that modified adjusted gross income (MAGI) would be the new income test for most of Medicaid's covered populations beginning in 2014. For a legal analysis of the Court's decision on Medicaid, see CRS General Distribution Memorandum, *Selected Issues Related to the Effect of NFIB v. Sebelius on the Medicaid Expansion Requirements in Section 2001 of the Affordable Care Act*, by Kathleen S. Swendiman and Evelyne P. Baumrucker. For a comprehensive discussion about MAGI and ACA, see CRS Report R41997, *Definition of Income in ACA for Certain Medicaid Provisions and Premium Credits*, coordinated by Janemarie Mulvey.

Table 3. Criteria for Determining or Assessing MAGI-Based Eligibility for Enrollment in Medicaid and CHIP

An individual exchange may determine an applicant eligible or assess an applicant's eligibility for MAGI-based Medicaid and CHIP according to the following criteria:		
	Determination	**Assessment**
Enrollment in Medicaid	• Meets the non-financial criteria for Medicaid for populations whose eligibility is based on modified adjusted gross income (MAGI)[a] • Has a household income that is at or below the applicable Medicaid MAGI-based income standard • Is either a pregnant woman, under age 19, a parent or caretaker of a dependent child, or is under age 65 and not entitled to or enrolled in Medicare Parts A or B	• Makes the assessment based on the applicable Medicaid MAGI-based income standards and citizenship and immigration status, using verification rules and procedures consistent with Medicaid statute, regardless of how such standards are implemented by the state Medicaid agency • Must adhere to state Medicaid agency's final determination of applicant's eligibility
Enrollment in CHIP	• Meets the requirements for children to enroll in CHIP[b] • Has a household income at or below the applicable CHIP MAGI-based income standard	• Makes the assessment based on the applicable CHIP MAGI-based income standards and citizenship and immigration status, using verification rules and procedures consistent with CHIP statute, regardless of how such standards are implemented by the state CHIP agency • Must adhere to state CHIP agency's final determination of applicant's eligibility

Source: CRS analysis of ACA (as amended) and 77 *Federal Register* 18310, March 27, 2012.

a. For information about populations whose Medicaid eligibility is, in part, based on MAGI-based income, see CRS Report R41210, *Medicaid and the State Children's Health Insurance Program (CHIP) Provisions in ACA: Summary and Timeline*, by Evelyne P. Baumrucker et al.

b. For more information about children's eligibility for CHIP, see CRS Report R40444, *State Children's Health Insurance Program (CHIP): A Brief Overview*, by Elicia J. Herz and Evelyne P. Baumrucker.

Eligibility for Enrollment in a BHP

The Basic Health Program (BHP) is a health insurance program for low-income individuals who are not eligible for Medicaid, and is offered in lieu of eligible individuals obtaining coverage through an exchange. States have the option to implement the BHP, and therefore, exchanges will interact with BHPs in only those states that choose to implement a BHP.

If a state chooses to establish a BHP, an individual exchange is expected to *determine* an applicant's eligibility for a BHP, and facilitate the applicant's enrollment in the program. **Table 4** shows the criteria an individual exchange must use to determine eligibility for enrollment in a BHP.

Table 4. Criteria for Determining Eligibility for Enrollment in a BHP

	An individual exchange must determine an applicant eligible for a BHP if the applicant meets the following criteria:

Enrollment in the Basic Health Program (BHP)	• Resident of a state and not eligible for the state's Medicaid program
	• Not eligible for minimum essential coverage or is eligible for employer-sponsored insurance (ESI) that is not affordable[a]
	• Has not attained age 65 at the beginning of the plan year
	• Has household income that either
	  • exceeds 133% of the federal poverty level (FPL) but does not exceed 200% FPL; or
	  • is not greater than 133% FPL and is an alien lawfully present (but not eligible for Medicaid because of duration of U.S. residency)[b]

Source: CRS analysis of ACA (as amended) and 77 *Federal Register* 18310, March 27, 2012.

a. The definition of minimum essential coverage is discussed in CRS Report R41331, *Individual Mandate and Related Information Requirements under ACA*, by Janemarie Mulvey and Hinda Chaikind. ACA considers employer coverage "unaffordable" if the employee's contribution toward the employer's lowest-cost self-only premium exceeds 9.5% of household income.

b. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193) determined that most individuals who are not citizens but are lawfully present in the United States are barred from Medicaid for the first five years that they are in the United States.

SHOP Exchange

As the exchange for small businesses, the SHOP has responsibilities similar to the individual exchange in that the SHOP is also responsible for collecting and verifying information from employers and employees (both considered applicants), determining eligibility, and facilitating enrollment. An employer and each of its employees seeking coverage must submit an application to the SHOP. The SHOP must process the applications, and if the employer and employees are determined eligible, the SHOP must facilitate the enrollment of qualified employees into QHPs offered through the SHOP.

A qualified employee is an employee who receives an offer of coverage from a qualified employer. A qualified employer is a small group employer[45] that elects to make, at a minimum, all full-time employees eligible for one or more QHPs offered in the small group market through an exchange, and has its principal business in the exchange service area or offers coverage to each eligible employee through the SHOP serving the employee's worksite.[46]

The SHOP is required to verify applicants' eligibility as outlined in regulation.[47] The SHOP must permit an employer to purchase coverage for employees at any time during the year, but the employer's plan must consist of a 12-month period beginning with the employer's effective date

[45] Before 2016, states will have the option to define "small employers" either as those with 100 or fewer employees or 50 or fewer employees. Beginning in 2016, small employers will be defined as those with 100 or fewer employees.

[46] Beginning in 2017, a state may also allow an issuer of coverage in the large group market to offer QHPs in the large group market through an exchange. If that is the case, then a qualified employer would also include an employer in the large group market.

[47] 77 *Federal Register* 18310, March 27, 2012.

of coverage. Employees must adhere to annual open enrollment periods as determined by the SHOP, with special allowances for newly qualified employees.

Employers are not required to offer all the plans in an exchange to their employees. The SHOP must allow an employer to limit the selection of plans.[48] An employer who uses the SHOP is not required to contribute to employees' premiums; additionally, neither ACA nor regulations specify whether a SHOP can require a minimum contribution from employers.[49]

Plan Management Responsibilities

Exchanges are required to ensure that QHPs are certified.[50] An exchange may certify a plan as a QHP if the plan meets the required minimum criteria and if the exchange determines that it is in the best interest of qualified individuals and employers to have such a plan available.[51] The minimum certification criteria outlined in ACA and further defined through regulation include requirements related to marketing, choice of providers, plan networks, accreditation,[52] and other features.[53]

In addition to certifying QHPs, an exchange must establish processes for recertification and decertification of QHPs. The recertification process, at a minimum, must include a review of the general certification criteria and must be completed on or before September 15 of the applicable calendar year. The decertification process must, at a minimum, include the following requirements: the ability for an exchange to decertify a plan at any time if the exchange determines that the QHP no longer meets the certification requirements; an exchange must establish a process for the appeal of a decertification; and an exchange must provide a notice of the decertification to all affected parties, including the QHP issuer, the exchange enrollees, HHS, and the state insurance department.

An exchange has additional plan management functions. For example, the exchange must require plans seeking certification as QHPs to submit justification for premium increases before it takes effect, and the plans will have to post the information about their premium increases on their websites.[54] Also, the HHS Secretary is required to create a system that rates QHPs on the basis of

[48] Ibid. If a state merges its individual and small group risk pools, as is allowed under §1312(c)(3) of ACA, then the SHOP may permit an employee to enroll in any QHP (including one offered in the individual market), as long as the QHP meets certain requirements for small group market plans.

[49] This information was confirmed through correspondence with analysts from the Center for Consumer Information and Insurance Oversight (CCIIO) in September 2012.

[50] §1311(d)(4)(A) of ACA.

[51] Except that, according to §1311(e)(1)(B) of ACA, the exchange may not exclude a plan because it is a fee-for-service plan, through the imposition of price controls, or on the basis that the plan provides treatments necessary to prevent patients' deaths in circumstances the exchange determines are inappropriate or too costly.

[52] In the final regulation on entities for the accreditation of exchange plans, HHS stated that the National Committee for Quality Assurance and URAC (formerly known as the Utilization Review Accreditation Commission) would serve as accrediting entities during the first phase of the accrediting process. HHS will consider other accrediting bodies and individual states at a later time. 77 *Federal Register* 42662, July 20, 2012.

[53] §1311(c)(1) of ACA and 77 *Federal Register* 18310, March 27, 2012.

[54] §1311(e)(2) of ACA.

relative quality and price. An exchange is expected to assign a rating to each QHP according to the HHS Secretary's criteria and provide the quality rating information through its website.[55]

Consumer Assistance and Accountability

Exchanges have a number of responsibilities related to assisting consumers in accessing and obtaining coverage, including providing tools to help consumers access the exchange, helping consumers determine which plan or program to enroll in, and helping consumers determine their potential financial responsibility for a QHP offered through an exchange.[56] Additionally, exchanges are expected to adhere to accountability practices to increase an exchange's transparency.

The following are some of an exchange's responsibilities related to assisting consumers and being accountable to stakeholders, including consumers. An exchange must

- Provide for operation of a toll-free telephone hotline that addresses the needs of consumers requesting assistance and informs individuals with disabilities and limited English proficiency of the availability of services to assist them.
- Maintain a website which, among other things, provides standardized comparative information on each QHP available through the exchange and allows qualified individuals to select a QHP in which to enroll.[57]
- Make available an electronic calculator (through its website) that facilitates the comparison of available QHPs (including the impact of any advance payments of tax credits and cost-sharing subsidies in the individual exchange and the impact of any employer contribution in the SHOP exchange).
- Conduct outreach and education activities that will educate consumers about the exchange and insurance affordability programs (IAPs) to encourage participation.[58]
- Establish a Navigator program with grants to eligible individuals and entities to provide information about the exchange and help individuals select a QHP. Navigators are also required to conduct activities to raise awareness of an exchange.[59]

[55] §1311(d)(4) of ACA. In the final rule on the establishment of exchanges (77 *Federal Register* 18310, March 27, 2012) it is indicated that the rating system will be addressed in future rulemaking.

[56] HHS more specifically describes the consumer assistance functions of federally-facilitated exchanges, including partnerships, in guidance available at http://cciio.cms.gov/resources/files/FFE_Guidance_FINAL_VERSION_051612.pdf.

[57] The standard format an exchange is expected to use to present QHPs is required to include the uniform outline of coverage as established under §2715 of the PHSA (§1001 of ACA). For more information about the uniform outline of coverage, see CRS Report R42069, *Private Health Insurance Market Reforms in the Patient Protection and Affordable Care Act (ACA)*, by Annie L. Mach and Bernadette Fernandez.

[58] The final rule on exchange establishment (77 *Federal Register* 18310, March 27, 2012) does not specify the content or quantity of these outreach and education activities, but it does require that the activities must be accessible to all audiences, including to individuals with disabilities and those with limited English proficiency.

[59] §1311(i) of ACA and 77 *Federal Register* 18310, March 27, 2012.

- Include results on its website from the Secretary's survey on enrollee satisfaction with the QHPs offered through the exchange, in a manner that allows for easy comparisons of enrollee satisfaction levels.[60]
- Regularly consult with stakeholders regarding the accessibility and administration of an exchange. These stakeholders include enrollees of QHPs; individuals and entities with experience in facilitating enrollment in health insurance coverage; advocates for hard to reach populations (e.g., individuals with substance abuse problems); small businesses, large employers, and self-employed individuals; state Medicaid and CHIP agencies; federally recognized Tribes; public health experts; issuers; and health insurance agents and brokers.[61]
- Share financial information on its website, regarding: any regulatory fees or other payments required by the exchange; administrative costs of the exchange; and monies lost to waste, fraud, and abuse.[62]
- Determine the role of agents and brokers in the exchange. An exchange may allow agents and brokers to be Navigators, provided they otherwise meet the Navigator eligibility criteria.[63] An exchange may also allow agents and brokers to enroll individuals and employers in QHPs offered through an exchange if the agents and brokers meet certain requirements.[64]

Financial Management

Exchanges are responsible for financial management and are expected to be self-sustaining by 2015. They have been given authority to generate funding to support their operations; however, while the law and regulation describe this authority, neither specify how an exchange may or may not generate funding.[65] An example provided in regulation is that exchanges could charge participating issuers assessments or user fees.[66]

Exchanges are expected to play a role in collecting premiums and distributing the premiums to issuers. ACA requires exchanges to perform certain functions relating to financial oversight and integrity, including keeping an accurate accounting of all financial activities and submitting a report annually to the HHS Secretary concerning such accountings. Exchanges are also required to cooperate with investigations into the affairs of exchanges, conducted by the HHS Secretary in coordination with HHS Inspector General.[67]

[60] §1311(c)(4) of ACA. The survey is only for those QHPs that had more than 500 enrollees in the previous year. To date, HHS has not released any information about this survey.

[61] §1311(d)(6) of ACA.

[62] §1311(d)(7) of ACA.

[63] 77 *Federal Register* 18310, March 27, 2012.

[64] Ibid.

[65] §1311(d)(5) of ACA.

[66] 77 Federal Register 18310, March 27, 2012.

[67] §1313 of ACA.

ACA Risk Mitigation Programs

Exchanges are expected to deal with the potential for adverse selection. Adverse selection occurs when a large number of individuals who expect or plan for high use of health services enroll in more generous and often more expensive health plans (i.e., a woman who plans to become pregnant switches from a plan with less generous maternity benefits to a plan with more generous maternity benefits), while simultaneously individuals who expect or plan for low use of health services enroll in more modest plans, both in terms of price and benefits. Adverse selection can lead to health plans that have risk pools with a large number of high-cost individuals, which can lead to higher costs for individuals in the pool, and in extreme instances, possible dissolution of the pool due to an increasingly expensive risk pool.

ACA establishes three risk programs to help mitigate the potential impact of adverse selection: reinsurance, risk corridors, and risk adjustment. The first two programs are temporary and are intended to provide some protection against risk in the short term before a full risk adjustment program can be developed. None of the programs are specific to exchanges; rather, they are tools that can be used both inside and outside the exchanges to mitigate the impact of adverse selection. For more information about ACA's risk programs, see **a**.

Federal Responsibilities for Establishment and Administration of All Exchanges

ACA requires federal agencies, primarily HHS, to oversee the exchanges, thus carrying out a number of responsibilities related to the establishment and administration of exchanges. Many of these responsibilities require federal agencies to create systems and criteria. For example, the HHS Secretary is required to develop the minimum criteria an exchange will use to certify QHPs to be offered through an exchange.[68] The HHS Secretary is also required to grant financial awards to states to be used to establish exchanges.

Federal Oversight

Federal agencies, primarily HHS, have oversight and other responsibilities for exchanges. These responsibilities not only relate to the general operation of the exchange, but they also relate to how an exchange is expected to share information and coordinate its duties with federal agencies.

It is beyond the scope of this report to detail all of the responsibilities ACA gives to federal agencies;[69] however, the following are general examples of duties required of federal agencies. Other examples are included in this report, where appropriate.

- The HHS Secretary is required to promulgate regulations relating to, among other things, setting standards for the establishment and operation of exchanges, the offering of QHPs through exchanges, and the establishment of the reinsurance and risk adjustment programs established by ACA.[70]

[68] These criteria are included in the final rule related to the establishment of exchanges (77 *Federal Register* 18310, March 27, 2012).

[69] For an overview of the rulemaking authority given to federal agencies under ACA, see CRS Report R42431, *Upcoming Rules Pursuant to the Patient Protection and Affordable Care Act: Fall 2011 Unified Agenda*, by Maeve P. Carey and Michelle D. Christensen.

[70] §1321(a)(1) of ACA.

- The HHS Secretary is expected to coordinate efforts between the exchange and other federal agencies (such as the Social Security Administration) to verify information collected by the exchange from applicants and related to eligibility for the exchange and other programs (e.g., premium tax credits).[71]
- The HHS Secretary is expected, through consultation with other entities (such as the National Association of Insurance Commissioners), to develop and maintain tools and set minimum standards for tools that exchanges may use to assist consumers with accessing the exchange.[72]

Federal Financial Assistance

While exchanges are expected to be self-sufficient by 2015, there is some limited federal assistance provided to states to help them as they develop their exchanges.[73] ACA requires the HHS Secretary to award planning and establishment grants to states for the purposes of activities related to establishing exchanges.[74] ACA gives the HHS Secretary the authority to determine the amount of the grants and to renew the grants if a state is making sufficient progress toward establishing an exchange. No planning and establishment grant may be awarded after December 31, 2014.[75]

Planning grants were given to 49 states and the District of Columbia.[76] These grants of up to $1 million each were intended to provide resources to states to help them conduct research and planning related to establishing exchanges. Establishment grants have also been awarded to a number of states. Level one establishment grants are annual awards to states that are still in the initial phases of developing exchanges, and level two establishment grants are multi-year awards intended to assist states that have made significant progress in implementation of exchanges. To date, 34 states and the District of Columbia have received level one grants, and 11 states and the

[71] §1411(c) of ACA.

[72] §1311 of ACA.

[73] The CRS Congressional Distribution (CD) memorandum, "Patient Protection and Affordable Care Act: Health Insurance Exchange Planning and Establishment Grants" by C. Stephen Redhead and Annie L. Mach, includes a table that shows the federal grants (discussed in this section) that have been awarded to each state and the District of Columbia. The memorandum is available upon request from the memorandum's authors.

[74] §1311(a) of ACA. Some contend that the law does not contain explicit appropriation authority for the operation of federally-facilitated exchanges, as §1311 only says that the Secretary may award planning and establishment grants to states. However, in regard to the federally-facilitated exchange, the law does say that, "…the Secretary shall (directly or through agreement with a not-for-profit entity) establish and operate such exchange within the state and the Secretary shall take such actions as are necessary to implement such other requirements" (§1321(c)(1)(B)).

[75] All exchanges are expected to be self-sustaining by January 1, 2015. In guidance, however, HHS clarified that planning and establishment grants awarded through December 31, 2014, may be used for approved establishment activities after that date. For more information, see http://cciio.cms.gov/resources/files/Files2/11282011/exchange_q_and_a.pdf.pdf.

[76] Alaska is the only state that did not apply for a planning grant. Three states, Florida, Louisiana, and New Hampshire, have stated that they plan to return some or all of their planning grant funds. For more information about which states have received grants, see http://www.healthcare.gov/news/factsheets/2011/05/exchanges05232011a.html.

District of Columbia have received level two grants.[77] In total, the states and the District of Columbia have received about $3.5 billion in establishment grants.[78]

The HHS Secretary is also required to award grants to eligible entities to help them develop and adapt technology systems to be used by an exchange to determine eligibility and process enrollment.[79] These "early innovator" grants were given to seven entities to help them design and implement the information technology infrastructure needed to operate an exchange.[80] The grants were awarded to entities that have "demonstrated their technical expertise and ability to develop these IT systems on a fast track schedule, and their willingness to share design and implementation solutions with other states."[81] The seven entities combined have received more than $249 million in early innovator grants.[82]

Coverage Offered through the Exchanges

Most private health insurance plans sold through exchanges must include a comprehensive set of benefits. The law specifies standards for the types and levels of coverage that can be offered through exchanges.

Coverage Levels and Benefits

Generally, exchange plans must (1) cover "essential health benefits" (EHBs), at a minimum; (2) limit cost-sharing, including out-of-pocket costs; and (3) provide coverage that meets one of four levels of plan generosity based on actuarial value (defined below).[83] These requirements will become effective beginning in 2014, to dovetail with the establishment of exchanges. The following discusses them in greater detail.

[77] The 34 states that have received a level one grant so far are: AL, AZ, AR, CA, CO, CT, DE, HI, ID, IL, IN, IA, KY, ME, MD, MA, MI, MN, MS, MO, NE, NV, NJ, NM, NY, NC, OR, PA, RI, SD, TN, VT, WA, WV, and D.C. The states that have received level two grants, to date, are CA, CT, KY, MA, MD, NV, NY, OR, RI, VT, WA, and D.C.

[78] For more information, see CRS Congressional Distribution Memo, "Patient Protection and Affordable Care Act: Health Insurance Exchange Planning and Establishment Grants," by Annie L. Mach and C. Stephen Redhead. The memorandum is available to congressional staff upon request from the authors.

[79] §1561 of ACA: §3021 of PHSA.

[80] The seven grantees are Kansas, Maryland, New York, Oklahoma, Oregon, Wisconsin, and a multi-state consortium led by the University of Massachusetts Medical School (which includes Connecticut, Maine, Massachusetts, Rhode Island, and Vermont). Three states, Kansas, Oklahoma, and Wisconsin, have since stated their intention to return some or all of the grant. For more information, see http://www.cbpp.org/files/CBPP-Analysis-on-the-Status-of-State-Exchange-Implementation.pdf.

[81] HealthCare.gov, "States Leading the Way on Implementation: HHS Awards "Early Innovator" Grants to Seven States," press release, February 16, 2011, http://www.healthcare.gov/news/factsheets/2011/02/exchanges02162011a.html.

[82] Center for Consumer Information and Insurance Oversight, "Affordable Insurance Exchanges: Update and Upcoming Implementation Forums," press release, May 16, 2012, http://cciio.cms.gov/resources/factsheets/affordable_insurance_exchanges.html.

[83] §1302(a)-(d) of ACA.

Essential Health Benefits

ACA does not explicitly list the benefits that comprise essential health benefits (EHBs). Instead, the law identifies 10 broad benefit categories which must be included in EHBs, at a minimum:

- ambulatory patient services;
- emergency services;
- hospitalization;
- maternity and newborn care;
- mental health and substance use disorder services, including behavioral health treatment;
- prescription drugs;
- rehabilitative and habilitative services and devices;
- laboratory services;
- preventive and wellness and chronic disease management; and
- pediatric services, including oral and vision care.

States may impose additional benefit mandates beyond what is required under EHBs. However, any state that requires health plans to offer benefits beyond EHBs must assume the total cost of providing those additional benefits, for all the plans, and regardless of whether or not an individual is receiving any financial assistance with premiums or cost-sharing. The state must make payments either directly to the individuals enrolled in health plans affected by the state benefit mandates, or to such plans on behalf of enrolled individuals.[84]

The bulk of the responsibility for defining EHBs is given to the HHS Secretary, who must then notify the public and provide the opportunity for comment. The HHS Secretary has certain guidelines that must be followed in developing the EHBs, including ensuring that the scope of EHBs is equal to the scope of benefits under a "typical" employer-provided health plan (as certified by the Chief Actuary of the Centers for Medicare & Medicaid Services), and that EHBs meet equity and other standards specified in the law. To assist the HHS Secretary in this determination, the law requires the Secretary of the Department of Labor (Labor) to conduct a survey of employer-provided health coverage.[85]

ACA did not specify a deadline for when the Secretary is required to define EHBs. As of the cover date of this report, HHS has not issued regulations defining EHBs; however, in a bulletin and in proposed rules, HHS indicated that the EHBs would be defined by a benchmark plan selected by each state.[86] HHS identified four benchmark plan types that a state could use for the purpose of defining EHBs in that state:

[84] This applies to all exchange enrollees whose insurance is affected by additional state benefit mandates, not just those exchange enrollees eligible for premium tax credits and cost-sharing subsidies. §1311(d)(3)(B) of ACA.

[85] See "Selected Medical Benefits: A Report from the Department of Labor to the Department of Health and Human Services," Department of Labor, April 15, 2011, http://www.bls.gov/ncs/ebs/sp/selmedbensreport.pdf.

[86] "Essential Health Benefits Bulletin," Center for Consumer Information and Insurance Oversight, December 16, 2011, p.8, http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf; Department of Health (continued...)

- one of the three largest plans in the state's small group health insurance market;[87]
- one of the three largest state employees health benefits plans;
- one of the three largest national plans offered through the Federal Employees Health Benefits Program (FEHBP); or
- the largest commercial non-Medicaid health maintenance organization in the state.

To assist states in this effort, HHS conducted studies that identified the largest plans (by enrollment) for several of the benchmark plan types listed above, and documented the prevalence of certain benefits in health plans that are currently offered.[88] HHS found that the largest national FEHBP plan, by far, is offered through Blue Cross and Blue Shield; and while small group plans vary by state, the ones with the largest enrollment generally are offered by large, commercial insurance carriers.

In general, HHS found that most of the EHB categories specified in ACA are consistently covered across different health plans and insurance markets, including benefits such as doctor visits, surgery, hospitalization, transplants, emergency department services, maternity care, mental health and substance abuse services, therapy, medical equipment, laboratory work, preventive care, and pediatric and child services. However, there are three EHB benefit categories that are excluded from many private health plans: pediatric oral care, pediatric vision care, and habilitative services. For these benefit categories, HHS proposes alternative approaches for supplementing benchmark plans that do not cover pediatric vision/oral care or habilitative services.[89]

HHS required states to specify a benchmark plan by December 26, 2012.[90] Each state's benchmark plan will apply to their respective exchanges for plan years 2014 and 2015. HHS will then revisit this issue for the 2016 plan year.[91] The default benchmark option, the largest plan by enrollment in the largest product in the state's small group market, will apply in cases where a state did not voluntarily select a benchmark plan.

(...continued)

and Human Services, "Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation; Proposed Rule," 77 *Federal Register* 70644, November 26, 2012.

[87] In the final regulation on data collection to support essential health benefits standards, HHS stated that it will collect data from the insurance carriers that offer the three largest health plans (by enrollment) in the small group market within each state. The data collection is for purposes of identifying a potential "default benchmark plan" for each state. HHS intends to make publicly available the "information on the final state selections of benchmarks…as soon as possible." 77 *Federal Register* 42661, July 20, 2012.

[88] See "Essential Health Benefits: Comparing Benefits in Small Group Products and State and Federal Employee Plans," Office of the Assistant Secretary for Planning and Evaluation, December 2011, http://aspe.hhs.gov/health/reports/2011/MarketComparison/rb.shtml; "Essential Health Benefits: List of the Largest Three Small Group Products by State," Center for Consumer Information and Insurance Oversight, July 3, 2012, http://cciio.cms.gov/resources/files/largest-smgroup-products-7-2-2012.pdf.PDF; and "Frequently Asked Questions on Essential Health Benefits Bulletin," Centers for Medicare and Medicaid Services, February 17, 2012, http://cciio.cms.gov/resources/files/Files2/02172012/ehb-faq-508.pdf.

[89] Center for Consumer Information and Insurance Oversight, Frequently Asked Questions on Essential Health Benefits Bulletin, February 17, 2012, available at http://cciio.cms.gov/resources/files/Files2/02172012/ehb-faq-508.pdf.

[90] Each state's proposed benchmark plan is available at, http://cciio.cms.gov/resources/data/ehb.html.

[91] Ibid.

Cost-Sharing Requirements

Cost-sharing includes deductibles and co-payments for services rendered. ACA limits the amount of cost-sharing that exchange plans generally may impose on enrolled individuals. These cost-sharing limits prohibit

- any deductible applicable to preventive health services;
- deductibles, in small group health plans, that are greater than $2,000 for self-only coverage, or $4,000 for any other coverage in 2014 (annually adjusted thereafter); and
- annual cost-sharing limits that exceed existing limits specified in the tax code, relating to certain high deductible health plans.[92]

Levels of Plan Generosity

Health plans that provide the essential health benefits package must tailor cost-sharing to meet one of four levels of generosity, based on actuarial value.[93] Actuarial value (AV) is a summary measure of a plan's generosity, expressed as the percentage of medical expenses estimated to be paid by the issuer for a standard population and set of allowed charges. In other words, AV reflects the relative share of cost-sharing that may be imposed. On average, the lower the AV, the greater the cost-sharing.[94]

Each level of plan generosity is designated according to a precious metal and corresponds to a specific actuarial value:

Levels	Actuarial Value
Bronze	60%
Silver	70%
Gold	80%
Platinum	90%

While the term actuarial value may imply a high level of precision,

> actuarial analysis is inherently an estimation process and hence is somewhat inexact. Actuarial value estimates will vary by the data sources, projection methods, and assumptions

[92] The cost-sharing limits that are part of the essential health benefits package mirror the limits applicable to high-deductible health plans (HDHPs) that qualify to be paired with health savings accounts (HSAs). For 2012, the cost-sharing limits for HSA-qualified HDHPs are $6,050 for single coverage, and $12,100 for family coverage. Given that the existing limits are updated annually and ACA cost-sharing requirements become effective in 2014, the cost-sharing limits in 2014 will likely be different than the 2012 levels.

[93] While actuarial value (AV) is a useful measure, it is only one component that addresses the value of any given benefit package. AV, by itself, does not address other important features of coverage, such as total (dollar) value, network adequacy, and premiums.

[94] While actuarial value is calculated based on costs for an entire population, it does not mean that every person enrolled in the same plan will have the same expenses, because in any given group some people use relatively little care while others use a great deal. Given that actuarial value reflects cost-sharing, such a measure may be useful to consumers when comparing different health plans.

> used, and there may be a reasonable range of appropriate methods and assumptions used to develop these estimates.[95]

Given this, ACA requires the HHS Secretary to promulgate regulations regarding the determination of the levels of plan generosity. The determination will be based on a benefit package consisting of essential health benefits and a standard population. To date, HHS issued a bulletin that described its proposed definition for actuarial value and solicited comments. In the bulletin, HHS proposes to use a standard data set based on a countrywide standard population, with the option for individual states to "develop State standard populations based on State claims data."[96]

Exchange Health Plans

Exchanges will offer several types of health plans, as specified in statute and regulation. Exchange plans will provide a comprehensive set of covered benefits (i.e., the essential health benefits), except for stand-alone dental plans (which will have to meet a narrow set of benefit requirements). While most of these comprehensive plans will be available to any individual or employer who is qualified to enroll in exchanges (such as multi-state QHPs and CO-OP QHPs),[97] some plans will be available only to specific subpopulations (child-only QHPs and catastrophic QHPs).[98] Finally, some plans offered in exchanges may also be offered outside of exchanges.[99]

Qualified Health Plans

In general, exchanges will offer comprehensive coverage that meets the standards to be certified as "qualified health plans" (QHPs),[100] provided it meets requirements related to marketing, choice of providers, plan networks, and other features, or is recognized by each exchange through which such plan is offered.[101] In addition, all QHPs are required to comply with benefit, cost-sharing, and generosity components of the essential health benefits package (described above). In addition to qualified health plans, exchanges will also offer multi-state QHPs, child-only QHPs, and CO-OP QHPs (described below).[102]

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[95] "Critical Issues in Health Reform: Actuarial Equivalence," American Academy of Actuaries, May 2009, p. 4, available online at http://www.actuary.org/pdf/health/equivalence_may09.pdf.

[96] "Actuarial Value and Cost-Sharing Reductions Bulletin," Center for Consumer Information and Insurance Oversight, February 24, 2012, http://cciio.cms.gov/resources/files/Files2/02242012/Av-csr-bulletin.pdf, p. 5.

[97] For more information about these plan types, see the "Multi-State Plans" and the "Consumer Operated and Oriented Plans" sections of this report.

[98] For more information about these plan types, see the "Child-Only Qualified Health Plans" and the "Catastrophic Plan" sections of this report.

[99] Plans that are offered both inside and outside of exchanges must charge the same premium. In addition, ACA allows the types of health plans that are currently offered in the private market to continue to be offered once the exchanges have been established, as long as those other plan types comply with applicable federal and state law.

[100] §1301 of ACA.

[101] §1311(c) of ACA.

[102] In guidance released December 10, 2012, HHS indicated that a state can allow an issuer that contracts with the state's Medicaid agency as a managed care organization (MCO) to offer a QHP in an exchange. The QHP would be available on a limited-enrollment basis to certain populations, and its availability would be intended to ease individuals' transitions between Medicaid or CHIP and private insurance. HHS indicated that further guidance on these "bridge" QHPs is forthcoming. For more information, see http://cciio.cms.gov/resources/files/exchanges-faqs-12-10-(continued...)

An issuer of QHPs must be licensed and in good standing with each state in which it offers coverage; must offer at least one QHP each providing silver and gold levels of coverage; and must comply with regulations applicable to exchanges. An issuer may offer QHPs outside of exchanges as well as inside, but the premiums would have to be the same, even if the QHP is sold through an insurance agent.[103]

Multi-State Plans

Multi-state plans (MSPs) are designed to offer nationally available QHPs, so that individuals and small businesses will all have access to these plans, regardless of where they live. The Director of the Office of Personnel Management (OPM) will enter into contracts with issuers to offer at least two MSPs ultimately through every exchange in all the states.[104] Any individual eligible to purchase insurance through the exchange may enroll in an MSP. Enrollment is voluntary, and individuals may be eligible for premium credits and cost-sharing assistance.

Each contract for an MSP will be for at least one year and can be automatically renewed if neither party provides notice to terminate. At least one contract will be with a nonprofit entity, and at least one contract cannot provide coverage for abortion services.[105] The OPM Director will enter into a contract with an issuer if the issuer offers the plan in at least 60% of states in the first year, at least 70% in the second year, at least 85% in the third year, and in all states thereafter.

An issuer offering a MSP must meet certain requirements and adhere to certain policies. For example, an issuer offering a MSP must meet the requirements in every state's exchange, offer a uniform benefits package in each state consisting of the essential health benefits, and comply with the minimum standards prescribed for carriers offering health benefits plans under the Federal Employees Health Benefits Program (FEHBP).[106] However, unlike other QHPs offered through an exchange, which are regulated by a state, MSPs will be licensed by states, but regulated by OPM. For example, OPM has the authority to certify, recertify, and decertify MSPs for participation in an exchange. If OPM certifies an MSP, the MSP is deemed certified to participate in every state's exchange.[107]

Child-Only Qualified Health Plans

ACA requires an issuer that offers a QHP through an exchange to also offer that plan as a "child-only plan."[108] Child-only plans will provide QHP coverage for individuals who are less than 21 years of age. The final regulation on exchanges stated that a child-only plan must be provided at

(...continued)

2012.pdf.

[103] §1301(a)(1)(C)(iii) of ACA; and 77 *Federal Register* 18415, March 27, 2012.

[104] §1334 of ACA.

[105] §1334(a) of ACA.

[106] OPM administers FEHBP and, among other duties, is authorized to negotiate benefit and premium levels with health plans that participate in FEHBP. For more information about OPM's role in FEHBP, see CRS Report RS21974, *Federal Employees Health Benefits Program (FEHBP): Available Health Insurance Options*, by Annie L. Mach.

[107] 77 *Federal Register* 18310, March 27, 2012. To date, OPM has not yet promulgated regulations related to MSQHPs.

[108] §1302(f) of ACA.

the same level of coverage (bronze, silver, gold, or platinum) as a qualified health plan, as specified in the law.[109]

Consumer Operated and Oriented Plans

ACA establishes the Consumer Operated and Oriented Plan (CO-OP) program, with an intent to "foster the creation of qualified nonprofit health insurance issuers to offer qualified health plans in the individual and small group markets in the states in which the issuers are licensed to offer such plans."[110] ACA gives the HHS Secretary the authority to grant start-up and solvency loans to non-profit organizations applying to become qualified issuers.

Health plans offered by a CO-OP loan recipient may be deemed certified as a CO-OP QHP; if a plan is deemed a CO-OP QHP, then an exchange must recognize the plan as eligible to participate in an exchange. CO-OP QHPs are eligible to participate in an exchange for two years and may be recertified every two years after that for up to 10 years following the life of any loan awarded. To be deemed certified, a CO-OP QHP must comply with the following: standards for certifying QHPs; all state-specific standards established by an exchange for QHPs operating in that state (except where those standards operate to exclude loan recipients due to being new issuers or based on characteristics that are inherent to being a CO-OP); and the standards of the CO-OP program as set forth in the law and the final rule relating to the CO-OP program.[111] CMS, or an entity designated by CMS, has the authority to deem CO-OP QHPs as certified to participate in an exchange.

CO-OP loan recipients must offer a CO-OP QHP at the silver and gold levels in every individual market exchange that serves the geographic regions in which the CO-OP loan recipient is licensed and intends to provide health care coverage. If offering at least one plan in the small group market, CO-OP loan recipients must offer a CO-OP QHP at both the silver and gold levels in each SHOP that serves the geographic regions in which the entity is offering coverage. This indicates that CO-OP QHPs will be offered in at least the individual market in every exchange that shares a geographic region with a CO-OP loan recipient.[112] Individuals who enroll in CO-OP QHPs offered through the individual market are eligible for premium tax credits and cost-sharing subsidies.

The HHS Secretary began awarding CO-OP program loans in January 2012; as of December 21, 2012, 24 non-profits in 24 states had received loans.[113] On January 2, 2013, the American Taxpayer Relief Act of 2012 (P.L. 112-240) was enacted. The Act included a provision that

[109] 77 *Federal Register*, 18469, March 27, 2012.

[110] §1322(a)(2) of ACA.

[111] §1322 of ACA and 76 *Federal Register* 77392, December 13, 2011.

[112] According to the final rule on CO-OPs (76 *Federal Register* 77392, December 13, 2011), only two-thirds of plans offered by CO-OP loan recipients must be CO-OP QHPs offered in the individual and small group markets, indicating that CO-OP loan recipients may offer health plans that will not necessarily be available in the individual and small group markets, whether inside or outside an exchange (i.e., Medicare managed care plans).

[113] Non-profit entities in the following states have received CO-OP program loans: AZ, CO, CT, IA, IL, KY, LA, MA, MD, ME, MI, MT, NE, NJ, NM, NV, NY, OH, OR, SC, TN, UT, VT, WI. For more information, see http://www.healthcare.gov/news/factsheets/2012/02/coops02212012a.html.

rescinded nearly all unobligated funding for the CO-OP program. The only funding that was not rescinded was an amount set aside for governance and oversight of loans already awarded.[114]

Catastrophic Plan

Issuers may offer catastrophic plans in the exchanges,[115] which will have actuarial values less than what is required to meet any of the levels of plan generosity for qualified health plans (described above). These plans are expected to have lower premiums, because they will have less generous coverage and higher cost-sharing. Catastrophic plans must

- be available only to individuals under 30 years of age, or individuals exempt from the individual mandate,[116] because they do not have access to affordable coverage or experienced a hardship;
- include coverage for "essential health benefits";
- include coverage for at least three primary care visits;
- have a deductible equal to existing cost-sharing limits specified in the tax code, relating to certain high deductible health plans[117] (the deductible will not apply to "preventive health services");[118] and
- be offered only through the individual health insurance market.

Stand-Alone Dental Benefits

ACA allows issuers to offer stand-alone dental benefits through the exchanges, as long as such benefits include pediatric oral services (as specified under the essential health benefits provision).[119] The final exchange regulation clarifies that stand-alone dental benefits may be offered in a plan separate from a qualified health plan, or in conjunction with a QHP, as specified in the law. Exchanges may not limit the offer of stand-alone dental benefits to only one of these two options. In other words, issuers have sole discretion regarding (1) whether they will offer stand-alone dental benefits, and (2) the form in which those benefits will be provided (separate from or in conjunction with a QHP).

[114] §644 of the American Taxpayer Relief Act of 2012.

[115] §1302(e) of ACA.

[116] Beginning in 2014, ACA requires individuals to maintain health insurance, with some exceptions. For additional information about this provision, see CRS Report R41331, *Individual Mandate and Related Information Requirements under ACA*, by Janemarie Mulvey and Hinda Chaikind.

[117] The deductible for exchange catastrophic plans mirror the cost-sharing limits applicable to high-deductible health plans (HDHPs) that qualify to be paired with health savings accounts (HSAs). For 2012, the cost-sharing limits for HSA-qualified HDHPs are $6,050 for single coverage, and $12,100 for family coverage. Given that the existing limits are updated annually and the exchanges become operational in 2014, the deductible for exchange catastrophic plans in 2014 will likely be different than the 2012 HDHP/HSA limits.

[118] §1001 of ACA; Section 2713 of the Public Health Service Act.

[119] §1311(d)(2)(B)(ii) of ACA.

Cost Assistance

To make exchange coverage more affordable, certain individuals will receive premium assistance in the form of federal tax credits.[120] (As specified in the law, the Treasury Department will send monthly payments to the insurance company which issues the health plan in which a credit recipient is enrolled, to cover all or part of that person's monthly premium.)[121] Moreover, some recipients of premium credits may also receive subsidies towards cost-sharing expenses.[122] Exchanges have some responsibilities, as outlined below, in regard to determining an individual's eligibility for cost assistance and calculating the amount of cost assistance provided.

Premium Tax Credits

New federal tax credits were authorized in ACA to help low-middle income individuals pay for exchange coverage, beginning in 2014. The premium credit will be an advanceable, refundable tax credit, meaning tax filers need not wait until the end of the tax year in order to benefit from the credit (advance payments will actually go directly to the issuer),[123] and may claim the full credit amount even if they have little or no federal income tax liability.

To be eligible for a premium credit in an exchange, an individual must

- have household income[124] between 100% and 400% of the federal poverty level, with exceptions;[125]
- *not* be eligible "minimum essential coverage"[126] other than:
  - through the individual health insurance market; or
  - employer-sponsored insurance that is "unaffordable" or does not provide minimum value"; [127]

[120] §1401 of ACA.

[121] While a premium credit recipient could choose to wait until the end of the tax year to claim the credit, as part of filing federal income taxes, the most likely scenario is for that individual to choose to receive the tax credit in the form of advanced payments, to coincide with the monthly payment of insurance premiums.

[122] §1402 of ACA.

[123] §1412(a)(3) of ACA.

[124] Household income is measured according to the current tax definition for "modified adjusted gross income" (MAGI). For a comprehensive discussion about MAGI and ACA, see CRS Report R41997, *Definition of Income in ACA for Certain Medicaid Provisions and Premium Credits*, coordinated by Janemarie Mulvey.

[125] An exception is made for lawfully present aliens with income below 100% of the FPL, who are ineligible for Medicaid for the first five years that they are lawfully present. These taxpayers will be treated as though their income is exactly 100% of FPL for purposes of the premium credit.

[126] The definition of minimum essential coverage is broad. It includes Medicare Part A, Medicaid, the State Children's Health Insurance Program (CHIP), Tricare, the TRICARE for Life program, the veteran's health care program, the Peace Corps program, a government plan (local, state, federal) including the Federal Employees Health Benefits Program (FEHBP) and any plan established by an Indian tribal government, any plan offered in the individual, small group or large group market, a grandfathered health plan, and any other health benefits coverage, such as a state health benefits risk pool, as recognized by the HHS Secretary in coordination with the Treasury Secretary.

[127] ACA considers an employer-sponsored plan "unaffordable" if the employee's premium contribution to the employer's self-only plan exceeds 9.5% of household income. An employer-sponsored plan does not provide "minimum value" if it covers less than 60% of total allowed costs (on average).

- be enrolled in an exchange plan; and
- be part of a tax-filing unit.

The amount of the tax credit will vary from person to person: it depends on the household income of the tax filer (and dependents), the premium for the exchange plan in which the tax filer (and dependents) is (are) enrolled, and other factors. In certain instances, the credit amount may cover the entire premium and the tax filer pays nothing towards the premium. In other instances, the tax filer may be required to pay part (or all) of the premium.[128]

Exchanges are responsible for either determining an individual's eligibility for advance payment of premium credits or implementing a determination made by HHS.[129] If an exchange makes the determination, then the exchange is also responsible for calculating the amount of the credit in accordance with Section 36B of the Internal Revenue Code.

Cost-Sharing Subsidies

Certain individuals who are eligible for premium credits in the exchanges will also be eligible for subsidies towards service-related cost-sharing. (According to guidance issued by HHS, the federal government will provide monthly payments to the issuer of the health plan in which the subsidy recipient is enrolled, to reduce the amount of cost-sharing that individual would be responsible for when s/he uses health services.)[130] An individual who qualifies for the premium credit *and* is enrolled in a silver plan[131] through an exchange, will also be eligible for a cost-sharing subsidy. As discussed above, total cost-sharing in exchange plans will be limited according to amounts specified in the federal tax code.[132] Given that most exchange plans will already be required to meet such limits, the cost-sharing subsidies will further reduce the total amount those individuals who qualify for the subsidies will pay for using health services.[133]

Exchanges are required to either determine an individual's eligibility for cost-sharing subsidies or implement a determination made by HHS.[134] To do this, an exchange is expected to collect and verify the information necessary to make the determination and share that information with HHS.

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[128] For a comprehensive discussion of the premium tax credits, including illustrative examples of possible credit amounts, see CRS Report R41137, *Health Insurance Premium Credits in the Patient Protection and Affordable Care Act (ACA)*, by Bernadette Fernandez and Thomas Gabe.

[129] See the "Eligibility for Premium Tax Credits and Cost-Sharing Subsidies" section in this report for more information.

[130] This proposed approach for implementing the cost-sharing subsidies was discussed in a bulletin issued by HHS: "Actuarial Value and Cost-Sharing Reductions Bulletin," February 24, 2012, - http://cciio.cms.gov/resources/files/Files2/02242012/Av-csr-bulletin.pdf.

[131] See previous discussion of precious metal designations for exchange plans under the section "Levels of Plan Generosity" in this report.

[132] The cost-sharing limits that are part of the essential health benefits package mirror the limits applicable to high-deductible health plans (HDHPs) that qualify to be paired with health savings accounts (HSAs). For 2012, the cost-sharing limits for HSA-qualified HDHPs are $6,050 for single coverage, and $12,100 for family coverage. Given that the existing limits are updated annually and ACA cost-sharing requirements become effective in 2014, the cost-sharing limits in 2014 will likely be different than the 2012 levels.

[133] For additional information about the cost-sharing subsidies, including illustrative examples, see CRS Report R41137, *Health Insurance Premium Credits in the Patient Protection and Affordable Care Act (ACA)*, by Bernadette Fernandez and Thomas Gabe.

[134] See the "Eligibility for Premium Tax Credits and Cost-Sharing Subsidies" section in this report for more (continued...)

Interaction with Other ACA Provisions

Individual Mandate

Beginning in 2014, most individuals are required to have health insurance or potentially pay a penalty for noncompliance.[135] Generally, individuals will be required to maintain "minimum essential coverage" for themselves and their dependents.[136] Nearly all plans offered through exchanges qualify as minimum essential coverage. As follows, most individuals who have coverage through an exchange will meet the requirements of the individual mandate. Other coverage, such as employer-sponsored insurance and Medicaid, is also considered minimum essential coverage for the purpose of the individual mandate, so an individual does not have to enroll in an exchange plan to meet the requirements of the mandate.

Certain individuals will be exempt from the individual mandate. For example, some individuals will qualify for an exemption based on the affordability of coverage while others will qualify because of their religious beliefs. In screening applicants for eligibility for QHPs and IAPs, exchanges are required to determine whether an individual is exempt from the mandate and issue certificates of exemption accordingly.[137]

Employer Requirements

While employers are not required to offer health benefits to their employees, certain large employers may be subject to penalties whether or not they offer health insurance. Large employers who do *not* offer health insurance may be subject to penalties if any of their *full-time* workers enroll in exchange plans and receive premium credits. While most employers who *do* offer health benefits will meet the law's requirements, some also may be required to pay a penalty if any of their full-time workers receive a premium credit.[138]

In the latter scenario, one way that workers with an employer offer of health benefits may be eligible for premium credits is if the employer plan does not provide minimum value; that is, has

(...continued)

information.

[135] The constitutionality of the individual mandate has been the centerpiece of numerous legal challenges to ACA. In March of 2012, the United States Supreme Court heard arguments related to the constitutionality question, along with other legal issues. On June 28, 2012, the Court issued its decision in *National Federation of Independent Business v. Sebelius*, finding that the individual mandate in §5000A of the Internal Revenue Code (as added by §1501 of the Patient Protection and Affordable Care Act (ACA)), is a constitutional exercise of Congress's authority to levy taxes. For additional discussion about the Court's decision, the individual mandate, and other ACA issues, see the CRS Legal Sidebar posts under "Health and Medicine," http://www.crs.gov/analysis/legalsidebar/pages/default.aspx?source=legalSidebar.

[136] For a list of the types of coverage that qualify as "minimum essential coverage" and additional information about the individual mandate see CRS Report R41331, *Individual Mandate and Related Information Requirements under ACA*, by Janemarie Mulvey and Hinda Chaikind.

[137] In the final rule on exchange establishment (77 *Federal Register* 18310, March 27, 2012), HHS indicated that in future rulemaking it will address the process exchanges will use to provide certificates of exemption.

[138] For additional information about employer requirements under ACA, see CRS Report R41159, *Summary of Potential Employer Penalties Under the Patient Protection and Affordable Care Act (PPACA)*, by Janemarie Mulvey.

an actuarial value that is less than 60%.[139] So while employers are not required to offer coverage through the exchanges, certain large employers may be subject to a penalty if they offer coverage with an actuarial value lower than a bronze-level plan and one of their full-time workers enrolls in an exchange and receives a premium credit.

Exchanges are responsible for notifying an employer if an employee has been found eligible for advance payment of premium credits or cost-sharing subsidies. The exchange must identify the employee, indicate the employee's eligibility, explain that the employer may be subject to penalty, and notify the employer of the right to appeal the determination.

Reforms to Private Health Insurance Markets

ACA includes a number of private market reforms that impose requirements on health insurance carriers and others. Such reforms relate to the offer, issuance, generosity, and pricing of health plans, among other requirements. For example, ACA requires most health plans to extend dependent coverage to children under age 26, with exception.[140] Given that health insurance carriers will be offering plans through the exchanges, ACA's private market reforms will apply to exchange plans.[141]

As discussed under the "Plan Management Responsibilities" section of this report, one of the responsibilities of exchanges will be to certify that plans meet the criteria for a qualified health plan, and, therefore, may be offered through an exchange. While the certification process will consider plan marketing requirements, provider network adequacy, and other features, as specified in the law, the market reforms are requirements imposed generally on insurance companies. Since states remain the primary regulators of health insurance, even post-ACA enactment, states would enforce ACA insurance requirements.

Medicaid

While Medicaid is generally beyond the scope of this report, ACA's Medicaid and exchange provisions were originally designed to work in tandem with each other to provide a continuous source of subsidized coverage for low- to middle-income individuals and families, beginning in 2014. As previously discussed, exchanges are responsible for facilitating enrollment in Medicaid.

As *originally* enacted, ACA required states to expand Medicaid to certain individuals who are under age 65 with income up to 133%[142] of the federal poverty level (FPL), beginning in 2014. This reform not only expanded eligibility to a group that generally is not eligible for Medicaid (low-income childless adults), but also raised Medicaid's mandatory income eligibility level for certain existing groups to 133% of the FPL. States were required to do this mandatory expansion as a condition of receipt of Medicaid federal financial participation. Given that premium credits

[139] §1401(a) of ACA; adding a new §36B(c)(2)(C) to the Internal Revenue Code.

[140] For additional information about ACA's private market reforms, see CRS Report R42069, *Private Health Insurance Market Reforms in the Patient Protection and Affordable Care Act (ACA)*, by Annie L. Mach and Bernadette Fernandez.

[141] Note that ACA does not prohibit such carriers from offering coverage outside of exchanges – see §1312 (d)(1)(A) of ACA.

[142] In addition, there is a 5% income disregard, so that the effective limit is 138% of the FPL.

would be available through all state exchanges at the same time as this Medicaid expansion, the law envisioned that all individuals with income up to 400% FPL would have access to subsidized coverage, regardless of their state of residency.

On June 28, 2012, the United States Supreme Court issued its decision in *National Federation of Independent Business v. Sebelius*. The Court held that the federal government cannot terminate current Medicaid program federal matching funds if a state refuses to expand its Medicaid program to include non-elderly, non-pregnant adults under 133% of the federal poverty level. If a state accepts the new ACA Medicaid expansion funds, it must abide by the new expansion coverage rules, but, based on the Court's opinion, it appears that a state can refuse to participate in the expansion without losing any of its current federal Medicaid matching funds. All other provisions of ACA, including the entire Health Care and Education Reconciliation Act (HCERA, P.L. 111-152), remain intact. Given that some states may choose not to expand Medicaid, there is a possibility that some individuals will not have access to either Medicaid or the premium tax credits.

Regardless of whether or not a state expands its Medicaid program, the rules for coordination and facilitating enrollment between exchange plans and Medicaid will still apply. For example, an individual exchange may decide to determine eligibility for Medicaid.[143] If a person who has applied for exchange coverage is determined eligible for Medicaid, the individual exchange must enroll the person in Medicaid and share the person's information with the state Medicaid agency.

[143] For more information about Medicaid, see the "Eligibility for Medicaid and CHIP" section of this report.

Appendix A. Selected Exchange Implementation Dates

Table A-1. Selected Upcoming Exchange Implementation Dates

Date	Requirement
December 14, 2012	States seeking to administer a state-based exchange must submit a declaration letter and an exchange blueprint application no later than this date to be considered for exchange approval by January 1, 2013.
December 26, 2012	States must specify a benchmark plan to serve as the reference plan for the essential health benefits (EHB) for coverage years 2014 and 2015.[a] The default benchmark option, the largest plan by enrollment in the largest product in the state's small group market, will apply in cases where a state does not voluntarily select a benchmark plan.
January 1, 2013	Each state-based exchange must be approved to operate by HHS no later than this date in order to be operational on January 1, 2014.
February 15, 2013	States seeking to have a partnership exchange effective in 2014 must submit a declaration letter and an exchange blueprint application no later than this date.
October 1, 2013	Open enrollment must begin for coverage offered through an exchange for the 2014 coverage year.
January 1, 2014	Exchanges must be established and offer coverage in every state.

Source: Table prepared by CRS based on information collected from (1) ACA (P.L. 111-148, as amended); (2) 77 *Federal Register* 18310; and (3) *Blueprint for Approval of Affordable State-based and State Partnership Insurance Exchanges,* at http://cciio.cms.gov/resources/files/hie-blueprint-081312.pdf; (3) Letter from Kathleen Sebelius to State Governors, November 9, 2012, http://www.healthcare.gov/law/resources/letters/exchange-blueprint-letter.pdf and Letter from Kathleen Sebelius to Republican Governors Association, November 15, 2012.

a. This deadline was included in the proposed rule promulgated by HHS on standards related to the EHB (77 *Federal Register* 70644, November 26, 2012).

Appendix B. Risk Mitigation Programs Under ACA

Table B-1. Description of Reinsurance, Risk Corridors, and Risk-Adjustment Provisions of ACA

	Reinsurance	Risk Corridors	Risk- Adjustment
Description	Reinsurance typically is thought of as insurance for insurers. When issuing policies, an insurer faces the risk that the premiums it collects will not be sufficient to cover its expenses and generate profit. Reinsurance shifts the risk of covering high expenses from the primary insurer to a reinsurer. ACA requires all health insurance issuers and third-party administrators of group health plans to contribute to a reinsurance program administered by a nonprofit reinsurance entity.	Risk corridors refer to a mechanism that adjusts payments to health plans according to a formula based on each plan's actual, allowed expenses in relation to a target amount. If a plan's expenses exceed a certain percentage above the target, the plan's payment is increased. Likewise, if a plan's expenses exceed a certain percentage below the target, the plan's payment is decreased. Under ACA, a QHP issuer whose gains are greater than 3% of the issuer's "projections" must remit charges to HHS, while HHS must make payments to a QHP issuer that experiences losses that are greater than 3% of the issuer's "projections."	Risk adjustment refers to a mechanism that adjusts payments to health plans to take into account the risk that each plan is bearing based on its enrollee population. Plans with enrollment of less than average risk will pay an assessment to the state. States will provide payments to plans with higher than average risk.
Objective	Provide funding to plans that enroll highest cost individuals	Limit issuer loss (and gains)	Transfer funds from lowest risk plans to highest risk plans
Goal	Offset high-cost outliers	Protect against inaccurate rate setting	Protect against adverse selection
Who Participates	Non-grandfathered individual market plans (inside and outside of exchange) are eligible for payments	Qualified Health Plans (QHPs) in the individual and small group markets (inside and outside of exchange)	Non-grandfathered individual and small group market plans (inside and outside the exchange, excluding self-insured plans)
Time Frame	Three years (2014-2016)	Three years (2014-2016)	Permanent; begins after end of benefit year 2014

Source: CRS analysis of ACA.

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ConsumersUnion

POLICY & ACTION FROM CONSUMER REPORTS

Consumer Criteria for Value-Based Insurance Designs

HEALTH POLICY
RECOMMENDATIONS
JANUARY 2013

SUMMARY

The California Health Benefit Exchange (Covered California) may allow Qualified Health Plans to vary from the standard benefits package that will be offered all enrollees, through value-based insurance design (VBID) options. VBID incorporates financial incentives into health insurance cost-sharing approaches to encourage healthy outcomes. Consumers Union has developed a set of criteria that Covered California and other Exchanges should use to evaluate whether the proposals are in the best interest of consumers.

The California Health Benefit Exchange (Covered California) staff has proposed standardizing benefits and cost-sharing for Qualified Health Plans (QHPs) participating in Covered California. Coupled with the standard package of essential health benefits, this means that only a limited number of benefit designs would be sold in the individual and Covered California's SHOP exchanges, a position strongly supported by consumer advocates to allow for easier comparisons among plans. At the same time, Covered California staff also recommends permitting some QHP product variations to allow for "value-based insurance design" (VBID).[1] VBID builds into insurance products cost-sharing and other financial incentives to promote certain behaviors deemed beneficial.[2] The staff recommendation, endorsed by the Board, asserts that for the first few years, VBIDs permitted by Covered California would be

[1] In this paper, we have chosen to use the term "Value-Based Insurance Design" (VBID), rather sometimes used "Value-Based Benefit Design" (VBBD), to encompass benefit design for both insurance and health plan products and because it is more commonly found in the literature than VBBD.

[2] This paper deals solely with VBID as Consumers Union and much of the literature define it: benefit designs varying *cost-sharing* by and financial "rewards" to consumers, sometimes joined with consumer engagement activities, with a goal of improving health outcomes. Other steps to improve patient health or overall quality aimed at providers, such as pay-for-performance initiatives, and other steps to achieve cost savings and quality improvement through health care delivery reform, such as accountable care organizations, are not the subject of this paper.

"largely positive in nature ('carrots') to incent compliance with beneficial treatment plans." Other than the "carrot" concept, no specific criteria or metrics have been suggested by which to evaluate whether to approve VBID proposals.

While there are sound reasons to pilot a limited number of proven VBIDs that reduce or remove financial barriers for procedures or medications that are aimed at improving the quality of care and promoting better health outcomes, care must be taken to:

- Ensure that these programs are based on rigorous evidence of improved outcomes;
- Avoid risk selection, both among QHPs in Covered California (if some but not all QHPs offer them) and against Covered California, if such designs are not uniformly offered in the market outside Covered California, thereby attracting a less healthy risk mix to Covered California;
- Ensure that these programs provide equal access to enrollees and do not have a discriminatory impact; and
- Balance the likely benefit of VBID measures against undermining the standardization and level playing field approaches otherwise intended by Covered California.

Below, we recommend criteria for evaluating VBID proposals and preconditions to be met before Covered California permits them. In the event that approaches are considered in the future that put financial barriers in place for procedures or medications found to be ineffective ("sticks"), rather than just the removal of financial barriers for promoting certain "good behaviors" ("carrots") that Covered California staff has suggested to date, we recommend that the state proceed with particular caution to evaluate whether those proposals are in the best interest of California consumers.

What is value-based insurance design (VBID)?

Value-based insurance design incorporates financial incentives into health insurance cost-sharing approaches to encourage healthy outcomes.[3] In particular, the idea is to use differences in cost-sharing to steer enrollee behavior toward services that have proven to be more efficacious, toward healthy lifestyles (such as smoking cessation), and/or toward "high value" services[4] (generally those that meet some quality and efficiency performance threshold, usually aimed at systemic cost savings).

Incentives are not new in the insurance world. Insurers have historically used differential cost-sharing to incentivize patient behavior in an effort to lower costs overall. What VBID does is to strive for better patient outcomes by linking out-of-pocket incentives, rewards, and sometimes consumer engagement requirements to higher quality services. The patient cost-sharing incentive targets a specific clinical benefit of the service (e.g., diagnosis, medication, treatment, or program) based on available scientific evidence.[5] As used in this paper, under Consumers Union's definition of VBID, positive health outcomes must be a primary goal of any VBID proposal.[6]

As illustrated by the examples below, much of today's experience with VBID comes from large employers. In particular, many large employers have focused VBID efforts on cost-sharing reductions for prescription drugs, often targeted at those designed to treat chronic diseases. More recently, proponents of VBID have contemplated hybrid approaches, with cost-sharing incentives for "high value" services and disincentives for "low value" services.

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[3] Value-based insurance design directed at guiding consumer choices differs from "value-based purchasing," an approach that incentivizes plans or providers to improve outcomes and cut costs, such as paying plans or providers based on performance measures. VBID and value-based purchasing can be used in conjunction with each other.

[4] While there is no standard definition of "high value services," they are commonly viewed as affording better health outcomes per dollar spent. This may include the use of certain preventive services, certain prescription drugs, or providers with better outcomes who adhere to evidence-based treatment guidelines. See, e.g., *Value-based Benefit Design: A Purchaser's Guide*, National Business Coalition on Health (January 2009), p. 2.

[5] Fendrick, M., et al., A Benefit-based Copay for Prescription Drugs: Patient Contribution Based on Total Benefits, No Drug Acquisition, *The American Journal of Managed Care*, Volume 7. No. 9, pages 861-867 (September 2001).

[6] Again, other measures aimed at improving health outcomes that do not rely on financial incentives directed at consumers, of course, are worthy of consideration, but simply not applicable under the VBID label.

Carrots v. Sticks

In some instances, the VBID approach incentivizes patient behavior by lowering cost-sharing if patients engage in healthy behavior (the "carrot"). A far reaching example is the ACA ban on cost-sharing for preventive services (e.g., well-child visits, routine immunizations). Other examples come from large purchaser experience, such as removing co-payments for certain prescription medications. For example, a large employer eliminated or lowered cost-sharing for five classes of medications for all enrollees prescribed the medications, regardless of what condition they were being treated for, with zero cost-sharing for generic and a 50% decrease for brand name drugs. A three-year evaluation showed improved medication adherence for those patients using the reduced cost-sharing medications.[7]

In other instances, enrollees were provided incentives, coupled with the requirement to participate in a disease management program. In one study, a large retail employer reduced cost-sharing of certain classes of medications for those with diagnoses of diabetes, asthma, coronary artery disease, or heart failure, conditioned on enrollees participating in a disease management program. Those enrollees who did not participate in the disease management program (either out of choice or life circumstance restrictions) were not eligible for the reduced cost-sharing and their costs for medications remained the same as for all other medications covered by the company. The results indicated that the combination program of disease management and reduced cost-sharing had the potential to improve medication adherence.[8]

Recent VBID approaches use both financial sticks and carrots: plans increase co-payments for services determined to be of "low value" (the "stick") and decrease cost-sharing for "high value" services (the "carrot"). For example, Oregon's Public Employee's Benefit Board created a three-tiered benefit system that included a high value tier with little or no cost-sharing for patients, a standard tier, and then a third low value tier that had a separate deductible, higher out-of-pocket maximums, and higher co-insurance for services the insurer deemed "low value" services.

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[7] Chernew, M., et al., Impact of Decreasing Copayments on Medication Adherence Within a Disease Management Environment, *Health Affairs*, Volume 27, No. 1, pages 103-112 (2008); See also, Gibson, T, et al., A Value-based Insurance Design Program at a Large Company Boosted Medication Adherence for Employees with Chronic Illnesses, *Health Affairs*, Volume 30, No. 1, pages 109-117 (2011); Choudhry, N., et al., At Pitney Bowes, Value-based Insurance Design Cut Copayments and Increased Drug Adherence, *Health Affairs*, Volume 29, No. 11, pages 1995-2001 (2010).

[8] Yoona, A. K, et al., Evaluation of Value-based Insurance Design with a Large Retail Employer, *The American Journal of Managed Care*, Volume 17, No. 10, pages 682-690 (October 2011).

Most evidence to date examines the carrot approach. There is scant evidence for VBID programs that raise cost-sharing in order to reduce the use of lower value services. Researchers have struggled to effectively determine which services should be deemed "low value" in order to institute disincentive cost-sharing.[9] While some argue that cost-sharing formulas should discourage all services that "result in harm," others argue for a broader approach that discourages care that is "too expensive" for the health outcomes associated with the services, without necessarily defining what "too expensive" means.[10] A number of professional societies have recently identified multiple overused, often ineffectual tests and treatments that can cause more harm than benefit.[11] However, they have been careful to urge that their work not be used for benefit design at this point, since most of the items or services identified are appropriate in some circumstances, even if ineffective in many.

[9] Choudhry, N., Rosenthal, M., Milstein, A., Assessing the Evidence for Value-based Insurance Design, *Health Affairs*, Volume 29, No. 11, pages 1988-1994 (2010).
[10] Fendrick, M., Smith, D., & Chernew, M., Applying Value-based Insurance Design to Low-Value Health Services, *Health Affairs*, Volume 29, No. 11, pages 2017-2021 (2010).
[11] "Choosing Wisely" at http://consumerhealthchoices.org/campaigns/choosing-wisely/ Consumer Reports is a partner in the Choosing Wisely Campaign, translating the recommendations into plain language for consumers and promoting them with the public.

Six Proposed Criteria for Evaluating Value-Based Insurance Design Variations in Covered California

Requests for benefit design variations that are based on Value-based Insurance Design (VBID) considerations should be rigorously evaluated by Covered California to ensure that the variations are justified based on sound evidence. To keep the number of variations to a manageable level, Covered California should select the more thoroughly proven interventions over those less studied. Reintroducing variation in cost-sharing itself has a cost – it makes the health plans harder for consumers to compare[12] – and only the most valuable and evidence-based cost-sharing variations should be offered.

The burden of proof should be on the Qualified Health Plan (QHP) requesting the variation.[13] The requesting insurer must:

I. PROVIDE EVIDENCE OF HEALTH IMPROVEMENT UNDER THE VBID

- Demonstrate to Covered California that the **primary goal is to improve the health and well being of a specified sub-population** of enrollees, through the proposed financial incentives. If the insurer cannot demonstrate improved health and well being, the option should not be permitted under VBID. [14] This should be demonstrated using a two-part test:
    - The QHP proposal must demonstrate that there are **proven health benefits** to the VBID proposal **via a publicly available, independent assessment** of the strength of the evidence, with any

[12] L.Quincy. *What's Behind the Door: Consumers' Difficulties. Selecting Health Plans*, Consumers Union (January 2012).
[13] Other authors, as well, urge certain "preconditions" to broad adoption of these new approaches to payment and benefit design. See Lansky, D., Nwachukwu, B., Bozic, K., Using Financial Incentives to Improve Value in Orthopaedics, *Clinical Orthopaedics and Related Research*, Volume 470, No. 4, pages 1032-33 (April 2012).
[14] We recognize and support efforts throughout the health care delivery system to undertake responsible cost-saving measures. This paper is specifically on VBID, which proposes to link quality improvement to cost savings. Efforts that simply look at cost savings, while perhaps meritorious, would not meet the definition of VBID.

contrary studies identified. The relevance of the evidence must be assessed: if it comes from a large employer, can these better outcomes be realized by the Covered California population, given its specific demographic characteristics, rate of churn, etc.?[15] and

- The QHP proposal must show that the **cost-sharing variation has proven successful in directing patients to more healthy behaviors and/or improved clinical outcomes**. It should ensure that cost-sharing does not result in consumer confusion when comparing plans, benefits and the actual variations.

II. DEMONSTRATE CONSUMER AND PROVIDER UNDERSTANDING

- Demonstrate that **benefit variations are readily understood by consumers** at the point of plan shopping and that they can correctly gauge the relative generosity of their plan options. That is, can consumers accurately assess the effect of the VBID on cost-sharing limitations, deductibles and co-insurance within each of the metal tiers? This can be demonstrated from prior plan design evaluations or independent, carefully designed consumer testing of the cost-sharing variations demonstrating that consumers understand the VBID. Does the evidence appear to be applicable to the Covered California population, given its language characteristics, health insurance literacy levels, etc.? Covered California should carefully consider whether patient confusion over plan benefits would outweigh the potential for improved health. When there is no evidence of consumer understanding, Covered California should deny the benefit design.
- Require that plans provide a **multi-faceted communication plan** that clearly describes the terms and emphasizes the benefits of the program to enrollees in multiple languages, and to providers.[16] Providers should have a

[15] While generally supportive of the potential of VBID, a guide by the National Business Coalition on Health (NBCH) notes that the "currently available research evidence documenting a positive [short- or long-term] ROI [return on investment] from VBBD initiatives is limited, preliminary and mixed" (citing Hunt S, Maerki S, and Rosenberg W., Assessing Quality-Based Benefit Design, Prepared for the California HealthCare Foundation and Pacific Business Group on Health, April 2006.) Houy, M., *Value-based Benefit Design: A Purchaser's Guide*, National Business Coalition on Health (January 2009), p. 4. The NBCH Guide notes that VBID may not be worthwhile in places with high employee turnover – especially given that high-value services take several years to realize savings. And NBCH states that most experience with VBID is in companies with 10,000 or more employees. With fewer than 5,000 employees, the administrative costs may be too high to realize savings. Id. p. 7.

[16] The communication plan should explicitly include a clinical outreach strategy, a disease education initiative (including health promotion and a wide range of options to meet the needs of all enrollees), educational materials to help educate enrollees prior to initiation of the plan and information regarding the costs and benefits available at the point of decision making. The proposal should show that the plan

key role in implementing VBID and the health plan should produce a detailed communications approach that targets all providers in the plan's network.

- Avoid the term "value-based" in marketing and descriptions of the plan, in order to ensure that it does not confuse or unduly sway consumers; rather, ensure clear, specific descriptions of what the insurance design provides.

III. CONVENE AN ADVISORY COMMITTEE

Convene an advisory committee or stakeholder workgroup that includes consumers and independent practitioners to review the above evidence and advise Covered California on the VBID's likely value and feasibility.

IV. PROVIDE EQUAL ACCESS

- Ensure that the **incentives are applied evenly**, without discrimination, and identify the recourse available to the Exchange and individual enrollees if the proposal results in disparities during implementation. Additionally, the plan should provide assurances that its related data collection complies with the Affordable Care Act (ACA), Americans with Disabilities Act (ADA), HIPAA, the Civil Rights Act, and any other applicable laws.
- When the cost-sharing variation is tied to the use of certain providers, identify whether there is **adequate and meaningful access** to those certain high quality providers (e.g., if designed for heart disease management, is the provider network large enough to support enrollee participation – including a network sufficient to accept new patients, etc.). Further, network adequacy must be demonstrated for all geographies where the VBID is being proposed and include an adequate number of providers who speak in the languages of the targeted patient population, based on state standards such as the list of Medi-Cal Managed Care threshold languages.

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will provide a variety of consumer tools, in multiple languages to ensure understanding by limited English proficient populations, to assist potential consumers in benefiting from the design proposal – medical records access, optional personal health assessments, tools to track compliance, medication support, shared decision making support tools, quality and cost score sheets, community wellness resource lists, links to disease management services, and concise and accessible benefits explanations.

V. IDENTIFY POTENTIAL UNINTENDED CONSEQUENCES

Explicitly **identify any potential "side effects" of the proposed cost-sharing variation**, including its effect on rates overall. This pre-assessment should:

- Explain whether the reduced cost-sharing is expected to "pay for itself" by lowering costs elsewhere (and over what time frame), or if the cost of greater coverage will need to be made up by higher patient cost-sharing elsewhere.[17]
- Describe whether any **costs saved from the variations are reflected in reduced premiums** to the consumer.
- Describe the support the insurer will provide to **help enrollees overcome non-financial barriers to improved adherence**. It should identify how it will provide enhanced access to services for consumers and provide copies of written communications it will give enrollees and providers. For example, such support could include alternatives to face-to-face visits, office hours after work time, e-mail and web access to providers, and options for 24/7 practice.
- Even if the VBID variation has been demonstrated to work well on average, the insurer must **identify any specific sub-populations that might be worse off as a result of the VBID change** or unable to take advantage of lower cost-sharing for some reason.
- Identify a **multi-disciplinary team responsible for assessing the initiative**, including clinicians and social workers or case workers. Tools should be incorporated into the evaluation to ensure "real-time" tracking and assessment of the impact of the effort.

VI. DOCUMENT THE IMPACT AFTER THE VBID INTERVENTION AND TAKE APPROPRIATE CORRECTIVE ACTION, IF NEEDED

Covered California, working with the relevant state regulators and the Department of Health Care Services, should **conduct an ongoing, independent assessment of the impact on enrollees** regarding access to care, utilization rates, experience

[17] Though rewards and cost reduction incentives may seem indisputably positive, a financial incentive to some enrollees will mean a "penalty" for all others whose medical condition or circumstances hinder them from using the service or medication on which the reward or incentive is based. For example, reduced cost-sharing for one medication may be made up by higher cost-sharing for the less preferred medication, resulting in surcharges to those patients who need the alternate medication (e.g. one that is less efficacious for most patients). The evidence suggests that few interventions are a net savings, vaccines being an exception. Lieu, T, et al., Overcoming Economic Barriers to the Optimal Use of Vaccines, *Health Affairs*, Vol. 24, No.3, pages 666– 679 (2005), citing Miller, MA and Hinman, AR, Cost-Benefit and Cost-Effectiveness Analysis of Vaccine Policy, in *Vaccines*, 3d ed., ed. S.A. Plotkin and W.A. Orenstein, pages 1074-1088 (Philadelphia: W.B. Saunders, 1999).

accessing services, financial impact, and impact on the marketplace. This assessment must:

- Identify explicit metrics to **measure health outcomes** and assess whether they are a loose or close proxy for the desired behaviors (compliance, morbidity, cessation of a behavior or activity, rates of incidence – increase or decrease, patient satisfaction, etc.).
- Review and **report on patient impact**, such as access to care, financial implications, and satisfaction. These should be measured overall for the affected patient population, and also for vulnerable sub-populations. An independent expert should report to plan members on increased or decreased costs associated with the benefit design. If costs are decreased or increased, the expert should indicate what financial elements have been affected and who has received any savings or paid more.
- Provide **baseline benchmark data**, including a comparison group so results can be tracked contemporaneously.
- Require Covered California to **report all findings publicly**, including on its website.
- If, over time, robust evidence shows the VBID plan is beneficial, Covered California should **consider requiring *all* plans to address these benefits in subsequent offerings**.
- Closely and frequently **monitor the VBID for selection effects**, working with partner state agencies—the Department of Health Care Services, Department of Managed Health Care, and Department of Insurance— and track closely for adverse selection within sub-populations, among QHPs, and between Covered California and the outside market. In addition, determine whether any such adverse risk selection effects can be and are being addressed by the market's risk adjustment mechanisms.[18] If not, Covered California and the appropriate regulator should remediate the risk selection effects immediately, or through the QHP recertification process.

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[18] Weiner, J.P., et al., Adjusting for Risk Selection in State Health Insurance Exchanges will be Critically Important and Feasible, But Not Easy, *Health Affairs*, Volume 31, No. 2. pp 306–315 (2012).

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Policy INSIGHTS

February 6, 2013

Why Premiums Will Change for People Who Now Have Nongroup Insurance

http://policyinsights.kff.org/2013/february/why-premiums-will-change-for-people-who-now-have-nongroup-insurance.aspx

The federal government recently released **draft regulations that address the benefits, market rules, and rating practices for nongroup coverage**. Before reform, the nongroup market was widely acknowledged to be broken, with restricted access, limited benefits, high administrative costs, and frequent and large premium increases subject to inadequate oversight. Recent requests for large premium hikes for nongroup coverage in some states, at a time when the group market is experiencing very low increases, have revived **concerns** about current pricing practices and the effectiveness of regulatory oversight. The ACA seeks to address many of these issues, essentially remaking the nongroup market starting in 2014 by instituting new rules and a platform for increased transparency and price competition. Newly available premium and cost-sharing subsidies will vastly expand the number of people who will get coverage there. With so many changes and new participants, there understandably is a great deal of speculation about what the products will look like and how premiums in 2014 will compare to premiums in the nongroup market.

Overall, we expect that average, unsubsidized premiums for nongroup coverage will be somewhat higher under reform than they are today (as does the **Congressional Budget Office**). This is because many people will be getting better insurance. The law requires that all nongroup insurance provide a package of essential benefits, which includes items like maternity care and mental health that often are not covered in nongroup policies now. And, while **patient cost sharing will still be quite high**, everyone's out-of-pocket costs will be capped, which is not always the case today.

In addition, guaranteed access to coverage for people with pre-existing conditions may very well increase average premiums as well, as people with higher health costs come into the insurance system. Hopefully this will be balanced by attracting reasonably healthy young, uninsured enrollees also, using the carrot of premium subsidies in exchanges and the stick of the individual mandate.

Eliminating medical screening and other current industry practices, without other policy changes, would markedly increase premiums: this can be seen from the high premiums and low enrollment in the handful of states where insurers must accept all applicants today. The ACA, however, provides significant financial assistance that will help many of the current uninsured afford coverage. Cost is the primary reason people do not have health insurance, and new premiums subsidies (combined with cost-sharing assistance so that lower income families can use the coverage) will significantly reduce financial barriers to coverage in 2014. New premium subsidies will attract large numbers of new applicants to the nongroup market, many in good health. The individual responsibility provision will add an additional incentive for healthy people to purchase coverage, and restricting access to annual and special enrollment periods will reduce the likelihood that people will wait until they

develop health problems before seeking coverage. In addition, to address transitions issues (i.e., the concern that the less healthy will be the first to enroll), the ACA provides for $20 billion (a meaningful amount given the size of the market) in transitional reinsurance to offset adverse selection in the first three years of the program. The ACA also redistributes the premium burden among different enrollees by eliminating premium differences for gender and limiting variation premiums due to age to a maximum of three to one. Compared with existing practice, the new rules will lower premiums for older people and many women, while raising premiums for young people (particularly young men). This has led to concerns that these young people will suffer “rate shock,” though as we discuss below, the potential for premium increases among young people is mitigated by the fact that many of them will be eligible for premium subsidies. People under age 30 also are able to enroll in a special catastrophic plan that will provide coverage roughly similar to bronze plans and with rates that may be much less affected by the age limitation.

Each of the insurance market changes in the ACA that may raise or lower premiums overall or redistribute them among different groups of people is explained below.

Access to coverage

The ACA addresses access to coverage in two fundamental and related ways. First, insurers must accept all applicants, including those with pre-existing conditions, during open enrollment periods and charge sick people and healthy people the same premium. Second, the ACA provides significant premium and cost-sharing subsidies to assist low- and moderate-income people with the cost of coverage.

These provisions will change the population covered by nongroup insurance when they take effect in 2014. Health plans now offering nongroup coverage can exclude people with health problems, and the high turnover that market now experiences means that a significant portion of nongroup enrollment is made up of people who have recently passed health screening. Many nongroup policies also limit benefits for the first year or so for any pre-existing health issues that enrollees may have. Other industry practices, such as durational rating and opening and closing policies to new enrollees, can also be used to keep premiums for new enrollees low, but can mean significant increases for policyholders who keep their coverage for longer periods, particularly if they develop health problems. All of these techniques work together to produce low premiums for those who can pass underwriting and an overall risk pool of nongroup enrollees today that is healthier than the population who will be eligible in 2014.

Eliminating medical screening and other current industry practices, without other policy changes, would markedly increase premiums: this can be seen from the high premiums and low enrollment in the handful of states where insurers must accept all applicants today. The ACA, however, provides significant financial assistance that will help many of the current uninsured afford coverage. Cost is the primary reason people do not have health insurance, and new premiums subsidies (combined with cost-sharing assistance so that lower income families can use the coverage) will significantly reduce financial barriers to coverage in 2014. New premium subsidies will attract large numbers of new applicants to the nongroup market, many in good health. The individual responsibility provision will add an additional incentive for healthy people to purchase coverage, and restricting access to annual and special enrollment periods will reduce the likelihood that people will wait until they develop health problems before seeking coverage. In addition, to address transitions issues (i.e., the concern that the less healthy will be the first to enroll), the ACA provides for $20 billion (a meaningful

amount given the size of the market) in transitional reinsurance to offset adverse selection in the first three years of the program.

The ACA design is intended to open access to the now restrictive nongroup market, and, with a combination of market rules, tax credits and tax penalties, to produce stable risk sharing with risk pools that have a reasonable mix of people in good and poor health. It will probably not produce the "healthier-than-average" nongroup risk pools that seem to exist now in some states, which means that premiums for nongroup coverage under reform will need to be higher to reflect the cost of covering a more average mix of healthly and less healthy people.

Essential health benefits

A second set of factors affecting premium change is the benefit design and associated cost sharing. The ACA defines essential health benefits that must be offered in the nongroup market beginning in 2014. While there will be some variation from state to state, the benefits generally will be based on benefits provided now in the small group market, with a couple of small additions (e.g., habilitation and pediatric dental). This, combined with ACA requirements to cover preventive services and for mental health parity, will result in nongroup benefits under reform that will be more protective than those in many nongroup policies today. Nongroup policies offered in the market now often have no coverage for routine maternity care and impose limitations on mental health and prescription drug benefits that will not be permitted when reform rules take effect in 2014. The more complete benefits will increase premiums when compared to current nongroup policies because there is more coverage.

The ACA also specifies five levels of cost sharing for nongroup policies, defined in most cases by an actuarial value, which is the average percentage of costs for covered benefits that the health plan will pay for. The ACA allows for a wide range of actuarial values, from 60% (bronze) to 90% (platinum), plus a somewhat lower level of coverage (catastrophic) which will be available to people under age 30 and others who find other coverage offerings unaffordable. Policies after reform still will be able to have significant cost sharing: the actuarial value calculator recently proposed by HHS shows that a single policy with a $5,900 deductible, 10% patient cost-sharing and a $6,350 out-of-pocket limit will meet the requirements of the bronze actuarial value level, and a family policy could have a deductible and an out-of-pocket limit twice as high. While a policy with this much cost sharing would hardly qualify as generous (e.g., most employer-based plans have deductibles that are **thousands of dollars lower than this**, there certainly are nongroup policies currently available that require enrollees to pay even higher shares of their expenses. Setting a minimum actuarial value (in most cases) of 60% will, by itself, increase premiums for current nongroup enrollees with very high cost sharing.

The benefit and cost-sharing changes for nongroup coverage under the ACA move that market from one largely defined by coverage limitations to one with a more complete level of benefits and catastrophic protection, similar to the level of protection that people with group coverage enjoy. Nongroup cost sharing will still be higher on average, but with real limits on catastrophic expenses. This additional protection will increase premiums for current enrollees with more limited benefits and very high cost sharing, but will also lower their out-of-pocket expenses when they need care.

Premium rating rules

Another set of factors that affects premium change under reform is how risk will be pooled. The ACA changes the way that health plans use an individual's demographic and health characteristics when setting premiums, and also requires plans to pool the risk of all enrollees with nongroup coverage in a market when setting rates. Unlike the access and benefit provisions discussed above, which change the average cost of coverage in a market, changes in how rates are set primarily affect how costs are distributed across different enrollees within a market, which means that some people will pay less and others more. Age rating in particular has received a good deal of attention recently, but these other factors matter as well.

Demographic factors

Health plans under reform will be able to vary the premium for a nongroup policy only to reflect a policyholder's family size, age (with a 3 to 1 limitation), location, and tobacco use. Premiums in the current market vary much more widely based on demographics, so these limitations, by themselves, will result in some people paying more and some paying less. Two of the more important relate to age and gender. It is now common for health plans to use age as a rating factor because older people, on average, have many more claims than younger people. Premium differences for the same coverage between a 21-year-old male and a 64-year-old male can easily be 500 percent. The premium difference in current policies between women of those ages is less, because younger woman are generally charged higher premiums than men their same age (even when routine maternity is excluded) and older woman are often charged lower premiums than men their same age. The gender and age-rating limitations in the ACA, by themselves, will have the effect of raising premiums for younger people and lowering them for older people. Younger men in markets where health plans vary rates by age and gender will be most affected, because premiums will adjust both to reflect the limit on age rating and the elimination of gender rating. The premium impact of the gender and age limitations (assuming the same benefit and cost-sharing) may be quite large (an increase of maybe 65% to 75%, or perhaps more, for younger men), before taking into account any premium subsidies discussed below.

Health status rating and single risk pool

Beginning in 2014, health plans will no longer be able to surcharge new enrollees with health problems, and will be required to pool the experience of all nongroup enrollees in a market when setting rates. Current practices can cause less healthy people to pay more for the same coverage, even if their health issues developed after enrollment. In many states nongroup health plans can charge new entrants higher premiums. Insurers also are able to set premiums for a policy (i.e., distinct group of benefits) or group of policies based on who enrolls or is projected to enroll, which means that policies with similar benefits can have very different premiums depending on how they were sold, when they were sold and whether they are still being actively marketed. These practices can lead to less healthy people being disproportionately concentrated in certain policies, and the high premium increases they face can cause people to **give up coverage**. Ending these practices will tend to lower premiums for some current nongroup enrollees with health problems and will increase them for enrollees who are healthy.

Marketplace changes

The ACA changed not only the coverage that will be offered in the nongroup market but also the environment in which it will be offered. Several provisions should reduce costs associated with

selling coverage, but some new fees will work in the opposite direction. Two ACA provisions already in effect, enhanced review of nongroup premiums and higher minimum loss ratios (enforced through required rebates) have put pressure on health plans to reduce their administrative costs and lower their **rate requests**. Beginning in 2014, new health insurance exchanges will make nongroup coverage offerings more transparent, and provisions establishing a common essential health benefits package and standard cost sharing tiers will make coverage much easier to understand. These changes will allow consumers to more easily compare premiums and benefits and will focus competition more squarely on price and value. The variety of benefit constructs, coverage limits and cost sharing differences in the market today make meaningful comparisons quite difficult.

Price competition in exchanges will be enhanced by the premium tax credit structure, which ties the amount of the tax credits to the premium for the second lowest-cost silver plan in each market. Health plans with premiums above this level will be much less attractive to the millions of new and existing purchasers expected to receive premium tax credits, putting strong pressure on insurers to create more efficient networks and lower costs in order to be more price competitive. Health plans report pursuing strategies to reduce their costs through tighter, lower-cost networks to be offered though exchange plans [1] [2]. These efforts should complement the broader payment and delivery system reforms (spurred on by the Medicare provisions under the ACA) that health plans are pursuing in their other commercial and government lines of business.

There also are several ACA provisions that increase the cost of selling coverage. These include a new tax on health insurers, a small fee ($2 per member per month) to help fund the Patient-Centered Outcome Research Trust Fund, fees on medical devices that may be passed on to patients and purchasers, and fees (3.5% of premium) to fund the insurance exchanges.

The net impact of these changes is unknown, but there is a strong argument that they should result in lower premiums. The incentives for more efficient delivery and lower administrative costs, reinforced by the minimum loss ratio and rate review provisions, should set the stage for a more robust effort by the industry to limit costs and cost increases in this market. The large number of new enrollees also will provide greater incentive for the health plans to invest in cost control programs for the nongroup market.

The issue of rate shock for younger people who now have nongroup coverage

Recent discussion about premium rates under health reform have focused in on the potential rate shock for younger enrollees who will pay higher premiums under reform, with suggestions that phasing in the 3:1 age limitation could moderate the impact. As discussed above, there are a number of factors that will affect the premiums that nongroup enrollees will see under reform. Some will affect all buyers: the coverage is better; the limits on cost-sharing, while hardly generous, are more protective than some of the policies currently available, and the risk pool will more likely reflect the general population rather than a select, healthy one. Other changes, such as the elimination of gender rating and the limits on age variation, largely redistribute the premium burden, advantaging some populations and disadvantaging others (particularly younger men). The suggested phase-in of the 3:1 age rating limit is intended to address one part of the rate shock concern, at least temporarily, but it would not affect changes in premiums due to better benefits and cost-sharing protections and a more inclusive marketplace.

So does a phase-in make sense to at least partially mitigate the premium impact on younger

enrollees? There are a few additional factors that might be considered in answering that question.

The first is that most current nongroup enrollees will be eligible for premium tax credits, which will limit the share of the premium that they will be required to pay to a percentage of family income. We used income and coverage data from the Survey of Income and Program Participation to **estimate** the differences in the amounts that current nongroup enrollees would pay for the same silver plan under a 3:1 limit and the unlimited age rating that exists in the market today. We estimate that 80% of current nongroup enrollees would pay less under the 3:1 limit for equivalent coverage, once premium subsidies are taken into account. While many younger enrollees would see higher premiums under the 3:1 age limit, they would not pay more because they would receive a tax credit that caps their premium obligation as a percentage of their income. It is important to note that this is not an estimate of the percentage of current nongroup enrollees who might pay more for coverage under reform, taking all factors into account; we only looked at the impact of the different age-rate limits because that is a policy that has been advanced by some in the industry and others. This analysis does not consider premium increases because the coverage is better or because the risk pool is more representative of the general population.

A second consideration is that catastrophic plans available under reform may accomplish much of what the advocates of phasing in the 3:1 age limit are trying to accomplish: a low-cost plan with rates that reflect the medical spending of younger enrollees. The ACA permits health plans to offer a catastrophic health plan to people under age 30 and to people who otherwise would be required to pay more than 8% of their income for a health plan. While the catastrophic plans are part of the single risk pool that health plans must have for each market, the proposed regulations from CMS allow plans to adjust premiums for the catastrophic plans to reflect the demographics of its enrollees. Enrollment in catastrophic plans is likely to be younger, on average, than enrollment in the other tiers, because under the proposed rules people under age 30 can easily enroll in a catastrophic plan but people who are older must first get a certification from an exchange that premiums for other available coverage would exceed 8% of their income. The certification requirement will likely slow any enrollment of older people into catastrophic plans, leaving a younger risk pool. Catastrophic plans also will be treated separately under risk adjustment, which means that catastrophic premiums will not go up if enrollees in catastrophic plans are healthier on average than enrollee in other tiers.

This all means that the catastrophic plans, if implemented as proposed, may have premiums that are more reflective of a younger and healthier population than plans in other tiers. Since the actuarial value of the catastrophic plans is very close to that of bronze plans (57% v. 60%), the premiums for younger people in catastrophic plans may be quite close to what you would get if you permitted unlimited premium variation for age in bronze plans. We estimate that the premium for a younger person in their twenties may be as much as 29% less in a catastrophic plan than in a bronze plan, assuming that catastrophic enrollment is primarily under age 30. This would cushion the potential rate shock for existing, young nongroup enrollees with low cost coverage, particularly those who would not receive a premium tax credit or who would rather pay a very low price for less coverage.

A third consideration is the high turnover in the current market. A fairly high percentage of people who buy nongroup policies have their coverage for a year or less, which means that many of the people who the age rating phase-in is designed to help may not be planning to keep their current health plans anyway. A **project** that the Foundation did with the online broker eHealthInsurance found that, among nongroup purchasers aged 18 to 24, 38% of males and 44% of females had given up their policies by the end of their first year of coverage and 60% have given up their policies by the

end of the second year. This study is a little old and involved on-line purchasers, so it may not be representative of all younger purchasers. But given these high lapse rates, policy makers may want to get additional information about the purchase and retention of patterns of younger purchasers to help them understand how many current nongroup policyholders would actually benefit from a phase-in of the age rating limit. The availability of premium tax credits and the catastrophic plan already limit the number of current nongroup policyholders who would actually benefit from a phase-in; the high lapse rates only further reduce that number.

In the big picture, the ACA addresses many of the shortcomings of the current nongroup market by providing access to a complete set of health benefits with protections against catastrophic out-of-pocket costs. The higher level of benefits, the better protection against catastrophic costs and wider access to coverage each tend to increase the average level of premiums, although out-of-pocket costs for enrollees will go down due to the better protection they receive. The more competitive marketplace created under the ACA, greatly enhanced by the structure of the premium tax credits, will push in the other direction, forcing health plans to become more efficient and better managers of the premiums they receive. There already is some evidence that plans are working to create less costly, more efficient networks to offer with plans sold in exchanges.

Limiting premium variation for age to 3:1 will increase premiums for younger people when compared to current rating practices, but several policies in the ACA limit the impact. The premium tax credits will protect many current nongroup enrollees from paying more due to their age, and the manner in which the federal government has proposed to implement the catastrophic health plan may blunt the impact of the age constraint, providing younger people with access to a low-cost policy that is more reflective of their age and relative health.

--Gary Claxton, Larry Levitt, and Karen Pollitz (with analysis by Anthony Damico)

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[1] Justin Lake, Andrew Valen, Michael Newshel, J.P. Morgan Securities LLC, "Managed Care and Providers Wrap-Up," *J.P. Morgan Health Conference,* (January 2013).
[2] Christine Arnold, Cowen and Company, "4Q12 Hospital Survey Results Suggest Mixed Views on Reform Impact," *Health Care*, (February 2013).

Supporting Consumers' Decisions in the Exchange

Introduction

With the arrival of the insurance exchanges, an estimated 22 million people will have the opportunity to choose their coverage through an exchange. Many of these consumers could make the "wrong" plan choice, selecting a plan that doesn't meet their health care needs or is not a good value for them. Exchange leaders have a critical role to play in supporting consumers in their search for high quality, affordable options that best meet their individual needs.

Through the *Helping Vulnerable Consumers in the Exchange Project*, the Pacific Business Group on Health (PBGH) has created a set of resources that exchanges can use as they build their consumer choice decision support. The resources combine evidence from our plan choice research and the rich consumer choice architecture research literature. The resources have been prepared by PBGH, informed by research and guidance from research teams at Columbia University, the University of Pennsylvania, and Stanford University. This project is made possible by the generous support of the Robert Wood Johnson Foundation.

Resources

Issue Briefs provide an overview of important plan choice decision support topics. Each 3- to 4-page brief includes decision support rules that exchanges can use to build their consumer choice software rules as well as implementation guidance and research evidence.

1. **Plan Comparison Display Format**
2. **Cost Calculator**
3. **Organizing Plans Using Filters and Sorts**
4. **Important Dimensions of Plan Choice**
5. **QuickChoice: Shortcut to Plan Choice**
6. **Searching for Doctor in Plan**
7. Evaluating and Improving Plan Choice - *forthcoming*
8. SHOP - *forthcoming*
9. **Communicating Difficult Concepts**

Additional Resources

Decision Support Rules for Health Exchanges, Installments 1-3, is an in-depth report of plan choice decision support recommendations and research evidence.

Companion Excel file provides details about the information required of health plans to support consumers in making plan choices.

For more information, contact tglahn@pbgh.org .

Read the latest PBGH researching and recommendations on this topic.

Engaging Consumers Projects

The Health Plan Chooser

The California Healthcare Performance Initiative

The Patient Assessment Survey

Online Physician Ratings

Supporting Consumers' Decisions in the Exchange

Engaging Consumers Resources

California Chartered Value Exchange

Resources for Consumers: choosing a health plan and hospital (CA Office of the Patient Advocate)

Choosing Quality Health Care (AHRQ)

CalHospitalCompare.org

The Need for Tools to Choose Physicians (Commonwealth Fund)

Value Based Insurance Design (CA HealthCare Foundation)

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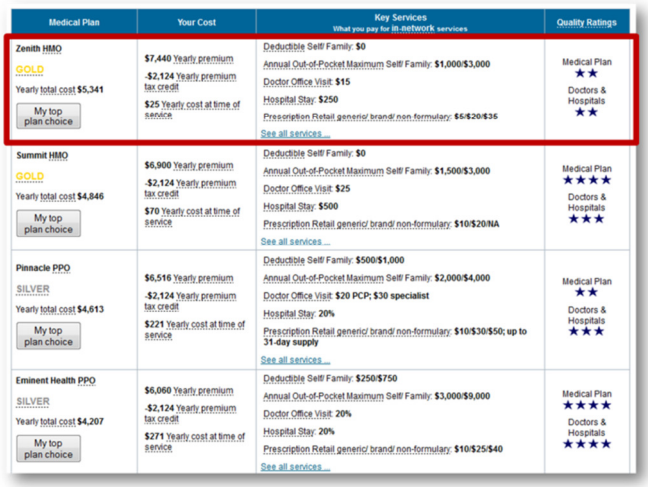
Consumer Choice of Health Plan
Decision Support Rules for Health Exchanges: Issue Brief #1

Plan Comparison Display Format

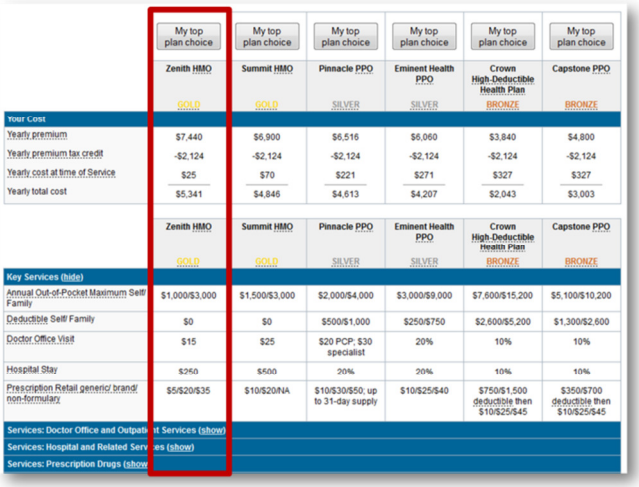
Display plans in a column format. In the Plan Comparison section, organize plans in columns (with plan dimensions in rows) rather than in rows (with plan dimensions in columns).

Figure 1. Plan Comparison with plans displayed in a) a row format or b) a column format.

Row Format for Plan Comparison



Column Format for Plan Comparison



RATIONALE

Reduced text: Compared to a row format (Figure 1a), a column format (Figure 1b) has less text. Moving descriptions to a left-hand legend reduces the density of text within each cell as well as the amount of repetition from cell to cell. This creates a cleaner look and feel; it also reduces the amount of reading required, which may be especially helpful for low-literacy populations. Finally, the reduced amount of text per cell may make it easier to compare plans along different dimensions by visually scanning left-to-right, mimicking familiar online retail shopping experiences.

Hierarchy of plan dimensions: Presenting dimensions as rows ensures that **key** dimensions are visible without scrolling. Key dimensions, such as plan name and expected cost, can be positioned in the first rows, ensuring that they will appear above the fold regardless of user-side variables (e.g., computer screen size or browser). Other dimensions, such as value-added plan services, can be viewed by scrolling down the page.

Intuitive cost display: Presenting dimensions as rows allows cost components to be displayed in a vertically-arranged equation (similar to a grade-school math problem). This arrangement may make it easier for consumers to understand their total cost calculation (e.g., premium minus tax credit plus cost at time of care equals total cost). This may be especially helpful for low-numeracy populations who struggle with numbers.

Flexible covered services display: Presenting plan dimensions as rows allows more flexibility in the display of covered services. Each service can appear as a row displaying the cost-sharing amount for the different plans. The rows of services can be organized into topic clusters that can be shown or hidden based on consumer preferences or policy objectives. The services can be organized in one of several ways:

- "Key services" that the consumer flagged as important in the User Perferences section
- Essential Health Benefits (EHB) categories
- A combination of "key services" and EHB clusters (similar to Figure 1b)

Match the choice experience to the product: Choice experiences vary across types of consumer products (Table 1). A row or tile display communicates brief information about a small number of product dimensions. This format fits simple, familiar products, such as hotel rooms, which have a limited number of well-understood dimensions (e.g., cost, customer rating). A column display flexibly communicates brief or detailed information about a larger number of product dimensions. This format is well suited to complex products, such as computers, which have a number of dimensions (e.g., cost, customer rating, memory, processor, display, etc.), many of which are unfamiliar to most consumers. Because health plans are complex products with many dimensions that are unfamiliar and/or difficult to understand (Consumers Union, 2012), a column display may be the best approach to help consumers identify high value health plans that meet their plan needs and preferences.

Table 1. Product display formats vary across products.

		Dimensions			
Product	Display	Number	Complexity	Familiarity	Link
Amazon	tiles	few	simple	high	http://www.amazon.com
Hotel room	rows	few	simple	high	http://www.travelocity.com
Computers	columns	many	varies, many complex	varies, many not familiar	http://www.cnet.com
Cars	columns	many	varies, many complex	varies, many not familiar	http://www.vw.com/en.html
Health plans	columns	many	varies, many complex	varies, many not familiar	

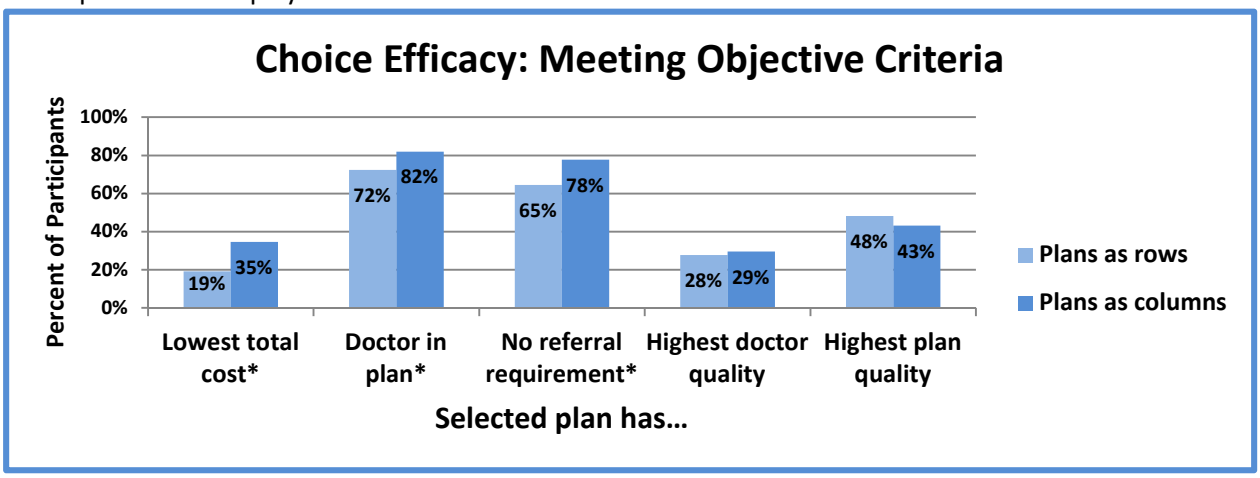
RESEARCH EVIDENCE

Our research indicates that study participants chose higher value plans when plans were displayed in a column format (with plan dimensions in rows) than in a row format (with plan dimensions in columns).

Participants (N = 280) used our online plan choice decision support tool to select a health plan. Although this choice was hypothetical, the health plans were based on real-world plan data and participants were asked to "make [their] medical plan choice as if it were [their] actual plan choice". Participants' preferences were queried in the User Preferences section. They were then randomly assigned to view a Plan Comparison section with plans displayed in a row format (Figure 1a) or in a column format (Figure 1b).

Participants chose higher value plans on two metrics. First, we looked at objective measures of choice efficacy using criteria such as the relative cost and quality of participants' selected plan. Compared to participants viewing a row format, participants viewing a column format were significantly more likely to choose better plans on a number of dimensions (Chart 1). For example, participants viewing plans displayed in a column format were almost twice as likely to select the plan with the lowest total cost.

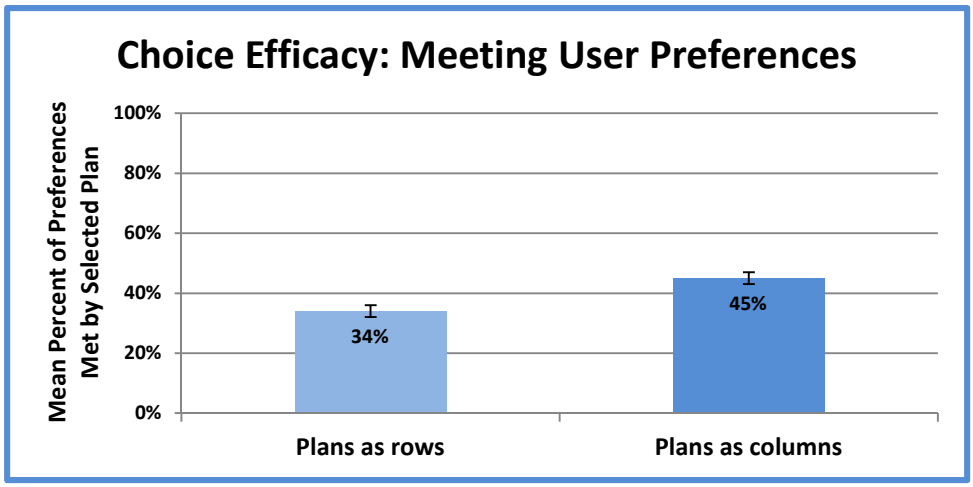
Chart 1. Participants were more likely to choose plans that were higher value on several dimensions when plans were displayed in a column format.



** Significant difference ($p < .05$)*

Second, we looked at subjective measures of choice efficacy. We asked participants to rank their top three most important plan dimensions. We then assessed how well their selected plan met those preferences. Compared to participants viewing a row format, participants viewing a column format chose plans that met significantly more of their own criteria (Chart 2).

Chart 2. Participants chose plans that better fit their self-identified criteria when plans were displayed in a column format.[†]



† *Error bars indicate standard error.*

REFERENCES

For more information or other recommendations for plan choice decision support, including additional issue briefs and in-depth report, visit http://www.pbgh.org/key-strategies/engaging-consumers/216-supporting-consumers-decisions-in-the-exchange or contact Ted von Glahn (tglahn@pbgh.org).

Quincy, L. (2012, January). What's behind the door? Consumers' difficulties selecting health plans. (Health Policy Brief). Yonkers, NY: Consumers Union.

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Consumer Choice of Health Plan
Decision Support Rules for Health Exchanges: Issue Brief #2

Cost at Time of Care Calculator

Include a cost at time of care calculator. Use a calculator to provide consumers with their cost at time of care given the plan's covered benefits and the consumer's expected medical services use. Combine this cost with the plan's premium net of any tax credit to provide a total cost estimate.

IMPLEMENTATION

Cost calculator inputs: Query consumers about their expected use of medical services in the User Preferences section (Figure 1a). These questions should:

- **Be a core step** in the plan selection process, rather than positioned separately in a "toolkit".
- **Be fully explained** to consumers. Explaining how the calculators work (e.g., how cost at time of care is estimated) helps consumers understand plan costs and identify high value health plans (Johnson et al., 2012).
- **Ask about levels of expected use**, rather than specific conditions. This can help address consumers' concerns about privacy and how their information is used (e.g., misperceptions that it will be used to deny coverage or determine premium rates).
- **Distinguish use of medical services and prescription drugs.** Many consumers have distinct patterns of usage for medical services versus prescription drugs.
- **Not use defaults** (i.e., pre-selected answers), unless there is sufficient information to estimate each consumer's expected usage (Goldstein et al., 2008). Consumers may retain defaults even when they are not a good fit. Because the expected use questions drive the calculators, consumers retaining ill-fitting defaults may see plan costs that are not good estimates for their expected use, and this may lead to poor plan choices.

Calculating costs: Calculate estimated costs for each plan.

- **Cost at time of care:** Query consumers about their expected services use by asking them to match their expected use to typical yearly use profiles. For example, the yearly use profiles can be drawn from a generalizable claims distribution dataset – the profiles are based on consumption of services along the population distribution (e.g., 25th, 50th, and 75th percentiles). Create a basket of services (e.g., number of office visits, diagnostic tests, hospitalizations, etc.) that is typical of consumers at a given percentile.[1] Determine the cost for the basket of services using prevailing market-area unit costs. Combine this with plans' rules about coverage and cost-sharing to provide an estimated cost at time of care for each plan.[2]
- **Total cost:** Sum cost at time of care and premium (net of any tax credit) to provide a total cost for each plan.

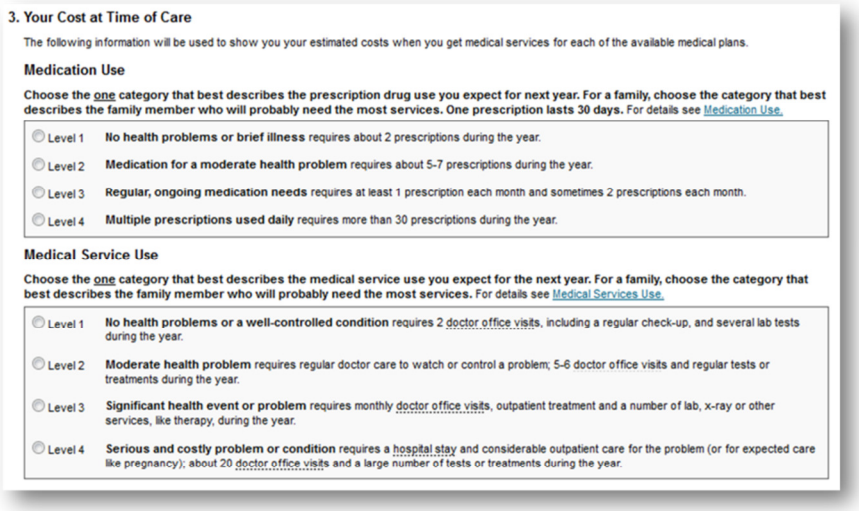
[1] This approach assumes no benefit-design impact – that is, utilization demand is not influenced by cost-sharing as the consumer is declaring their expected medical care needs in the upcoming year.
[2] Depending upon the benefit design complexity, various assumptions are adopted in the set of cost calculator rules (e.g., family members' costs that accumulate to individual versus aggregate out-of-pocket maximums).

Displaying costs: Display calculated costs in the Plan Comparison section (Figure 1b). The cost display should:

- **Emphasize total cost** (i.e., premium minus any tax credits plus cost at time of care) because it is a threshold dimension for many consumers and it allows straightforward comparisons of costs across plans.
- **Be intuitive** (e.g., a vertical cost display mimicking a grade-school math problem set-up) to help consumers understand how total cost is calculated.
- **Be clear that these are not absolute or guaranteed costs**, but are intended instead to give consumers an estimate of the relative differences in costs across plans. Educate consumers that this is not a budgeting tool.
- **Allow sensitivity analyses** that enable consumers to explore "what-if" scenarios, such as alternative utilization profiles or tax credit amounts. This can help interested consumers understand: 1) their potential cost-sharing obligation if considerable medical services are needed, and 2) their potential premium costs if income varies.

Figure 1. a) User Preferences questions assessing expected medical services use. b) Plan Comparison display of total cost and cost components.

User Preferences: Cost Calculator Inputs



Plan Comparison: Cost Display

RATIONALE

Reduce decision complexity: If cost calculators are included, consumers do not need to understand an insurance product's cost-sharing elements to compare health plan costs. Instead, the decision is simplified by presenting consumers with a single, easy-to-compare total cost number for each plan. This frees up limited cognitive attention and allows consumers to consider other plan dimensions (e.g., quality ratings, rules to see a doctor). Because cost calculators reduce the required levels of mathematical skills **and** plan comprehension, they may be especially helpful for consumers with low numeracy and low health insurance literacy.[3]

Emphasize important dimensions: Our research indicates that consumers commonly cite cost as the most important dimension. For many consumers, cost is a threshold attribute that determines whether they will consider a given plan. Thus, total cost should be emphasized in the Plan Comparison display. Give less emphasis to cost-sharing elements (e.g., deductible, coinsurance, copay) because consumers often overweight this information – ascribing greater costs than would be realized given their expected medical services use (Abaluck & Gruber, 2011; Johnson et al., 2012).

[3] In the absence of a cost calculator, metals tier can be used as a rough proxy for total cost. However, this substitution may be misleading in some cases: if there is a lot of variability between possible benefit structures within a metals tier, there may be instances in which plans from different tiers are more similar and plans from higher tiers are more cost-effective for certain consumers than plans from lower tiers (Krughoff et al., 2012; Lore et al., 2012).

Communicate difficult concepts: Many consumers are unfamiliar with health insurance terminology (Consumers Union, 2012); our research indicates that many consumers struggle to understand the differences among plans across metals tiers and product types. Cost calculators can help illustrate these differences by communicating how plans compare on total cost and its components (i.e., premium and cost at time of care). Cost calculators synthesize multiple difficult-to-understand plan dimensions into a single number, which may be especially helpful for vulnerable populations.

Encourage eligible consumers to consider cost sharing reduction (CSR) plans. Our research indicates that, although consumers consider both total cost **and** covered services to be important plan dimensions, many consumers believe they must choose between the two. Silver tier CSR plans' combination of better coverage and subsidized prices are likely to be attractive to many eligible consumers, if these benefits are communicated clearly. Sorting plans by total cost highlights silver CSR plans' special cost savings and may make it easier for eligible consumers to recognize their value. Again, this may be especially important for vulnerable populations.

RESEARCH EVIDENCE

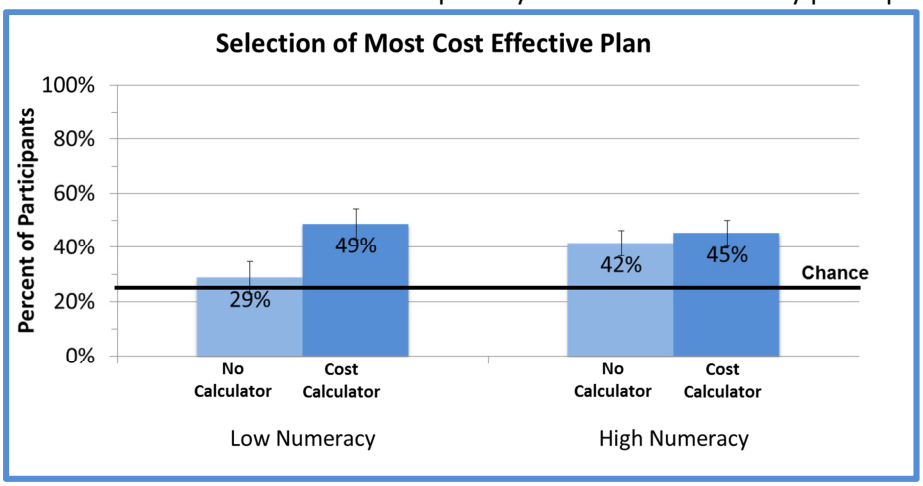
Research indicates that study participants choose more cost-effective plans when a cost at time of care calculator is included in plan choice (Johnson et al., 2012).

In a study conducted at Columbia University, participants used an online plan choice decision support tool to select a health plan. Participants were randomly assigned to a decision support tool that did or did not include a cost at time of care calculator.

When the tool did **not** include a cost calculator (i.e., cost dimensions were not summarized and participants had to convert benefits coverage into expected costs), odds were equal to or worse than random chance that participants chose a less expensive plan. When the tool **did** include a cost calculator, participants performed much better: they were more likely to choose the most cost effective plan and overweighted plans' cost-sharing elements less.

Participants with lower numeracy skills were particularly helped by cost calculators. Although low-numeracy participants were less likely to choose a cost effective plan, their decision-making improved markedly when a cost calculator was included – the proportion of low-numeracy participants who chose the right plan doubled (Chart 1).

Chart 1. Participants were more likely to choose plans that were cost-effective when a cost at time of care calculator was included in Plan Choice. This was especially true for low-numeracy participants.



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PBGH
PACIFIC BUSINESS GROUP ON HEALTH

Consumer Choice of Health Plan
Decision Support Rules for Health Exchanges: Issue Brief #3

Organizing Plans Using Filters and Sorts

Smart organization of plans using filters and sorts. Organize plans in the Plan Comparison display using filters and sorts. To meet consumers' plan needs and preferences, use these tools carefully.

IMPLEMENTATION

We recommend a two-step approach to organizing plans:

1. Use automatic settings to provide an initial organization of the Plan Comparison display.
2. Provide tools to allow consumers to reorganize plans once they have viewed the initial Plan Comparison display.

Initial plan organization: Based on information provided by consumers in the Eligibility Determination and User Preferences sections, initial filters and sorts are applied automatically to organize the plans for consumers' first view of the Plan Comparison display.

- **Initial or "pre"-filters:** Pre-filters narrow the set of plans displayed initially. Candidate dimensions:
  - Geographic service area (e.g., plans available in consumers' zip code)
  - User eligibility status
- **Initial or "pre"-sorts:** Pre-sorts order the plans displayed initially. Multiple sorts can be applied simultaneously to handle ties (e.g., if several plans have the same total cost, use a secondary sort). Candidate dimensions:
  - Total cost[1] as primary sort
  - Policy objective (e.g., encouraging consumers to consider quality ratings) or designated consumer preference (e.g., doctor in plan) as secondary sort[2]

Optional plan reorganization: Additional filters and sorts are tools positioned directly on the Plan Comparison page(s) that consumers can optionally apply to reorganize the plan display to better meet their plan needs and preferences.

- **Additional filters:** Additional filters allow consumers to choose personally relevant criteria to narrow the set of plans under consideration. Candidate dimensions include:
  - Plan name
  - Total cost limits (minimum or maximum cost consumers are willing to consider)
  - Doctor in plan
  - Rules to see a doctor
  - Provider quality ratings limits (minimum or maximum quality consumers are willing to consider)
  - Plan quality ratings limits (minimum or maximum quality consumers are willing to consider)

[1] Total cost combines premium minus any tax credit and cost at time of care; for more details about cost calculators, see Issue Brief #2. In the absence of a cost calculator, metals tier can be used as a rough proxy for total cost. However, this substitution may be misleading: if there is a lot of variability between benefit structures within a metals tier, there may be instances in which plans from different tiers are more similar than plans within a tier (Krughoff et al., 2012; Lore et al., 2012).

[2] Exchanges may assign an importance ranking to plan dimensions or ask consumers to rank plan dimensions. The highest ranked dimension for which consumers express a preference in the User Preferences section can be used as the secondary pre-sort.

- **Additional sorts:** Additional sorts allow consumers to choose personally relevant criteria to re-order plans. Candidate dimensions include:
    - Plan name
    - Total cost
    - Doctor in plan
    - Rules to see a doctor
    - Provider quality ratings
    - Plan quality ratings
    - Cost sharing for specific Essential Health Benefits (including annual out-of-pocket maximum)
- **Additional adjustments:** Provide tools or navigation for consumers to adjust the assumptions that drive the Plan Comparison display. Candidate dimensions include:
    - Plan service area
    - Expected income
    - Expected care needs (e.g., expected medical services use and expected medication use)

RATIONALE

Reduce decision complexity: Consumers can be overwhelmed by a large number of complex choice options (for a discussion, see Consumers Union, 2012). Filters and sorts organize plans so consumers can focus on a small number of plans that best meet their needs and preferences. Because filter and sort tools are flexible (i.e., consumers can "undo" any filters or sorts applied), they can reduce choice complexity while preserving consumers' freedom of choice – consumers can choose to consider smaller or larger sets of plans as well as if and how to re-order the plans.

Help consumers find high value plans: Many consumers may choose from a narrowed set of plans and/or only consider plans that appear near the beginning of the plan display. If filter and sort criteria are not selected carefully, consumers may inadvertently miss high value plans. For example, a pre-filter on doctor in plan could exclude low cost, high quality plans that some consumers may prefer to a plan that includes their doctor. Thus, we recommend using pre-filters to exclude only plans that are not available. If any other pre-filters or pre-sorts (e.g., doctor in plan) are used, alert consumers that a number of available plans may not be shown at all, or not displayed in the first screen of the plan display. Further, if consumers select a plan from a narrowed set of plans when one or more hidden plans are better on several dimensions, the functionality should alert consumers about these plans.

Meet user preferences: Decisions about which dimensions to include as criteria for filter and sort tools should be informed by plan choice dimensions that matter to many consumers.[3] For example, because total cost (i.e., premium minus any tax credits plus cost at time of care given consumers' expected medical services use) is the dimension most commonly cited as most important, we recommend using it as the primary pre-sort criterion. Using key plan dimensions as criteria lets consumers reorganize plans to address their plan needs and preferences.

Accommodate changing preferences: Preferences are malleable (Lichtenstein & Slovic, 2006; Tversky & Kahneman, 1981). Consumers' preferences may change once they view the available plans (for more details, see Issue Brief #4). Filters and sorts should be easily reversed so that consumers are not locked into a set of plans or a particular ordering of plans.

Reduce uncertainty: Many aspects of plan choice are based on consumers' expectations for the next year and confidence in these assumptions may vary. Allowing consumers to adjust the assumptions that drive the Plan Comparison display may help them better understand "what-if" scenarios.

[3] Regardless of the criteria used, alert consumers to the number of plans that each filter would exclude.

Accomplish policy objectives: Filters and sorts also can address policy objectives. Exchanges can include plan choice dimensions that are aligned with policy and program objectives as criteria for filters and sorts.

RESEARCH EVIDENCE

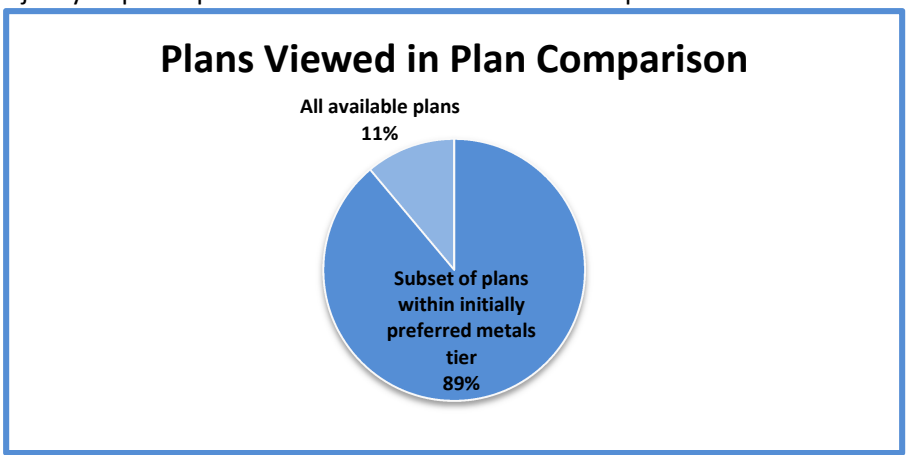
Our research indicates that filtering had a powerful impact on plan choice. When plans were **pre-filtered** based on participants' initial metals tier preference (i.e., bronze, silver, or gold), most participants chose plans from this narrowed set of plans without viewing the full set of plans. When plans were **pre-sorted** based on participants' initial metals tier preference, a material proportion of participants crossed metals tiers to select a plan from a different metals tier.

Participants (N = 359) used our online plan choice decision support tool to select a health plan. Although this choice was hypothetical, the health plans were based on real-world plan data and participants were asked to "make [their] medical plan choice as if it were [their] actual plan choice". Participants' preferences were queried in the User Preferences section. They then were randomly assigned to one of two versions of the Plan Comparison.

1. In the sort condition, participants' initial metals tier preference determined how plans were **pre-sorted**: plans matching participant's initial metals tier preference were ordered first followed by plans belonging to other metals tiers (e.g., if the participant indicated a preference for bronze plans, the order was bronze plans first, followed by silver plans and then gold plans).[4]
2. In the filter condition, participants' initial metals tier preference determined how plans were **pre-filtered**: only plans matching participant's initial preference were shown in the initial plan display (e.g., if the participant indicated a preference for bronze plans, only bronze plans were displayed), but participants could unhide the remaining plans by clicking on "Show all plans".

Set of plans viewed: In the filter condition, participants could choose a plan from the set of three plans within the metals tier for which they initially indicated a preference, or they could unhide the remaining plans and choose from the full set of nine plans across metals tiers. The bulk of participants did not unhide the full set of plans and instead chose from the narrowed set of plans (Chart 1).

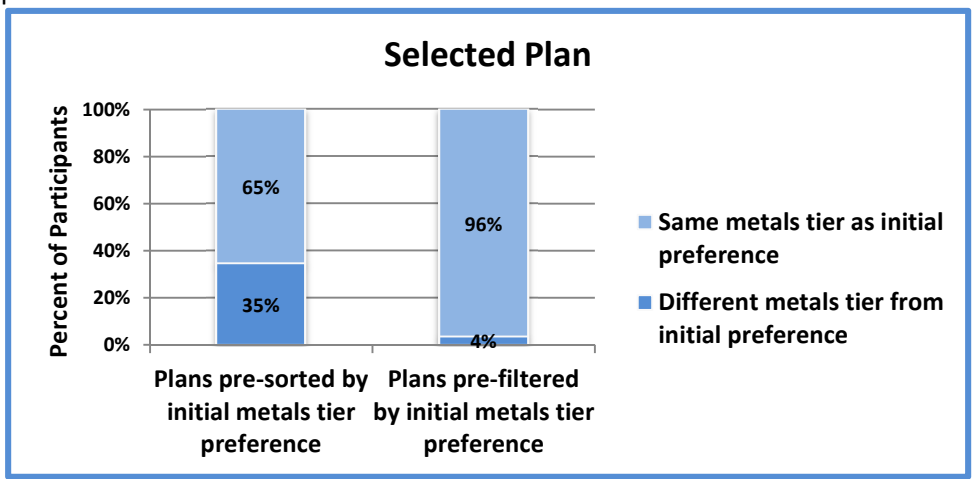
Chart 1. The majority of participants in the filter condition chose a plan from the narrowed set.



[4] If participants indicated a preference for silver plans, plans were displayed in the order: silver, bronze, gold. If participants indicated a preference for gold plans, plans were displayed in the order: gold, silver, bronze.

Metals tier of selected plan: Participants in the sort condition were significantly more likely to cross metals tier to choose a plan from a different metals tier than their initial preference (Chart 2). Whereas almost all participants in the filter condition selected a plan drawn from their initially preferred metals tier, roughly one-third of participants in the sort condition selected a plan that was not from their initially preferred metals tier.

Chart 2. Participants in the sort condition were more likely to choose a plan from a different metals tier than their initial preference.



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UPDATE FORTHCOMING: We are conducting ongoing research on this topic. We expect to update this brief at the end of March 2013.

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PACIFIC BUSINESS GROUP ON HEALTH

Consumer Choice of Health Plan
Decision Support Rules for Health Exchanges: Issue Brief #4

Important Dimensions of Plan Choice

Important dimensions of plan choice. Dimensions rated important by wide swaths of consumers should be emphasized in both the User Preferences and the Plan Comparison sections. Because preferences vary among consumers and can change as consumers consider their decision, decision support should give consumers the flexibility to adjust their preferred plan dimensions.

IMPLEMENTATION

Certain plan dimensions are important to many consumers:

1. Cost
2. Covered services
3. Rules to a see a doctor
4. Doctor in plan

Emphasize popular dimensions throughout plan choice by having them be:

- Set as defaults (i.e., preselected options) in the User Preferences section
- Organized to appear in the top layer of information, and even highlighted, in the Plan Comparison section
- Used as criteria for filtering plans in the Plan Comparison section (for more details, see Issue Brief #3)
- Used as criteria for sorting plans in the Plan Comparison section (for more details, see Issue Brief #3)

Accommodate changing preferences by using flexible Plan Comparison displays that allow consumers to:

- Show or hide information to adjust the density of information to fit their interests
- Apply, remove, and switch filters to compare different subsets of plans
- Apply, remove, and switch sorts to (re-)organize plans along different dimensions

RATIONALE

Meet user preferences: Design informed by popular preferences will by definition match many consumers' preferences. Emphasizing popular dimensions can make it easier for consumers to identify plans that meet their needs.

Help vulnerable populations: Our research indicates that some consumers begin plan choice without a clear idea of their preferred plan features. Because an emphasis on popular dimensions conveys norms (i.e., indicates common preferences), it can help these consumers identify their needs and preferences and understand the trade-offs among available plans. This could be especially helpful for consumers with low health insurance literacy or with no previous insurance experience.

Accommodate varied and changing preferences: Building user flexibility into decision support is important for several reasons. First, it allows consumers to adapt the decision support to their needs and preferences when these are not met by the default design. Second, it allows consumers to spend more or less time on plan choice,[1] including allowing them to explore without penalty (e.g., letting them do and undo actions such as show/hide, filter, and sort). Third, preferences are malleable (Levin & Gaeth, 1988; Tversky & Kahneman, 1981) and flexibility accommodates changing preferences.

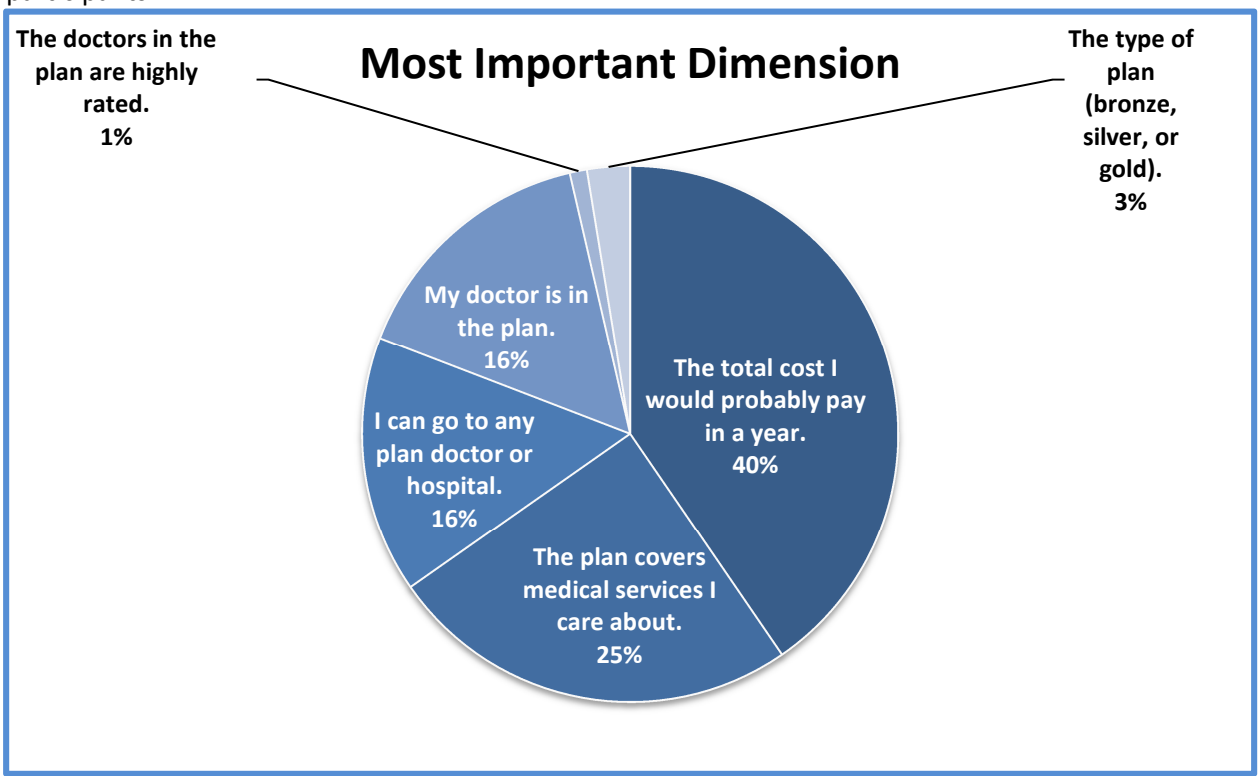
RESEARCH EVIDENCE

Our research indicates that plan choice dimensions were weighted differently by different participants. However, there was agreement around a few dimensions, which were rated as important by material segments of participants. Notably, the stability of participants' dimension importance ratings varied over the course of the decision.

Participants (N = 193) used our online plan choice decision support tool to select a health plan. Although this choice was hypothetical, the health plans were based on real-world plan data and participants were asked to "make [their] medical plan choice as if it were [their] actual plan choice". Participants were asked about their plan needs and preferences in the User Preferences section. They then used the Plan Comparison to select a plan. Participants were asked about their most important plan dimensions before and after selecting a plan.

Important dimensions: After selecting a plan, participants were shown a list of six plan dimensions and asked to rank their top three most important dimensions. Total cost was significantly more popular than any other dimension (Chart 1). Covered services was significantly more popular than the remaining dimensions. Rules to see a doctor and doctor in plan were significantly more popular than doctor quality ratings and metals tier.

Chart 1. Total cost, covered services, rules to see a doctor, and doctor in plan were important to many participants.

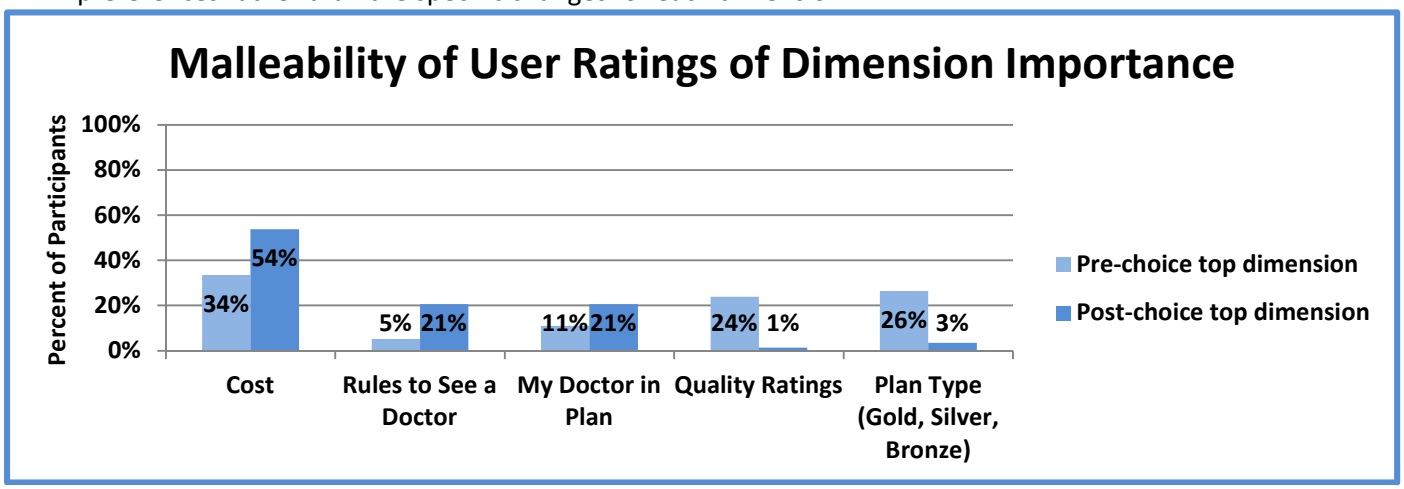


[1] For more details on ways to allow consumers to spend more or less time on plan choice, see Issue Brief #5.

Malleability of dimension importance ratings: Participants were asked to report their top plan dimension in the User Preferences section (pre-choice) as well as in the exit questionnaire (post-choice). Many participants (20%) reported not having a predefined most important dimension before viewing the Plan Comparison. This was particularly true of those who had never been insured: 36% of those who have never been insured reported no preference, compared to only 18% of those who were currently or previously insured.

For participants reporting a most important dimension in the User Preferences section, their dimension importance ratings often changed after viewing the Plan Comparison and choosing a plan (Chart 2). Only 22% of participants reported the same top dimension pre- and post-choice, and only 48% of participants ranked their pre-choice top dimension in their post-choice top three dimensions.

Chart 2. Many participants' dimension importance ratings changed from pre- to post-choice. Because changes in importance ratings depend on study-specific factors,[2] Chart 2 is included to convey the general malleability of preferences rather than the specific changes for each dimension.



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[2] Consumers' dimension importance ratings and the malleability of these ratings depend on several factors. First, the amount of variation between plans can affect ratings. For example, a consumer may rate having his doctor in his plan as the most important dimension pre-choice. If, however, all of the available plans include his doctor, this will not be a deciding factor and he may decrease this dimension's importance rating post-choice. Second, consumers may make trade-offs between dimensions and this can affect ratings. Using the example above, suppose instead that the only available plan that includes the consumer's doctor is also the most expensive plan. The consumer may choose a plan that does not include his doctor and change his importance ratings to reflect this compromise. Third, consumer characteristics can influence ratings. Consumers with different levels of plan choice experience, health insurance literacy, or health status may have different preferences and be more or less set in their preferences. Using the example above, a consumer with a chronic condition may be less likely to concede doctor in plan and continue to rate that dimension as important. Finally, how dimension importance is queried can affect ratings. Preferences are influenced by how a question is asked and by the set of response options provided (Lichtenstein & Slovic, 2006; Tversky & Kahneman, 1981). A limitation of this study is that the questions and response options pre- and post-choice differed. Additionally, the response options were not exhaustive.

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PACIFIC BUSINESS GROUP ON HEALTH

Consumer Choice of Health Plan
Decision Support Rules for Health Exchanges: Issue Brief #5

QuickChoice

QuickChoice: Offer a shortcut to plan choice. Allow consumers flexibility to spend more or less time and effort on plan choice. Consumers choosing a streamlined "QuickChoice" experience enter only key health plan needs in the User Preferences section and view only the top plan dimensions in the Plan Comparison section. Consumers choosing a standard "See Details and Choose" path can enter more plan preferences and view more plan dimensions.

IMPLEMENTATION

A streamlined choice experience is a balancing act between keeping plan choice brief and providing sufficient information for consumers to select high value health plans.

User Preferences: Distinguish key information that always should be queried from those preferences that are optional.

- **Questions about plan needs are required[1]:** Responses influence the set of available plans and plan costs.
  - Coverage level (e.g., self, family)
  - Geographic service area (e.g., residence zip code)
  - Expected health care needs (e.g., expected use of medical services and medications)[2]
- **Questions about plan preferences are optional:** Responses influence the information displayed in the Plan Comparison section, but not the set of plans displayed.
  - Doctor in plan
  - Rules to see a doctor
  - Quality ratings
  - Covered services
  - Wellness services

Plan Comparison[3]: Distinguish key information that always should be displayed from optional additional information.

- **Key dimensions should always be displayed;** other dimensions are displayed if consumers indicate an interest, or if the Exchange seeks to encourage consumers to consider certain dimensions (e.g., quality ratings).
  - Plan name
  - Metals tier
  - Total cost and its components (i.e., premium cost and cost at time of care)

[1] Information collected in the Eligibility Determination section does not need to be re-queried in the User Preferences section.
[2] Cost calculators use consumers' expected health care needs to compute cost at time of care and total cost (for more details, see Issue Brief #2). An ill-fitting expected health care needs default retained by a consumer can lead to a poor plan selection. Therefore, questions about expected health care needs should be required and no response options should be defaulted.
[3] We recommend sorting plans by total cost in all choice experiences (for more details, see Issue Brief #3).

Operationalizing flexibility: There is more than one way to give consumers a choice between experiences.

- **Upfront choice:** Ask consumers about their preferred choice experience (e.g., quick or detailed) before they reach the User Preferences section.
- **Midcourse choice:** In the User Preferences section, after consumers have responded to the required questions, ask if they would like to skip directly to the Plan Comparison section or continue on to share more preferences.

QuickChoice trade-offs: "QuickChoice"-style experiences may help consumers identify high value health plans, but they offer fewer opportunities to educate consumers about plan choice. Given that the alternative may be high levels of drop-off (e.g., frustrated or tired consumers abandoning plan choice before selecting a plan), this may be an acceptable trade-off. Additionally, "QuickChoice" can be customized to draw attention to a few dimensions (e.g., dimensions aligned with policy objectives) for which consumer education is crucial.

RATIONALE

Meet user preferences: Consumers may differ in the amount of time and effort they prefer to spend on plan choice. Some consumers, satisficers, want to find a "good enough" plan without spending too much time and effort (Simon, 1957). Other consumers, optimizers, want to spend as much time and effort as needed to identify the best possible plan (Simon, 1957). These consumers differ in their preferred plan choice experience (e.g., the number of plans, plan dimensions, and details they prefer to consider). Plan choice decision support can better meet consumers' preferences by allowing consumers to spend more or less time and effort in selecting a plan.

Reduce decision complexity: Offering consumers a choice between a streamlined choice experience and the standard choice experience eases decision making by reducing the number of decisions consumers must make, while preserving their freedom of choice. Consumers can skip making decisions about plan preferences and viewing a large number of plan dimensions, or, if they wish, they can choose to make more decisions and view more plan dimensions.

RESEARCH EVIDENCE

Our research supports offering consumers a choice between experiences. The streamlined "QuickChoice" experience was popular with participants and decreased the amount of time they spent on plan choice.[4] Compared to participants choosing "See Details and Choose", participants choosing "QuickChoice" chose higher value health plans. Importantly, "QuickChoice" was not associated with any significant decreases in plan comprehension for the dimensions displayed.[5]

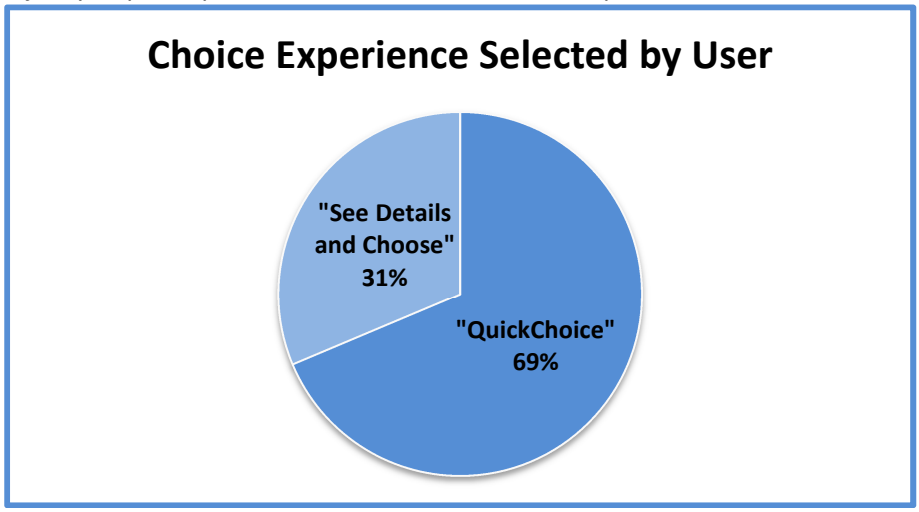
Participants (N = 284) used our online plan choice decision support tool to select a health plan. Although this choice was hypothetical, the health plans were based on real-world plan data and participants were asked to "make [their] medical plan choice as if it were [their] actual plan choice". Participants were asked to choose between two choice experiences: "QuickChoice" was described as a simpler way to choose a plan, whereas "See Details and Choose" was described as a way to see more information to help choose a plan (for more details, see the Appendix).

[4] Compared to participants using "See Details and Choose", participants using "QuickChoice" spent significantly less time on plan choice. This was driven by the amount of time spent on the User Preferences section, which was truncated for "QuickChoice" but full-length for "See Details and Choose". Importantly, participants in both experiences spent the same amount of time on the Plan Comparison section, indicating that they took the plan choice decision equally seriously.

[5] Plan comprehension was assessed by asking participants questions about their selected plan, such as its relative total cost, and scoring their answers based on the plan's actual features. In general, there were no significant differences in comprehension between choice experiences; however, comprehension of deductibles and doctor visit cost-share was lower for "QuickChoice" participants as this information was not displayed prominently in the "QuickChoice" Plan Comparison section.

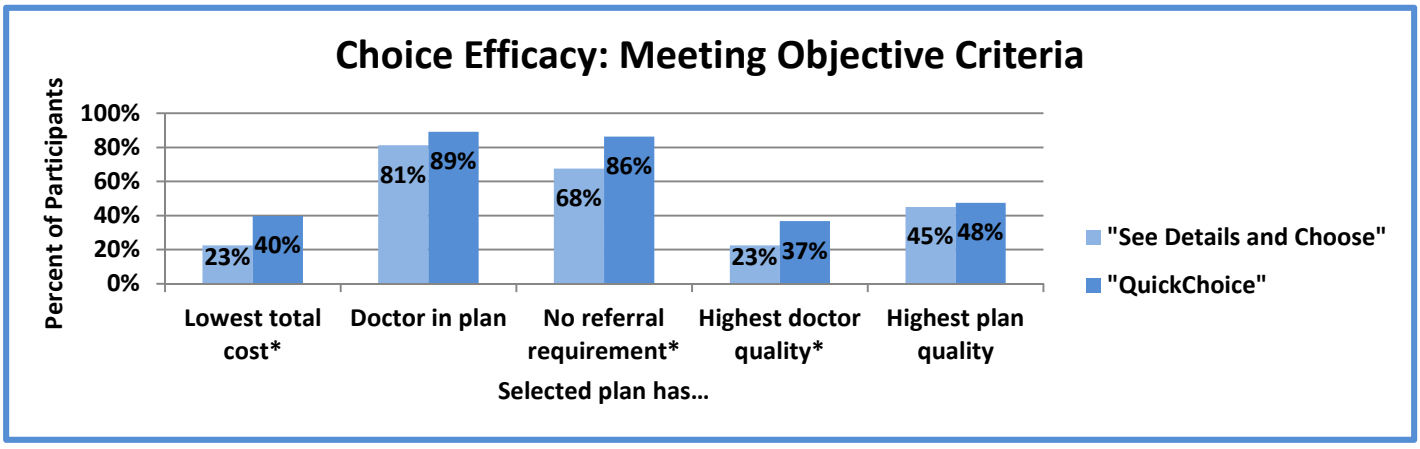
Preferred choice experience: "QuickChoice" was popular and appeared to meet participants' needs as few participants opted out. The majority of participants chose the "QuickChoice" experience upfront (Chart 1). Participants were able to switch experiences at any point, but only 10% of participants opted to switch. Of these, two-thirds switched from "See Details and Choose" to "QuickChoice". Thus, over the course of plan choice, "QuickChoice" saw a small gain in participant share, whereas "See Details and Choose" saw a small loss in participant share. Although the percent of participants who opted to switch experiences was small, it is important to allow consumers to switch in all sections of the decision support so that their information needs and plan preferences are met.

Chart 1. The majority of participants chose the "QuickChoice" experience.



Choice efficacy: "QuickChoice" participants chose higher value plans on two metrics. First, we looked at objective measures of choice efficacy using criteria such as the relative cost and quality of participants' selected plan. Compared to participants using "See Details and Choose", participants using "QuickChoice" were significantly more likely to choose plans that were better on a number of dimensions (Chart 2). For example, "QuickChoice" participants were almost twice as likely to select the plan with the lowest total cost.

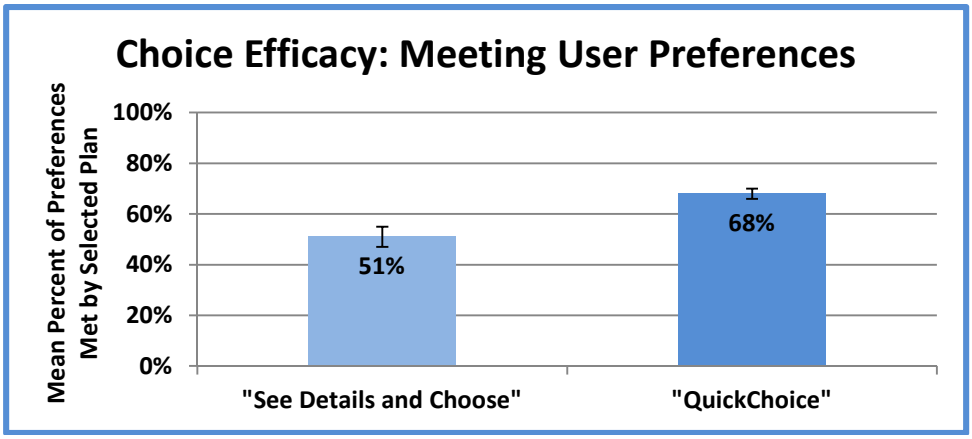
Chart 2. Participants using "QuickChoice" were more likely to choose plans that were higher value on several dimensions.



*Significant difference

Second, we looked at subjective measures of choice efficacy. We asked participants to rank their top three most important plan dimensions. We then assessed how well their selected plan met those preferences. Compared to participants using "See Details and Choose", participants using "QuickChoice" chose plans that met significantly more of their own plan criteria (Chart 3).

Chart 3. Participants using "QuickChoice" chose plans that better fit their self-identified criteria. †



† *Error bars indicate standard error.*

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APPENDIX

Table 1. Key differences between the "See Details and Choose" and the "QuickChoice" experiences.

	"See Details and Choose"	"QuickChoice"
USER PREFERENCES SECTION		
How many plan needs and preferences are reported	All	Subset†
PLAN COMPARISON SECTION		
How many plan dimensions are displayed	All	Subset‡
How plans are sorted	Alphabetically	By fit to user§
How best-fitting plan is flagged	Not flagged	"Your Best Plan" decal

† *Participants were asked their self/family coverage level and zip code.* ‡ *Plan name, metals tier, total cost and components, doctor in plan, rules to see a doctor, and quality ratings were displayed. Covered services and wellness services were not.*
§ *Plans were sorted based on a combination of relative cost, quality, doctor in plan, rules to see a doctor, and coverage. For all participants using "QuickChoice", plans were displayed in the same order with the same plan flagged as "Your Best Plan".*

UPDATE FORTHCOMING: We are conducting ongoing research on this topic. We expect to update this brief at the end of March 2013.

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Consumer Choice of Health Plan
Decision Support Rules for Health Exchanges: Issue Brief #6

Searching for Doctor in Plan & Rules to See a Doctor

Help consumers find health plans that include their doctor or have the provider choice flexibility they want. Include a provider search directory for consumers to check which plans include their preferred doctor(s). Include and explain plan rules to see a doctor (e.g., primary care provider (PCP) selection requirements, referral requirements, and specialty or tiered networks).

IMPLEMENTATION

Distinguish consumer preferences for a specific provider from preferences for flexibility in choosing and using providers by providing the option of considering either or both of these dimensions.[1] Depending upon the availability of provider-level information, Exchanges can organize information in several ways to help consumers:

- Find a doctor/clinic with whom they have an existing relationship
- Find a doctor/clinic that meets their needs
- Find a health plan whose network includes conveniently located primary care or other doctors
- Find a health plan whose rules to see a doctor match their needs

Provider search: Provider directories help consumers find specific doctors and/or doctors that meet their needs.[2] A consolidated, all-plans provider directory is more user-friendly than segregated, single-plan provider directories.

- **Consolidated, all-plans provider directory:** In an all-plans directory, provider data is centralized so that a single search returns results about a doctor's participation in each of the available plans.
    - **User Preferences:** Query consumers about their interest in a specific doctor/clinic or type of doctor. If consumers indicate interest, an interface should appear for consumers to enter their search criteria.
        - To help consumers find particular providers, they should be able to search by provider name(s) or practice/clinic name or address. Ideally this would work as a type-down that displays matching names and practice addresses so that consumers can confirm a match.
        - To help consumers find providers that meet their needs, they should be able to search by many criteria, such as commercial/Medicaid, health plan, location, specialty, and language.[3]

[1] We do not recommend using doctor in plan or rules to see a doctor as initial plan filters or sorts because doing so may inadvertently exclude low-cost options (for more details, see Issue Brief #3). These dimensions can be used as optional filters or sorts once consumers have already seen the initial plan display.

[2] Provider search functionality should either include information about whether the doctor/clinic is accepting new patients through the specified health plan or encourage consumers to contact the doctor/clinic to inquire.

[3] If state-wide provider-level quality ratings are available, a consolidated provider directory can also help consumers find high-quality providers. This would require incorporating quality information from a multi-payer database program, state quality improvement initiatives, and/or quality performance collaboratives into the provider directory.

- **Plan Comparison:** Because of its importance to many consumers, doctor in plan information should be emphasized. For example, if plans are displayed in a column format, there should be a designated row (e.g., a "Doctor(s) in Plan" row) near the top of the plan display.
    - For consumers who indicated interest, the "Doctor(s) in Plan" row should be expanded (i.e., showing the doctor search results) when consumers first arrive at the Plan Comparison.
        - If consumers searched for specific providers, indicate the search results for each plan (e.g., "Dr. John Doe in plan" or "your doctor not found").
        - If consumers searched for specific provider needs, indicate, for each plan, the number of providers meeting the search criteria. For example, a search for convenient access could indicate the concentration of specified provider types in consumers' geographic area (e.g., the number of pediatricians in a 5-mile radius from consumers' zip code).
    - For consumer who did not indicate interest, the "Doctor(s) in Plan" row should be collapsed when consumers first arrive at the Plan Comparison. If consumers expand this row, they should be notified about the provider search functionality, whether they are able to search directly in the Plan Comparison or by returning to the User Preferences.

- **Single-plan provider directories:** In segregated, single-plan directories, provider data is maintained separately by each plan – a single search returns results about a doctor's participation in that one plan only. Separate searches must be conducted for each plan of interest.
    - **User Preferences:** Query consumers about their interest in doctor in plan.
    - **Plan Comparison:** Because of its importance to many consumers, doctor in plan information should be emphasized. For example, if plans are displayed in a column format, there should be a designated row (e.g., a "Doctor(s) in Plan" row) near the top of the plan display. This row should include links to the provider directory for each plan.
        - For consumers who indicated interest, the row should be expanded (i.e., showing the directory links) when consumers first arrive at the Plan Comparison.
        - For consumer who did not indicate interest, the row should be collapsed (i.e., not showing the directory links) when consumers first arrive at the Plan Comparison

Plan rules to see a doctor: Explanations about plan rules to see a doctor can help interested consumers understand plan requirements, like PCP selection requirements, referral requirements, and specialty or tiered networks.

- **User Preferences:** Query consumers about their interest in plan rules to see a doctor.
- **Plan Comparison:** Because of its importance to many consumers, plan rules to see a doctor should be emphasized. For example, if plans are displayed in a column format, there should be a designated row (e.g., a "Getting Care" row) near the top of the plan display.
    - For consumers who indicated interest, the row should be expanded (i.e., showing information about plan rules) when consumers first arrive at the Plan Comparison.[4] Because plan rules are difficult for consumers to understand, include tools (e.g., in-line glossary) to help consumers understand the differences between plans.[5]
    - For consumer who did not indicate interest, the row should be collapsed when consumers first arrive at the Plan Comparison.

[4] Consumers should have the option to drill down for details, such as: a) specialty care networks that restrict access either via an authorization process (e.g., specialty referral/authorization rules) or a limited network (e.g., pharmacy, vision, behavioral health, centers of excellence), b) provider services such as languages spoken and interpreter availability, and c) pharmacy network services such as mail-order, specialty drugs, and online medication purchasing. These details can be presented in secondary displays (e.g., side-by-side comparison of plans or single, plan-specific details pages).

[5] Because rules to see a doctor are complex, special approaches may be required to simplify them (for details, see Issue Brief #9).

RATIONALE

Emphasize important dimensions: Our research indicates that consumers commonly cite doctor in plan and rules to see a doctor as important dimensions of plan choice. For many consumers, doctor in plan is a threshold attribute that determines whether they will consider a given plan. Thus, provider search functionality and information about plan rules to see a doctor should be included and emphasized in plan choice decision support.

Meet consumer preferences: Provider search and rules to see a doctor can help consumers who want to continue an existing doctor relationship, families whose members span commercial and Medicaid program eligibility and want to have access to the same provider(s), and consumers with fluctuating income who want to ensure continuity of providers across commercial and Medicaid plans.[6]

Reduce decision burden: Without a consolidated provider directory, interested consumers must separately search each relevant plan's provider directory. Not only is this sequential search more time consuming than a single, simultaneous search, it is also more cognitively taxing because consumers must remember or record the search results for each plan. Since provider directories are not standardized across plans, consumers face the added difficulty of navigating markedly different provider search experiences (e.g., learning how to search and what results mean). In the face of such difficulties, consumers may consider fewer plans or focus on less important, but easier to compare plan dimensions.

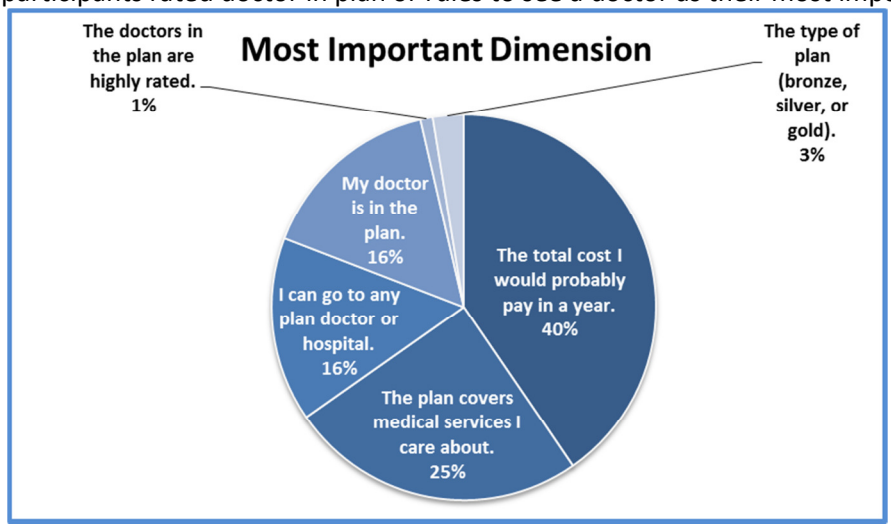
RESEARCH EVIDENCE

Our research indicates that doctor in plan and rules to see a doctor are important topics for many consumers. Our research also indicates that rules to see a doctor is a difficult topic to understand.

Participants used our online plan choice decision support tool to select a health plan. Although this choice was hypothetical, the health plans were based on real-world plan data and participants were asked to "make [their] medical plan choice as if it were [their] actual plan choice". Participants' preferences were queried in the User Preferences section. They then selected a plan in the Plan Comparison section. Finally, they completed a post-choice questionnaire.

Importance of doctor topics. After selecting a plan, participants were shown a list of six plan dimensions and asked to mark their top dimension. Following total cost and covered services, rules to see a doctor and doctor in plan were the next most popular dimensions (Chart 1).

Chart 1. Many participants rated doctor in plan or rules to see a doctor as their most important plan dimension.

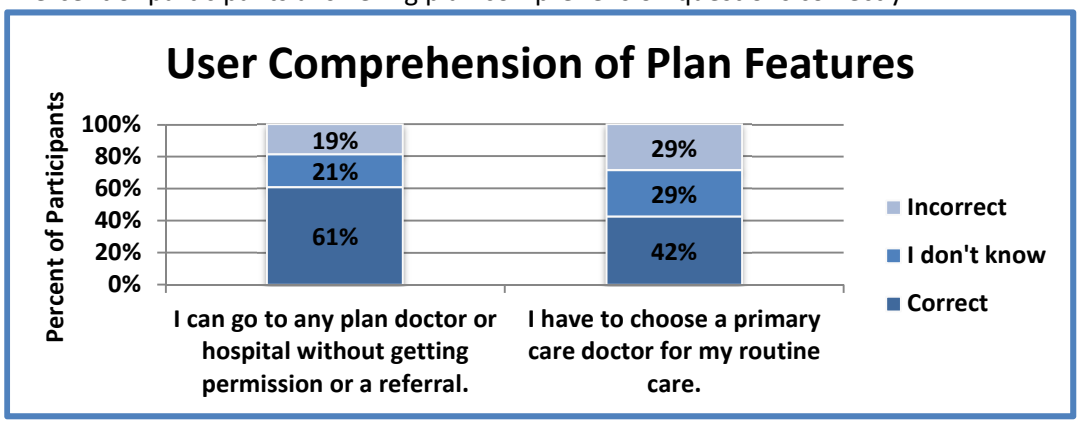


[6] Among adults whose household incomes are below 200% of the federal poverty level, as many as 50% may experience one or more changes in eligibility between commercial and Medicaid plans in a single year (Sommers & Rosenbaum, 2011).

Decision burden. Research with employees from large businesses indicates that an all-plans provider search directory offers substantial time savings. Compared to consumers using a consolidated directory, consumers using stand-alone directories for each plan spent, on average, 3.3 times as long using the provider search function (PBGH Plan Chooser).

Comprehension of rules to see a doctor. When asked to rate how easy or difficult plan dimensions were to understand, participants reported that plan rules to see a doctor were the most difficult dimension to understand. We also asked participants factual questions about their selected plan and scored their answers against the actual features of that plan. Interestingly, participants tended to understand referral requirements better than PCP selection requirements (Chart 2). These findings echo other work indicating that consumers have trouble understanding rules to see a doctor (PBGH Plan Chooser). Given that Exchange enrollee populations will include large numbers of previously uninsured consumers and consumers with intermittent coverage, it is likely that many Exchange consumers will not have had experience with managed care plans and rules to choose and use doctors will be perplexing.

Chart 2. Percent of participants answering plan comprehension questions correctly.



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For more information or other recommendations for plan choice decision support, including additional issue briefs and an in-depth report, visit http://www.pbgh.org/exchange-plan-choice or contact Ted von Glahn (tglahn@pbgh.org).

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PBGH
PACIFIC BUSINESS GROUP ON HEALTH

Consumer Choice of Health Plan
Decision Support Rules for Health Exchanges: Issue Brief #9

Communicating Difficult Concepts

Use multiple approaches to communicate difficult concepts. Choosing a plan is a difficult task in part due to the large number of unfamiliar and/or confusing concepts. To reach the largest number of consumers, communicate key concepts via multiple methods.[1] Appropriate assistance varies by concept, but can include techniques, such as in-line definitions, to explain unfamiliar terms and special approaches, like calculators, to summarize complex information.

IMPLEMENTATION

Simplify complex concepts: Special approaches may be required to simplify and communicate particularly complicated concepts. Our research has identified five such concepts and also suggested approaches to address them.

- **Rules to see a doctor:** Organize rules about choosing and using providers so that consumers can single out a particular rule or consider the full set. Simplifying rules helps consumers understand how different plans affect their ability to get care. This may be especially important for: i) families whose members span commercial and Medicaid program eligibility and want to have access to the same provider(s), and ii) consumers with fluctuating income who want to ensure continuity of providers across commercial and Medicaid plans.[2]
    - Group rules into a topic area that most consumers readily understand – getting care.
    - Within this group, parse rules into component requirements:
        - Primary care provider (PCP) election requirements
        - Doctor or service referral/authorization requirements
        - Access to care for specialty networks (e.g., behavioral health)
        - Seeing providers in high-value networks
    - Particular attention should be given to high-value networks as many consumers equate narrow networks, available at a lower cost share, with inferior quality.
- **Cost at time of care:** Include a calculator that computes estimated cost at time of care given the plan's covered benefits and the consumer's expected medical services use.[3] Combine this cost with the plan's premium net of any tax credit to provide a total cost estimate. By giving consumers a single, easy-to-compare total cost number for each plan, calculators overcome the complexities of numerous covered services categories and their associated cost-sharing amounts.
    - Explain how the calculator works (i.e., how cost at time of care is estimated).
    - Encourage consumers to consider checking "what ifs" (i.e., worst case scenarios) to better understand their potential cost sharing obligation if considerable medical services are needed.

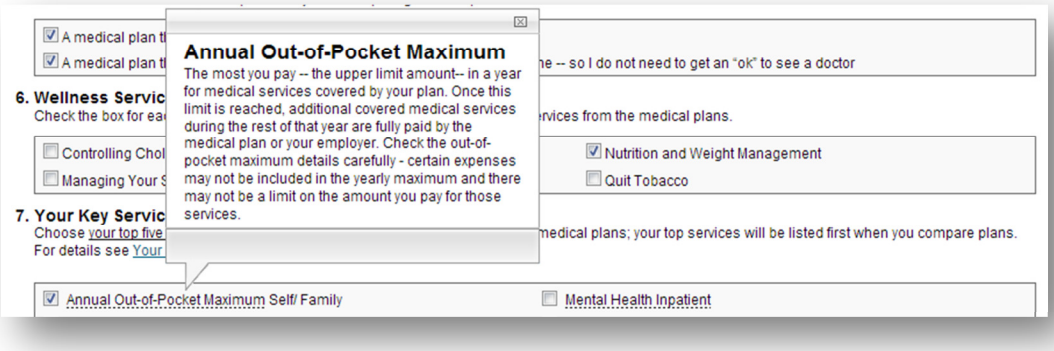
[1] This brief does not address in-person or phone assistance from assistors, customer service representatives, or other persons.
[2] Among adults whose household incomes are below 200% of the federal poverty level, as many as 50% may experience one or more changes in eligibility between commercial and Medicaid plans in a single year (Sommers & Rosenbaum, 2011).
[3] If there is no cost calculator, annual out-of-pocket maximum can serve as a blunt "what if" guide. However, consumers should be alerted to excluded services or costs, such as non-participating provider fees exceeding the plan's allowed amount.

- **Quality ratings:** To communicate quality ratings, use a single, familiar metric, such as stars or "thumbs up" icons. Include a legend that reflects the ratings' nature (e.g., "better" to "worse" for relative ratings and "poor" to "excellent" for absolute ratings), displays the possible range (e.g., 0 to 5 stars), and appears in close proximity to the ratings display. Converting performance scores into quality ratings overcomes consumers' struggle to understand quality information by standardizing scores and avoiding difficult numerical concepts, like percents.
- **Product type:** Avoid focusing consumers' attention on product type labels, like HMO, PPO, HDHP, etc. Instead highlight how plans compare on dimensions that matter to consumers, such as plan rules to see a doctor, key differences in provider networks, covered benefits, and estimated yearly cost at time of care. Deemphasizing product type labels helps consumers focus on key dimensions.
    - High-deductible health plans (HDHPs) may be particularly difficult to understand. Consumers who select a HDHP could be shown an alert warning them about potentially high costs should they experience unanticipated medical services use (e.g., "In this plan, you are responsible for more of the costs when you use medical services. If you have unexpected health care needs, you may have to pay as much as $<deductible amount> before your insurance coverage starts.").
- **Metals tier:** Avoid focusing consumers' attention on metals tiers and instead use cost calculators to emphasize how the available plans compare on estimated yearly total cost.[4] Positioning metals tiers labels as secondary or less prominent information allows metals tiers to be used to further organize and compare health plans without requiring consumers to grapple with yet another health insurance concept.

Explain difficult concepts: Communicate important concepts clearly and via multiple channels. This may include reaching out to consumers to educate them about difficult concepts before they start the process of choosing a plan and continuing this education throughout plan choice. In all communications, text should be written in plain English and targeted toward readers with sixth-grade reading levels.

- **Key terms:** Explain key terms using in-line definitions (Figure 1) and an easy-to-access glossary and/or FAQ section. (For a sample glossary with strawman language, see the Appendix.)

Figure 1. Hovering the cursor over an underlined term produces a pop-up definition.



RATIONALE

Meet user preferences: Our research indicates that consumers struggle with some plan choice concepts more than others. Interventions to explain and/or simplify difficult concepts can improve consumers' understanding of the available plans and their ability to find health plans that fit their needs.

Help vulnerable populations: Our research indicates that health insurance literacy (i.e., comprehension of health insurance terminology) and plan comprehension (i.e., understanding of the selected plan) are lower among consumers who have never been insured and consumers with low numerical ability. Interventions to explain or simplify difficult concepts may be especially helpful for these and other vulnerable populations.

[4] If there is no cost calculator, emphasize metals tiers tradeoffs – higher benefits coverage and higher premiums go hand-in-hand.

RESEARCH EVIDENCE

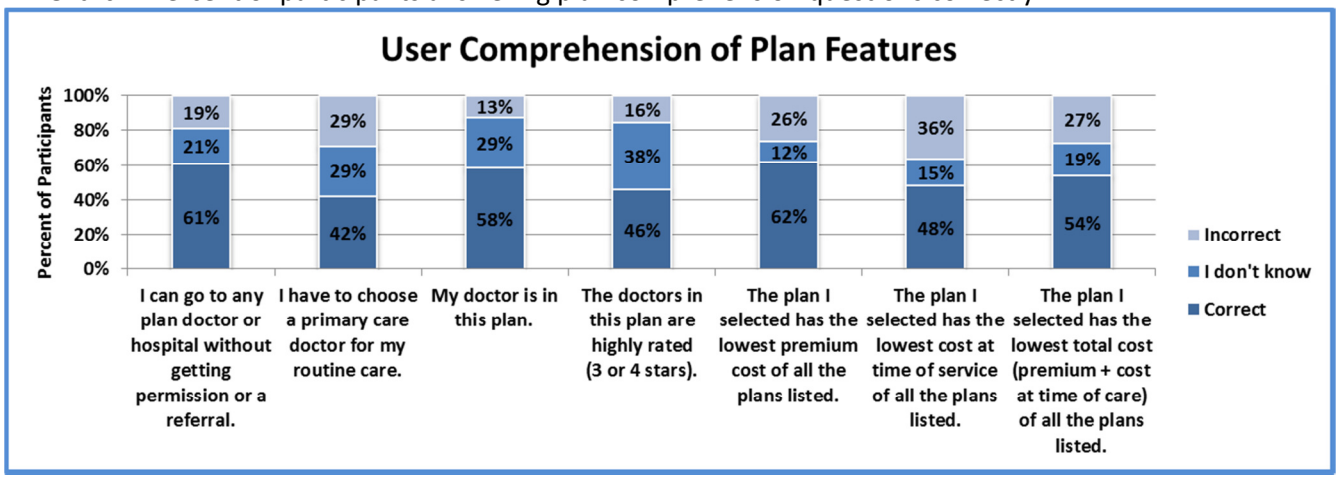
Our research confirms that consumers struggle with certain health insurance concepts.

Across four of the studies, participants (N = 1116) used our online plan choice decision support tool to select a health plan. Although this choice was hypothetical, the health plans were based on real-world plan data and participants were asked to "make [their] medical plan choice as if it were [their] actual plan choice". Participants' preferences were queried in the User Preferences section. They then selected a plan in the Plan Comparison section. Finally, they completed a post-choice questionnaire.

We assessed plan comprehension using two metrics. First, we asked participants to rate plan dimensions based on how easy or difficult they were to understand. Second, we asked participants factual questions about their selected plan and scored their answers against the actual features of that plan.

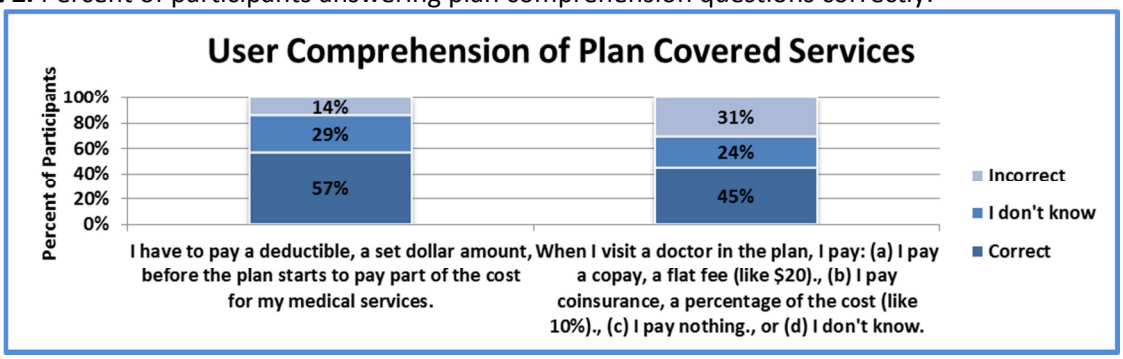
Rules to See a Doctor: Participants reported that rules to see a doctor were the most difficult dimension to understand, followed by cost at time of care and doctor quality ratings. This mirrors other work indicating that consumers have trouble understanding plan rules to see a doctor (PBGH Plan Chooser). Interestingly, participants' tended to understand referral requirements better than PCP selection requirements (Chart 1).

Chart 1. Percent of participants answering plan comprehension questions correctly.



Cost at Time of Care: Cost at time of care is another difficult concept. To manually estimate cost at time of care, consumers must understand many health insurance concepts (such as copay, coinsurance, deductible, and annual out-of-pocket maximum), how these apply to their plan, and how to process the relevant numbers based on their expected health care needs for the following year. Our research indicates that many participants struggle with understanding the necessary cost-sharing concepts (Chart 2).

Chart 2. Percent of participants answering plan comprehension questions correctly.



A cost at time of care calculator sidesteps this issue because it automatically processes the relevant numbers, which means that consumers do not need to comprehend the array of insurance terms, nor do they need to perform any math. A total cost calculator that computes an estimate of annual total cost gives consumers a single cost value for each plan that can be straightforwardly compared. Cost calculators may be especially helpful for vulnerable populations, such as those who have never been insured, the less literate, the less health insurance literate, and the less numerate.

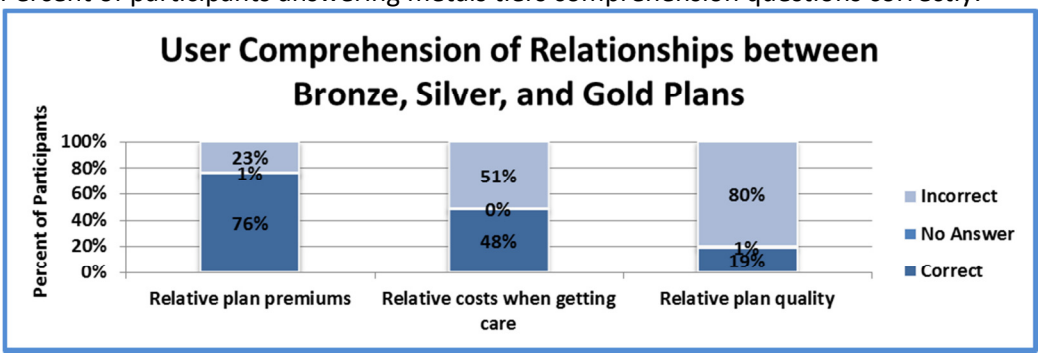
Our research indicates that a cost at time of care calculator is helpful, but not sufficient: Even when cost at time of care was estimated by a calculator, many participants' did not understand their plan's relative cost at time of care (Chart 1). Other work has found that explaining how the calculator works (i.e., how cost at time of care is estimated) helps consumers better understand cost at time of care and identify high value health plans (Johnson et al., 2012).

Quality Ratings: Many participants did not understand quality ratings (Chart 1). This is consistent with work indicating that quality ratings are not communicated clearly (Hibbard et al., 2012; Sinaiko et al., 2012), underused by consumers (Quincy, 2012; Kolstad & Chernew, 2008), and particularly difficult for different cultural groups (Derose et al., 2007).

Product Type: PBGH's experience with the Plan Chooser has shown that consumers have a hard time understanding the differences between different benefit structures (e.g., high deductible, fixed copay, personal account plans, etc.).

Metals Tier: Many participants did not have a firm understanding of the metals tiers (Chart 3).[5] Roughly three-quarters of participants (76%) correctly understood the relative premium differences across tiers (i.e., bronze plans have lower premiums and gold plans have higher premiums), but only half of participants (48%) correctly understood how cost at time of care changes across tiers (i.e., bronze plans have higher costs and gold plans have lower costs). Even fewer participants (19%) understood that plan quality ratings are independent of tier. Importantly, half of participants (51%) incorrectly believed that quality increased across tiers such that gold plans are higher quality than bronze plans.

Chart 3. Percent of participants answering metals tiers comprehension questions correctly.



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[5] We did not include platinum plans in these studies. Participants were asked how gold plans compare to silver and bronze plans, or how bronze plans compare to silver and gold plans.

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APPENDIX

Table 1. Sample list of important concepts and strawman language to illustrate needed content.

Concept	Explanation
Plan Type[6]	
Metals tier	These plans differ on the monthly insurance premium you pay and on how much you spend when you get medical services.
Bronze	Bronze plans have the lowest monthly premium cost. However, your coverage is lower – you pay more when you get medical services compared to other plans.
Silver	Silver plans are in the middle between Bronze and Gold plans. Your monthly premium cost falls between the Bronze and Gold plans. When you get medical services you pay less compared to Bronze plans but you pay more compared to Gold plans.
Gold	Gold plans are in the middle between Silver and Platinum plans. Your monthly premium cost falls between the Silver and Platinum plans. When you get medical services you pay less compared to Silver plans but you pay more compared to Platinum plans.
Platinum	Platinum plans have the highest monthly premium cost. However, your coverage is higher – you pay less when you get medical services compared to other plans.
Product Type	
Cost sharing reduction plans (CSR)	Medical plans that provide more savings for lower income individuals or families. You pay less when you get care under these plans. Be sure to double check your expected income that you listed – your income must be below <specify $ amount or reference info> to be eligible for these medical plans.
Consumer directed health plan/health reimbursement account	The medical plan includes money that your employer puts in an account, called a health reimbursement account (HRA), that you use to pay for eligible medical expenses. If you spend all of your HRA money, you pay for your share of additional medical expenses like you would in a regular health plan. Any remaining money in the account at year-end is added to your HRA next year if you re-enroll in the plan. You cannot "cash out" HRA money.

[6] Rule contingent on Exchange decision regarding cost at time of care calculator. For concepts such as metals tier and product type, the best approach may be to emphasize how plans compare on cost components.

High deductible health plan/health savings account	In a High Deductible Health Plan you pay a lower monthly premium but it has a higher deductible, which means you pay all medical costs up to the deductible level before the plan begins to pay for any medical services. You can set aside tax-free funds in a Health Savings Account (HSA). You can use this account to pay for qualified medical expenses, including deductibles, coinsurance, and other costs. If you have money in the HSA account at year-end, you keep those dollars and can use them for future health care expenses.
HMO	An HMO (Health Maintenance Organization) is a type of medical plan in which you use a limited set of doctors, hospitals, and other providers. Typically, you choose a primary care physician (PCP) who is your regular doctor and refers you to specialists for any other care. If you get care from a provider who does not belong to the HMO, often you pay the full cost.
PPO	A PPO (Preferred Provider Organization) is a type of medical plan in which you can decide which doctor or other provider you see when you get medical care. You choose providers from the PPO list of 'network' doctors and hospitals. For example, you may choose to see a doctor that belongs to the medical plan (a 'network provider') or see a 'non-network provider'. You pay less when you use network providers, but you pay more when you use non-network providers.
Doctor in Plan	
PCP	Primary Care Physician or Primary Care Provider (PCP) is the regular, personal doctor for many people. Typically, people see this doctor for their check-ups, preventive screenings, and other routine care. People with serious health problems often see a specialist doctor in addition to their PCP. Many HMOs require each member to have a PCP.
Provider directory	A listing of doctors, hospitals, and other health care providers who belong to a medical plan. You pay less for 'in-network providers' compared to those providers who do not belong to the plan.
Rules to See a Doctor	
Preferred provider	Doctors, hospitals, laboratories, and other health care professionals and facilities that belong to a medical plan. Typically, these providers agree to medical service fees and the provider cannot bill the patient for any amount higher than that fee. You pay less when seeing providers that belong to your medical plan. Check if the plan has rules about which in-network providers you can see, or if the plan has a "tiered" network and you pay extra to see some providers.
Non-preferred provider	Doctors, hospitals, laboratories, and other health care professionals and facilities that do not belong to a medical plan. You pay more for non-preferred providers than you pay for preferred providers.
Specialist	A physician specialist treats patients who have certain types of health problems – like a heart condition or a lung disorder. Check the plan's rules to see if you need a referral, an "ok", to see a specialist.
In-network	Doctors, hospitals, laboratories, and other health care providers who belong to a medical plan. You pay less for 'in-network providers' compared to those providers who do not belong to the plan. Check if the plan has rules about which in-network providers you can see, or if the plan has a "tiered" network and you pay extra to see some providers.
Out-of-network	Doctors, hospitals, laboratories, and other health care providers who do not belong to the medical plan. You pay more for 'out-of-network providers' compared to those providers who belong to the plan.
Plan Cost Estimates[7]	These are estimated costs only - your actual costs will be different. Use these cost estimates as a general guide for the differences among plans. These cost estimates come from the information you provided. To see how these estimated costs change if your expected income, use of medical services, or use of prescription drugs is different, change your selections <add language explaining how to change these selections in User Preferences or Plan Comparison>.

[7] Rule contingent on Exchange decision regarding cost at time of care calculator. For concepts such as metals tier and product type, the best approach may be to emphasize how plans compare on cost components.

Cost at time of care	The estimated cost you pay when you get care -- like when you see a doctor or buy a medication. This is an estimate only -- it is based on the medical service and prescription drug use that you expect in the next year. This estimate assumes that you use network providers *only. If you use providers that do not belong to the plan, your costs are higher.* And, this estimate does not include costs for services that are not covered under the medical plan.
Premium	The cost of the medical plan. Typically, you make monthly payments to cover your share of the premium.
Tax credit	Your premium is reduced by this amount. This tax cut helps middle- and low-income people afford health insurance by paying a tax credit that reduces your cost for the medical plan. This is an estimate only -- it is based on the expected income that you listed for next year.
Total cost	The estimated cost you pay for the medical plan in a year. Your monthly premium cost plus the estimated cost you pay when you get care. This is an estimate only -- it is based on the information you provided. <Add language tailored to information user provides re expected income/tax credit, medical service use etc.>
Covered Services	A service that the medical plan provides to its members and pays a part or all of the cost. Often, you pay a share of the cost for a covered service, too.
Essential health benefits	Covered services that must be included in all of the medical plans offered in the Exchange. Your share of the cost can differ across the medical plans but every plan will include coverage for these services like routine preventive care, hospital stays, emergency services, and medications.
Out-of-pocket maximum	The most you would pay for your share of the costs of covered medical expenses in a year. Once this limit is reached, covered medical services received during the rest of that year are fully paid by the medical plan. Check the plan's yearly maximum carefully -- certain expenses may not be included in the yearly maximum and there may not be a limit on the amount you pay for those services.
Deductible	The amount you pay each year before the plan begins to pay any part of the cost of covered services. For example, if the deductible is $500, you pay all of the costs for your medical services up to $500 before the medical plan coverage starts; then, typically the medical plan pays for services though you pay a share of those costs, too. Check the plan's deductible carefully - certain expenses may not count toward the deductible and there may not be a limit on the amount you pay for those services.
Chiropractic/ acupuncture visit	Chiropractic services are provided by a licensed chiropractor to manage neuromusculoskeletal conditions through manipulation and related physiological treatment of joints to restore motion, reduce pain, and improve function. Acupuncture services are provided by a medical practitioner who specializes in acupuncture, which is part of a centuries-old medical system, Traditional Chinese Medicine (TCM). The practitioner is trained in one or more of the TCM interventions including needles (acupuncture), Qigong, and heat and touch (acupressure). The treatments are based on understanding the flow of energy (Qi) in the body and improving its flow to restore health.
Doctor office visit	A visit to a physician's office on an outpatient basis.
Emergency care	Health care services, delivered in an emergency service setting, that are required to treat a sudden, unexpected injury or serious sickness which could be expected to result in serious complications, permanent impairment, or death unless given immediate medical attention. For example, a heart attack, stroke, severe bleeding, shock, or allergic or sudden reactions to drugs.
Home health visit	Health care services a person receives at home.
Hospice	Services to provide comfort and support for someone who is in the last stages of a terminal illness.
Hospital stay	When a person is admitted to a hospital for care of a medical condition for an overnight stay of one or more days. The hospital is an institution with organized facilities for diagnosing and treating medical conditions and providing 24-hour nursing service and medical supervision.
Lab and radiology	Services include diagnostic lab tests and x-ray procedures including diagnostic imaging.
Maternity office visit	A physician office visit by a woman for care related to pregnancy and the delivery of a newborn child.

Mental health: Inpatient	A hospital, residential treatment center, partial hospitalization program, or other mental health care facility that is licensed by the state to provide acute or intensive psychiatric care, detoxification services, or chemical dependency rehabilitation services.
Mental health: Outpatient	A structured outpatient program, day treatment, partial hospitalization program, or other mental health care facility that is licensed by the state to provide acute or intensive psychiatric care, detoxification services, or chemical dependency rehabilitation services.
Outpatient therapy visit	Treatment under the direction of a physician and provided by a licensed or certified therapist such as a physical, speech, or occupational therapist.
Preventive care: Adult	Services include routine physical exams and listed screenings, tests, and immunizations for adults of specified ages.
Substance abuse: Inpatient	A hospital, residential treatment center, partial hospitalization program, or other mental health care facility that is licensed to provide chemical dependency detoxification services or rehabilitation services. These facilities often are known as a Chemical Dependency Treatment Facility.
Substance abuse: Outpatient	A visit on an outpatient basis for the treatment of alcoholism, drug addiction, or other chemical dependency problems.
Surgeon	Surgical services delivered by a licensed surgeon in either an inpatient hospital or outpatient setting.
Well baby visit	Services include routine physical exams and listed screenings, tests, and immunizations for infants and children of specified ages.
Prescription Drugs	
Brand-name drug	A drug that is made by a single company under a patent and costs more than the equivalent generic drug.
Formulary	A list of drugs included in the services paid by the medical plan. If a drug is not on the formulary list, you pay more or even the full cost for the drug.
Generic drug	A prescription drug which is chemically the same as a brand-name drug but costs less. The safety and efficacy are equivalent to the brand-name drug.
Prescription: Mail-order generic/ brand/ non-formulary	Prescriptions - up to a 90-day supply - that are obtained through the mail. Drugs that are approved by the Food and Drug Administration (FDA) and require a prescription either by Federal or State law. See coverage details for other medications and supplies - such as insulin - that may be included in the prescription drug coverage. Generic drugs are sold by their chemical name after the original brand drug patent has expired; their safety and efficacy are equivalent to the brand-name drug and they cost less than the brand-name drug. Brand drugs are made by a single company under a patent and cost more than any equivalent generic drug. Non-formulary drugs are not recommended by the medical plan and typically the member pays more for these medications.
Prescription: Retail generic/ brand/ non-formulary	Prescriptions that are obtained at a retail pharmacy. Drugs that are approved by the Food and Drug Administration (FDA) and require a prescription either by Federal or State law. See coverage details for other medications and supplies - such as insulin - that may be included in the prescription drug coverage. Generic drugs are sold by their chemical name after the original brand drug patent has expired; their safety and efficacy are equivalent to the brand-name drug and they cost less than the brand-name drug. Brand drugs are made by a single company under a patent and cost more than any equivalent generic drug. Non-formulary drugs are not recommended by the medical plan and typically the member pays more for these medications.
Related Covered Services Terms	
Coinsurance	Your share of the costs of certain health care services. For example, if your coinsurance for a service is 20% and the bill is $100 -- you pay $20 and the medical plan pays the remaining $80 of that bill.

Copay	A fixed dollar amount that you pay for certain health care services, usually when you get the service. For example, if your copay for an office visit is $30 – each time you have a doctor visit you pay $30.
Allowed amount	The most a medical plan will pay for a covered service. If the doctor or other provider has not agreed to accept the allowed amount then you may have to pay any costs above that amount. Usually, the doctors and other providers who belong to the plan (in-network providers) agree to accept the allowed amount as full payment and cannot bill you more. This also may be called an “eligible expense,” “payment allowance," or "negotiated rate."
Exclusion	A health condition or service that is not included in the medical plan coverage -- you pay the entire costs for such services.
Medically necessary	Health care services or supplies needed to prevent, diagnose, or treat an illness, injury, disease, or its symptoms and that meet accepted standards of medicine.
Preauthorization	A decision by your medical plan that a healthcare service is medically necessary. Sometimes called prior authorization, prior approval, or precertification. Check the plan’s rules -- preauthorization may be required for certain services before getting care.

Public and Private Health Insurance Exchanges

PBGH Discussion Guide

February, 2012

pwc

Agenda

- ACA Public Exchanges
- New Private Exchanges
- Strategic Issues

What is a public Health Insurance Exchange ?

A Health Insurance Exchange is a new marketplace to offer and sell health insurance

The Exchange will serve the individual and small group health insurance market

- Small group up to 50 employees (Option to extend to 100 employees, but no state has chosen this option)
- Option to expand to large group in 2017 and beyond
- May operate separate or combined individual and small group exchange
- Must serve entire state
- Will compete with individual and small group health plan products outside of the Exchange

Core functions of the Exchange

- *Consumer Assistance*: Education and Outreach
- *Plan Management*: Select and Certify Qualified Health Plans (QHPs) with on-going monitoring and oversight
- *Eligibility*: Accept applications, verify eligibility for enrollment in QHPs, connect Medicaid and CHIP eligibles to those programs
- *Enrollment*: Present QHP options, Enroll consumers into QHPS, administer consumer subsidy programs
- *Financial Management:* Collect health plan user fees, support of risk adjustment, reinsurance and risk corridor programs

Exchange to be Operational by January 1, 2014

Source:

Health Plans must offer Essential Health Benefits

A Qualified Health Plan must be certified to be offered on the Exchange

Covers the Essential Health Benefits (EHB)

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance abuse disorder services
- Prescription drugs
- Rehabilitative/habilitative services
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services

Each state EHB benchmarked to an existing benefit design

- One of the three largest small group plans in the state by enrollment
- One of the three largest state employee health plans by enrollment
- One of the three largest federal employee health plan options
- The largest HMO plan offered in the state's commercial market

Most states are using the largest small group plan as their benchmark – defines the quantity of covered services

Source: National Conference of State Legislatures - American Health Benefit Exchanges

Why Important?

-Federal government has deferred to the states to define Essential Health Benefits

- In 2014, large employers will have good faith standard for essential health benefits

- After 2014, employers will need to meet the Essential Health Benefits standard in each state (including no "annual or lifetime maximum")

- Potential erosion of ERISA preemption

In 2014, Public Exchanges will simplify product comparison and increase transparency;

Actuarial Value	60%	70%	80%	90%
Monthly premiums	Lowest	Moderate	Moderate	Highest
Offer essential benefits?	Yes	Yes	Yes	Yes
Must offer in Exchange	No	At least 1 plan	At least 1 plan	No

Will vary by state

- Plans will be able to offer HMO, PPO and other plan types within each of the metallic levels, so long as the plans can achieve the actuarial value of the level
- With requirement to cover essential benefits, and limitations on out-of-pocket expenses, payers will have limited levers to differentiate their products
  - Deductible & co-insurance levels
  - Provider network
  - Ancillary offerings
  - Customer Service / Satisfaction
  - Brand
- Many of the new rules apply to the entire Individual and Small Group Markets

Why Important?

- Need to communicate
- A new "standard" for benchmarking
- Focus on "preferred networks" with differential pricing
- Potential to accelerate entry for provider based plans (i.e. ACOs)
- Will accelerate health plan focus on "consumers"

Premium subsidy by income level will be applied to the "Silver Plan" and be significant

Premium Cost Net of Tax Credit for Subsidy Eligible Individuals				
Income (percent of Federal Poverty Level)	Family Size	Annual Income (based on 2012 FPL)	Premium Cost Net of Tax Credit for the Second Lowest Cost Silver Plan	
			Percent of Income	Monthly Amount (based on 2012 FPL)
Below 133%	Single	below $14,856	2.0%	$25
	Family of 4	below $30,657		$51
133%-150%	Single	$14,856 - $16,755	3.0% - 4.0%	$37 - $56
	Family of 4	$30,657 - $34,575		$77 - $115
150%-200%	Single	$16,755 - $22,340	4.0% - 6.3%	$56 - $117
	Family of 4	$34,575 - $46,100		$115 - $242
200%-250%	Single	$22,340 - $27,925	6.3% - 8.05%	$117 - $187
	Family of 4	$46,100 - $57,625		$242 - $387
250%-300%	Single	$27,925 - $33,510	8.05% - 9.5%	$187 - $265
	Family of 4	$57,625 - $69,150		$387 - $547
300%-400%	Single	$33,510 - $44,680	9.5%	$265 - $354
	Family of 4	$69,150 - $92,200		$547 - $730

Key Observations

- Subsidies not available if employer offers 'affordable minimum coverage"

- If eligible for subsidies, individuals not impacted by the overall "level "of the premiums

- Defined contribution on the margin - subsidies are tied to the second lowest priced silver plan

- Low income individuals may be better off to maintain eligibility for subsidies in exchange.

- Particularly true for family coverage since "affordability" is based on cost of single coverage under employer

Cost sharing subsidy by income level will substantially enrich the "Silver Plan"

Reductions in Maximum Out-of-Pocket Limits and Actuarial Value Requirements for Silver Level Coverage		
Income (percent of Federal Poverty Level)	**Reduction in Maximum OOP Limit****	**Required Actuarial Value of Benefit Plan**
100%-150%	2/3	94%
150%-200%	2/3	87%
200%-250%	½	73%
250%-300%	1/2*	70%
300%-400%	1/3*	70%

*HHS has proposed to eliminate the OOP maximum reduction for incomes between 250% and 400% of FPL because the actuarial value is already equivalent to that of the Silver plan.

**The OOP Limit is to be reduced first to meet the actuarial value goal. If that reduction is insufficient, other changes in cost sharing must be made.

Key Observations

- Silver Plan (the benchmark for subsidies) gets enhanced for lowest income individuals/families

- At the lowest incomes, "Silver Plan" is more comparable to a "Platinum Plan" (which will be better than most plans offered by employers)

Many states will have the federal government directly involved in running exchanges

		Public exchanges		
		State run	**State/ Federal partnership**	**Federally Facilitated Exchange**
Core Functions	Eligibility	●	●	●
	Enrollment	●	●	●
	Customer Service	●	●	●
	Plan Management	●	●	●
	Financial Management	●	●	●

● State function ● State or federal function ● Federal function

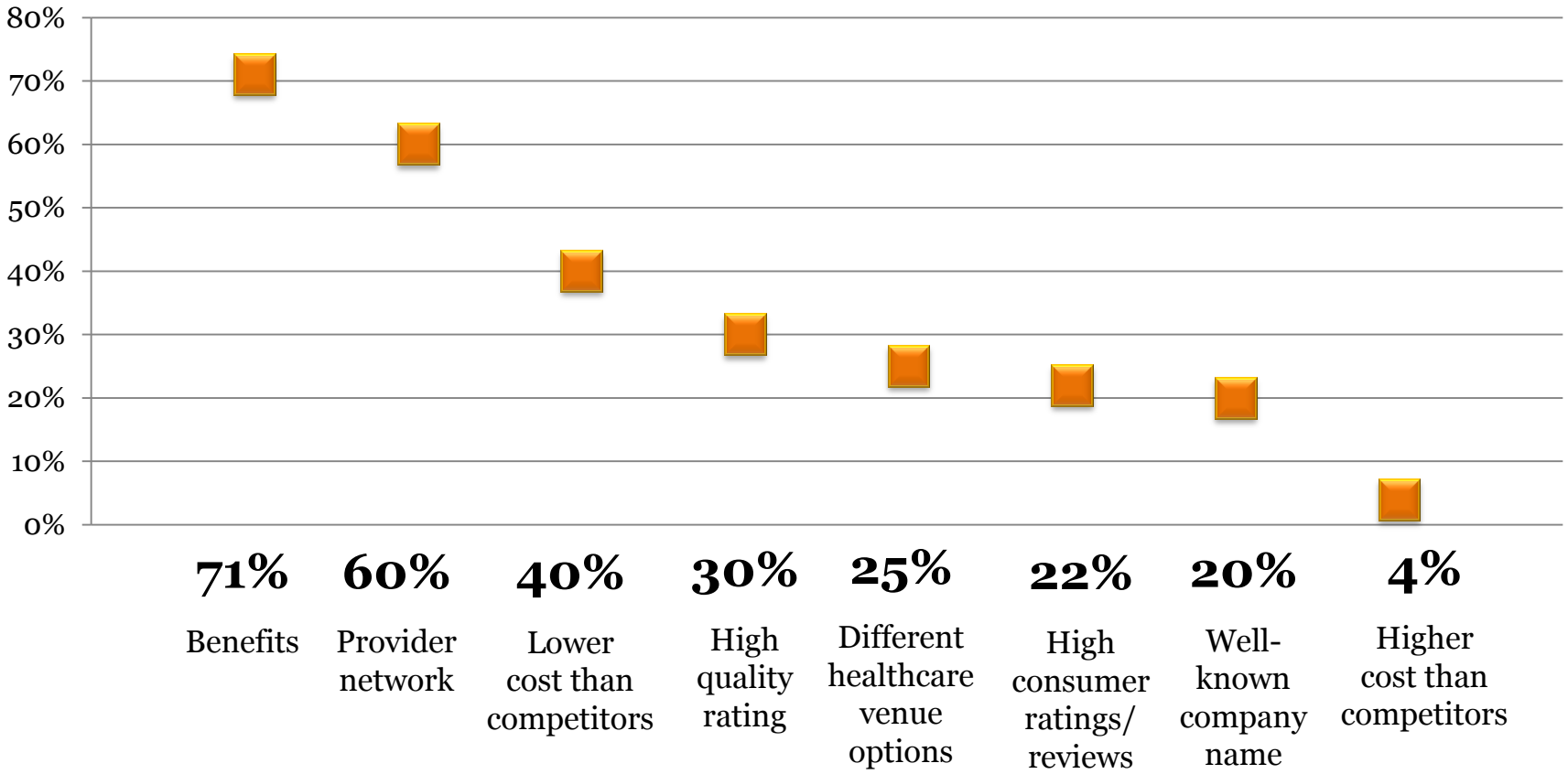
- 17 states and the District of Columbia are conditionally approved to establish their own exchanges
- Majority of remaining 34 states will have the federal government directly involved in running their exchanges
  - 31 will have a federally-facilitated exchange
  - 7 states have selected an approach that divides duties in a state/federal "partnership"

Key Observation

- State variation will make communications and coordination challenging for national employers

What will consumers value with standardized benefits?

Top characteristics that consumers look at to determine that a health plan is of high quality



Source: PwC Health Research Institute Consumer Survey, 2011

Payers will also focus on new rating rules requiring different risk management approaches

In 2014…

Health insurers are not permitted to:

- Deny coverage or charge different premiums based on a person's health or claims history.
- Charge premiums that are more than three times higher than the lowest premium, based on age, for the same product and geography.
- Spend less than 80% of premium dollars on medical expenses for the individual and small group market. If they do, they'll have to pay a rebate to members.

Health insurers are permitted to:

- Charge different rates based on geography, number of persons covered (e.g. single, family), age, and tobacco use. However, there are limitations on the premium variation for age and tobacco use.
- Charge smokers 1.5 times more the premium of a non-smoker.

Public Exchanges may be "active" or "passive"

- Every ACA public exchange must impose certain minimum standards:
  - Marketing Standards
  - Network Adequacy
  - Accreditation
  - Quality Improvement
- Most state administered exchanges will be "active purchasers"
  - Will act in role often played by major employers
- All federally facilitated exchanges will be "passive purchasers"
  - Will allow any health plans that meet minimum standards to participate

Examples of Active Purchasing

- Additional certification criteria
- Selective contracting
- Negotiation on price/quality
- Limiting the number of products
- Setting standards for cost-sharing
- Piloting new delivery system and reimbursement strategies
- Aligning with other state purchasers (i.e., Medicaid, state employee plans)
- Recruiting & assisting new market entrants
- Use of web-based decision tools to drive value-oriented decisions by consumers

Key Observation

- There is the potential for Public Exchanges to be key promoter of system change by market

There will also be federally-selected "National Plans"

- The Office of Personnel Management (OPM) will contract with two national health plans (at least one of which must be not for profit) that will be offered through all public exchanges
- State Qualified Health Plan criteria that are more stringent than federal criteria will not apply to these plans
- Since the plans have not yet been created and most states haven't defined QHP criteria, it is unknown whether this will result in important differences in criteria

Key Observation

- Since these plans will be universal, there will be potential to benchmark them nationally

In addition to the "Individual" Public Exchange, there will be a "SHOP" Exchange

- "SHOP " = Small Business Health Options Program
  - Initially the SHOP exchange can serve firms with up to 100 employees
  - Most States will initially limit eligibility up to 50 employees

- States are given significant flexibility to determine how to design and implement the SHOP exchange
  - May be merged with the individual exchanges
  - Rating practices may vary by states

- Beginning in 2017, states may allow employers with over 100 employees to purchase health plans through the SHOP exchange

Key Observations

- SHOP Exchanges "may" open up to large employers in 2017

- Variations by state will complicate how a national employer would participate

- Some states may elect not open up to large employers

- Unclear how this will be impacted by HRA regulations or how employer subsidies would be administered

Potential ACA Exchange Concerns

- Potential Implementation Delays
  - Fewer than 20 states will have a state-based exchange ready for 10/1/13 open enrollment
  - HHS to establish 30+ exchanges by 2014
  - Unclear whether the federal data hub will be ready for 10/1/13
  - Without information from hub, exchanges cannot make eligibility determinations
- Premiums in exchange too expensive?
  - Will Risk Adjustment and rating rules be sufficient to mitigate against adverse selection
  - Exchanges must be self-supporting by 2015; health plans will pay participation fees of about 3.5% of premium

Key Observations

- Some risk to "plan on" Exchanges being ready by 1/1/2014

- Not clear how premiums will ultimately shake out in individual market

- These risks could affect sustainability of subsidies, future employer assessments

- Still strong potential to support under 30 hour part time workers and early retirees

Large Employer obligations related to the public Exchange

- Provide minimum qualified benefits and premium contribution, or pay penalty
  - Single premium can cost no more than 9.5% of income; no restrictions on family premium
- Inform employees about Exchange availability
  - Department of Labor will provide guidance after March 1, 2013

Key Observations

- Although large employers cannot directly participate in public exchanges, some of their employees may

-Penalties may accrue to large employers if their employees access subsidies through the public exchange

Agenda

- ACA Public Exchanges
- New Private Exchanges
- Strategic Issues

What is a Private Exchange?

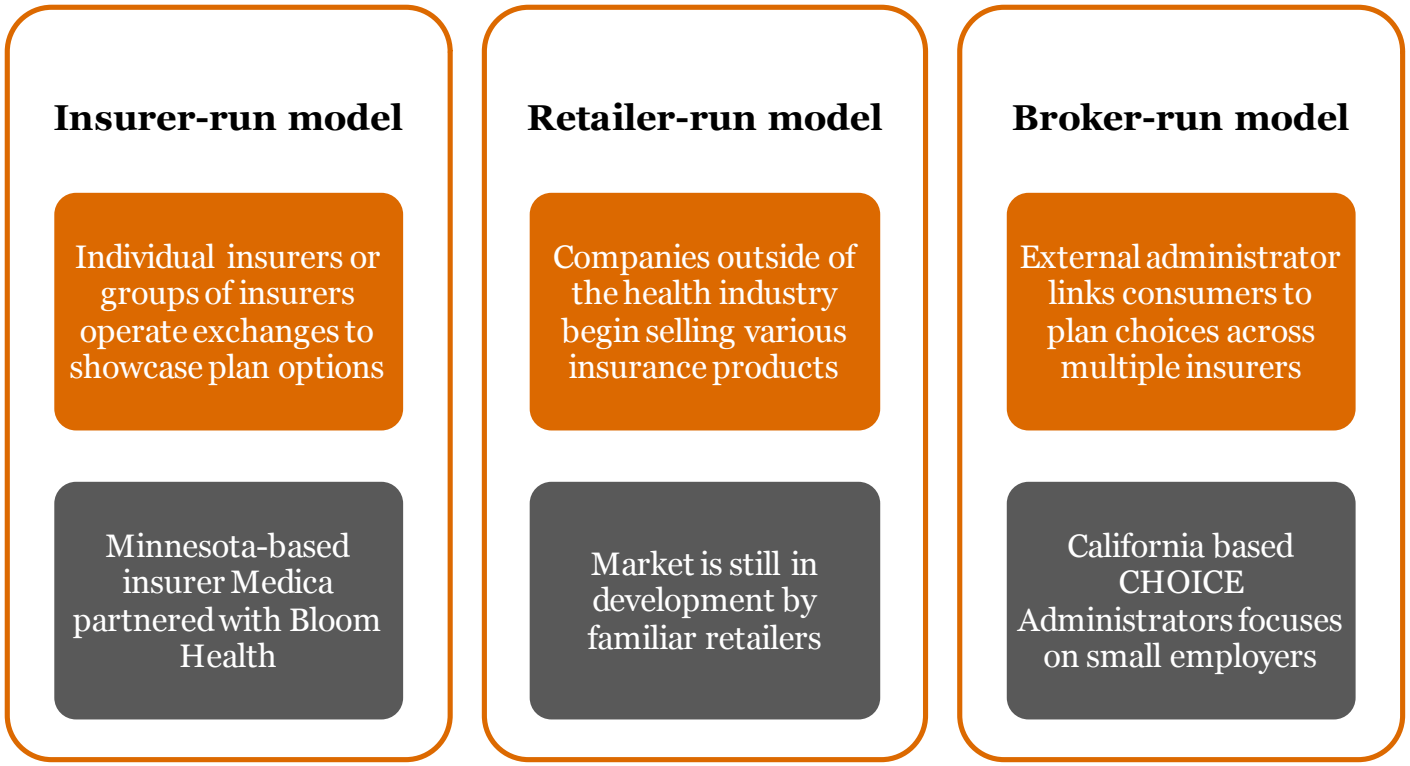
- Like the public exchanges, private exchanges offer an organized market place for health insurance plans with multiple designs and price points

- Unlike the public exchanges, private exchanges:
  - Are sponsored and managed in the private sector
  - May be offered on a "group" or "individual" basis (see impact of HRA regulation below)
  - Not directly eligible for government subsidies
  - May accept large employer sponsors and related employer subsidies

Key Observations

- Private Exchanges are potential vehicles to Defined Contribution in Health Care Benefits
- Private Exchanges may be key to simplifying emerging variations by market and leveraging new local solutions
- No two private exchanges are alike

Emerging private exchanges are being run by insurers, retailers or brokers



Key Observations

- The business model can be substantially different depending on the private exchange sponsor

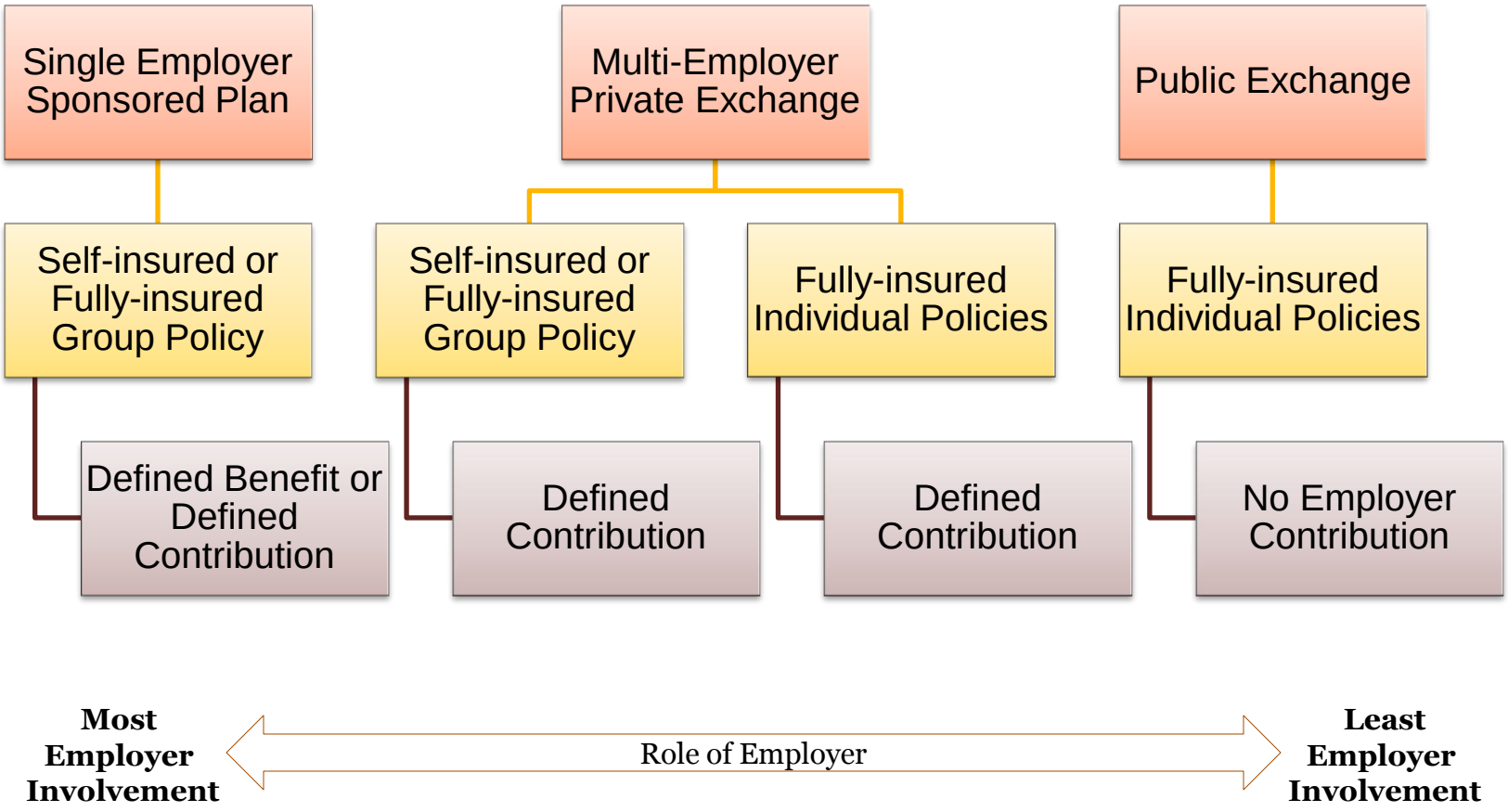
Potential Private Coordination with Public Exchanges

- "Agent/broker" may assist with enrollment into Public Exchange
  - facilitate access to related subsidies and reduced cost sharing
- Potential Interface:
  - Ensure applicant's completion of eligibility verification and enrollment application through Public Exchange Web site
  - the Public Exchange transmits enrollment info to the health plan issuer
- Minimum Requirements:
  - meet disclosure and display standards for health plan information (standardized comparative information on each available health plan)
  - provide consumers the ability to view all health plans offered through the Public Exchange
  - not provide financial incentives, such as rebates or giveaways
  - display all health data provided by the Exchange
  - maintain audit trails and records in an electronic format
  - provide consumers with the ability to use the Public Exchange Web site instead at any time

Key Observations

- Private Exchanges will not have access to public subsidies directly
- Private Exchanges may facilitate enrollment into the public exchanges
- Unclear whether employers will seek this service or private exchanges will provide

New Landscape for Healthcare Benefits



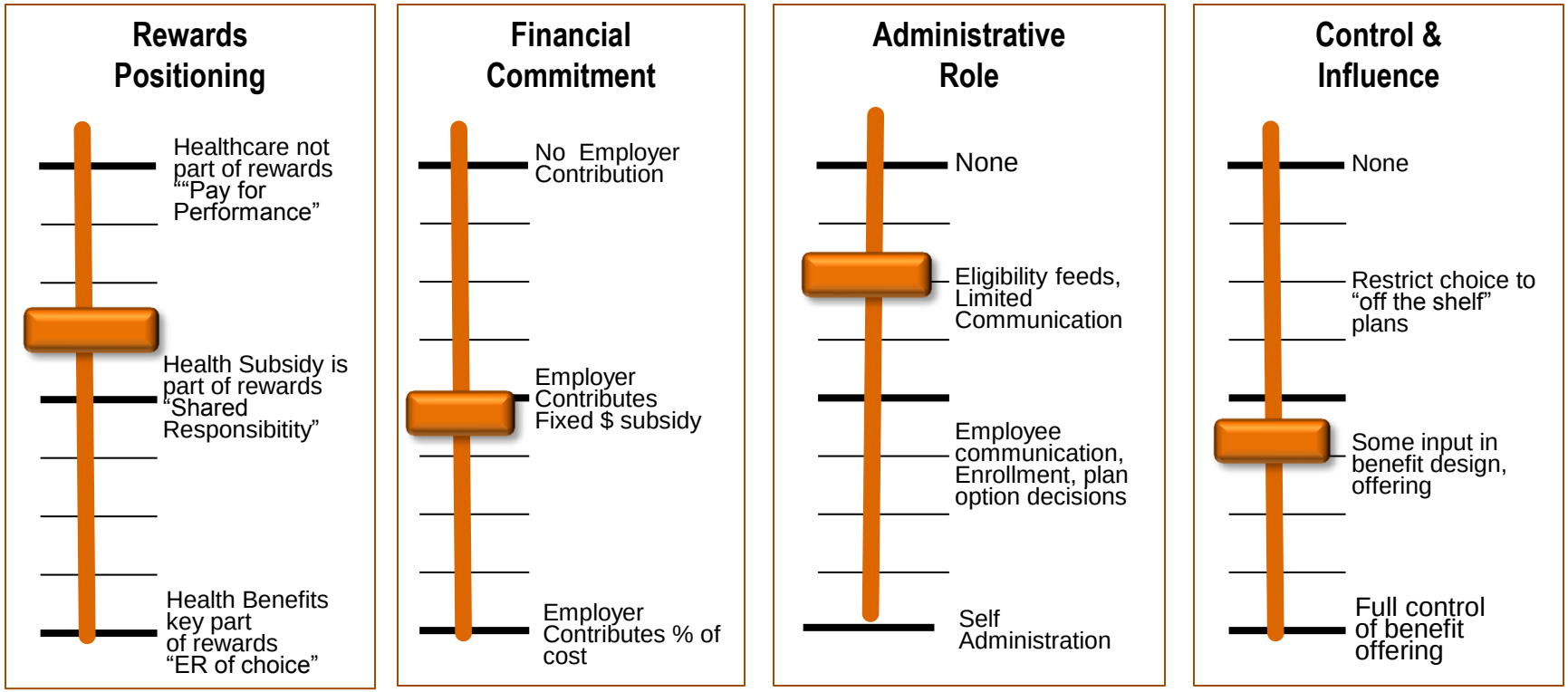
The "Defined Contribution" value proposition

Potential Benefits	Potential Issues
• Certainty of cost • Alignment with total compensation • Getting out of the business of healthcare • Positioning for 2018 excise tax on high cost • Accelerating consumerism • Increased choice • Group purchasing efficiencies	• Stewardship and control • Managing risk selection • Sustainability if cost shift over time • Degree of plan choice • Geographic and demographic cost variation • Integration of wellness and delivery strategies • Health literacy and advocacy

Comparative Value Propositions

Single Employer Sponsored Plan	- Full control of plan design(s) consistent with HR strategy and population specific cost drivers - Potential to save with self insurance - Potential to customize plan and avoid state benefit mandates - Ability to integrate with health and productivity initiatives - Cost reduction efforts directly affect own experience under the plan
Multi-Employer Private Exchange Group	- Ability to outsource for suite of products, networks and vendors - Potential greater uniformity in design and approach - Potential to leverage and adapt to market changes more quickly - Independent administration and stewardship of benefits and related costs - Option to fully insure, fixed rates could enable true defined contribution - Potential for costs to be based on or influenced by own experience
Multi-Employer Private Exchange Individual	- Ability to shift focus to market -based suite of products and networks - Potential to disassociate from market changes - Independent administration and advocacy on market health coverage choices - Fully insured, fixed rates enable true defined contribution - Costs based on community experience
Public Exchanges	- Ability to disassociate rewards strategy from healthcare coverage - Potential to leverage market reforms including government subsidies - Eliminate healthcare coverage as barrier to global competitiveness - Substitute controllable compensation for uncontrollable healthcare costs

Employer Healthcare Benefits Realignment



Active Employees – Market Assessment

- Currently, depending on the state, individual market restricts access through medical underwriting.
- ACA market reforms will mitigate these issues through guaranteed issue, community rating, 3/1 age-based pricing ratio limits, government subsidies through public exchanges.
- AON Hewitt is only national private exchange currently being marketed. Multiple other private exchanges (e.g. Bloom, TW, Mercer) are expected to enter this market shortly.

Category	Single Employer	Multi-Employer Private Exchanges		Public Exchanges
		Group	Individual	
Current status?	Most commonly self-insured; fully-insured rates less cost-effective for major employers	Choice limited nationally to Aon Hewitt	Local exchanges starting to arise. Currently not available nationally	Significant opportunity for individuals to get coverage on their own, starting in 2014
Access to coverage	Currently, guaranteed access to coverage is key benefit of employer sponsored coverage	Guaranteed issue, renewable coverage	Currently subject to medical underwriting	Government subsidies, age rating restrictions could make more affordable
Cost control	Difficult to keep costs from spiraling out of control due to anti-selection	Encourages competition among health plans and value based choices by consumers	Encourages competition among health plans and value based choices by consumers	Large employer subsidies not possible currently

Active Employees – New Development

- DOL releases guidance on 1/25/13 that clarifies that pre-tax employer contributions (through a Health Reimbursement Account) cannot be used to help employees purchase coverage on the individual market
  - Effectively deems DC approach to Individual Private Exchange for active employees impractical
  - Group approach remains viable as long as not a stand-alone HRA

Category	Single Employer	Multi-Employer Private Exchanges		Public Exchanges
		Group	Individual	
Current status?	Most commonly self-insured; fully-insured rates less cost-effective for major employers	Choice limited nationally to Aon Hewitt	Local exchanges starting to arise. Currently not available nationally	Significant opportunity for individuals to get coverage on their own, starting in 2014
Access to coverage	Currently, guaranteed access to coverage is key benefit of employer sponsored coverage	Guaranteed issue, renewable coverage	Currently subject to medical underwriting	Government subsidies, age rating restrictions could make more affordable
Cost control	Difficult to keep costs from spiraling out of control due to anti-selection	Encourages competition among health plans and value based choices by consumers	Encourages competition among health plans and value based choices by consumers	Large employer subsidies not possible currently

Pre-65 Retirees –Market Assessment

- Currently, individual market restricts access through medical underwriting. High costs, potentially rating up of poor risks, significant percentage not able to get coverage
- ACA market reforms will mitigate these issues through guaranteed issue, community rating, 3/1 age-based pricing ratio limits, government subsidies through public exchanges
- RHA is only retiree private exchange currently addressing pre-65 coverage. Unclear how pre-65 retirees will be handled in other retiree private exchanges post-ACA.

Category	Single Employer	Multi-Employer Private Exchanges		Public Exchanges
		Group	Individual	
Current status	Often self-insured; Plans tend to mirror one or more active plans.	Choice limited to Retiree Health Access	Currently not available	Significant opportunity for retirees to get coverage on their own,
Access to and cost of coverage	May be offered access only or subsidized. Access only can be cost-prohibitive for some.	Guaranteed issue. Costs can be very high based on age, health and selection impact.	Currently not available	Government subsidies, age rating restrictions could make more affordable
Cost control	Difficult to keep costs from spiraling out of control due to anti-selection	Offers wide range of coverage levels coupled with aggressive, population appropriate, cost management techniques.	Currently not available	Large employer subsidies not possible currently

Post-65 Retirees – Market Assessment

- Wide and diverse availability of value based choices through Medicare Advantage, Part D Rx plans and Medicare Supplements
- Post-65 retiree coverage has been rapidly shifting from DB / employer sponsored to DC / private exchanges.
- Leading private exchanges are Towers Watson/Extend Health, Retiree Health Access/HR Policy/Xerox, Aon Hewitt/Senior Educators, United Health Solutions

Category	Single Employer	Multi-Employer Private Exchanges		Public Exchanges
		Group	Individual	
Current status	Typically no choice of benefit options, self or fully-insured	Smaller market than individual, tends to be offered under single insurer	Mature market exists, multiple platforms and vendors, with many benefit options	Not Applicable
Access to coverage	Increasingly only available for grandfathered groups.	Often offered with broader access with or without subsidy	Rates vary by area and age band	Not Applicable
Cost control	Employer subsidies are increasingly capped. True cost management often handicapped by legacy grandfathered plans.	Employer subsidy are typically fixed dollar. Retiree choice of multiple cheaper and higher value options (e.g. MA, PDP).	Employer subsidy typically fixed dollar, with inflator in some cases	Not Applicable

Retiree Health Access® Background

- First to market….launched in 2006
  - Started out with group products
  - In 2012 introduced individual products
- Only Retiree exchange solution available today that offers:
  - individual and group products,
  - guaranteed access to all retirees and dependents
  - Pre-65 and Post-65 solutions
- Coalition currently has:
  - 71 member employers
  - Over 135,000 retirees enrolled in various retiree products

RHA Exchange Goals

- Flexible Transition (at employer's pace)
- 100% replacement with a mix of solutions based on cohort
- Savings and choice through multi carrier individual plans
- Legacy commitments kept through group pre/post plans
- Administrative and operational ease through a single source
- Positioned for flexible stewardship to optimize approach over time

RHA Exchange® Features and Benefits

- Stewardship & Advocacy
- Adaptable administrative platform
- Solution-oriented consult and underwriting
- Personalized plan comparison tools
- Single source to implement all transitions
- Can accommodate split families
- "Concierge" level navigation services for public exchanges
- Can enable group plan as "backstop"

Agenda

- ACA Public Exchanges
- New Private Exchanges
- Strategic Issues

Strategic Issues for Consideration

- Reward and Competitive positioning – benefits in recruitment and retention
- Employer Control – ability to directly influence healthcare benefits
- Employer Philosophy – context of healthcare benefits in broader human capital philosophy
- Health & Productivity – relationship to health and productivity initiatives
- Reversibility – ability to change course (e.g. revert back to single employer solution)

Multi-Employer Private Exchange Key Considerations - General

- How would moving our subsidy to a defined contribution impact employees?
- How will this impact our company brand?
- What are the risks of being an early adopter? When is right time?
- How will this impact our employee connectivity/productivity?
- How will we handle equity if prices vary by age, gender, area, or family status?
- How much choice are employees looking for? Should we limit or guide?
- Will I be able to cover all cohorts, including pre-65 retirees and those on disability?
- Are we ready to transfer control to outside entity? Does it fit with our core values?

Multi-Employer Private Exchange Key Considerations – Group vs. Individual

- How would the group model reflect our experience?
- How would the rate levels compare on group vs. individual?
- How will we handle participant equity on an individual exchange if prices vary by age, gender, area, and/or family status?
- Should we self-insure? What are my options on group vs. individual exchanges?
- What are the advantages of a single insurer exchange versus multiple? Are both available for group exchanges?

Path Forward - Health Benefits Strategy

Set Goals

- Clarify high-level Company goals
- Prioritize key considerations
- Set short and long-term milestones for transformation

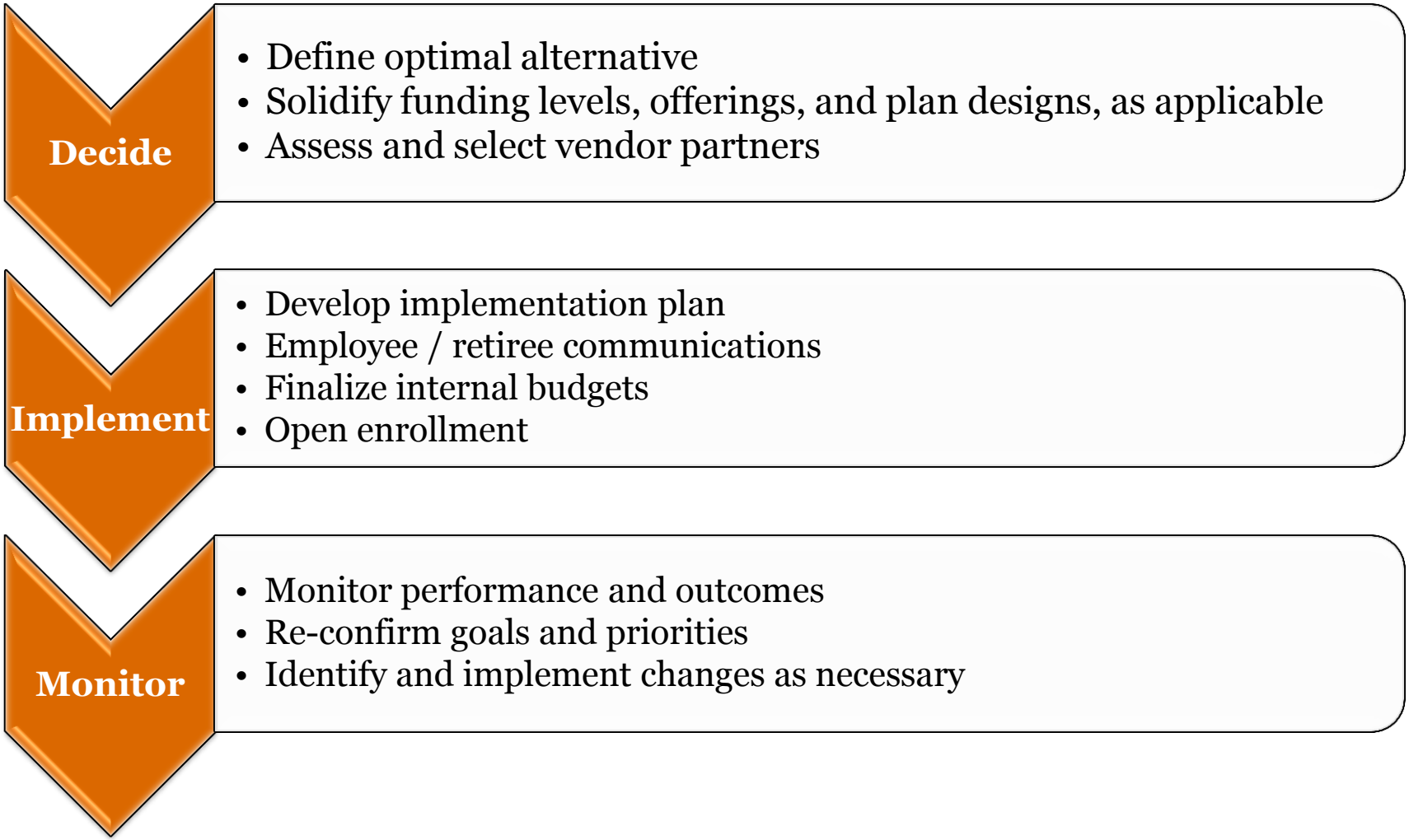
Assess

- Perform market scan of current and potential future offerings
- Assess vendor capabilities / perform vendor marketing
- Perform competitive benchmarking
- Perform research on employee values

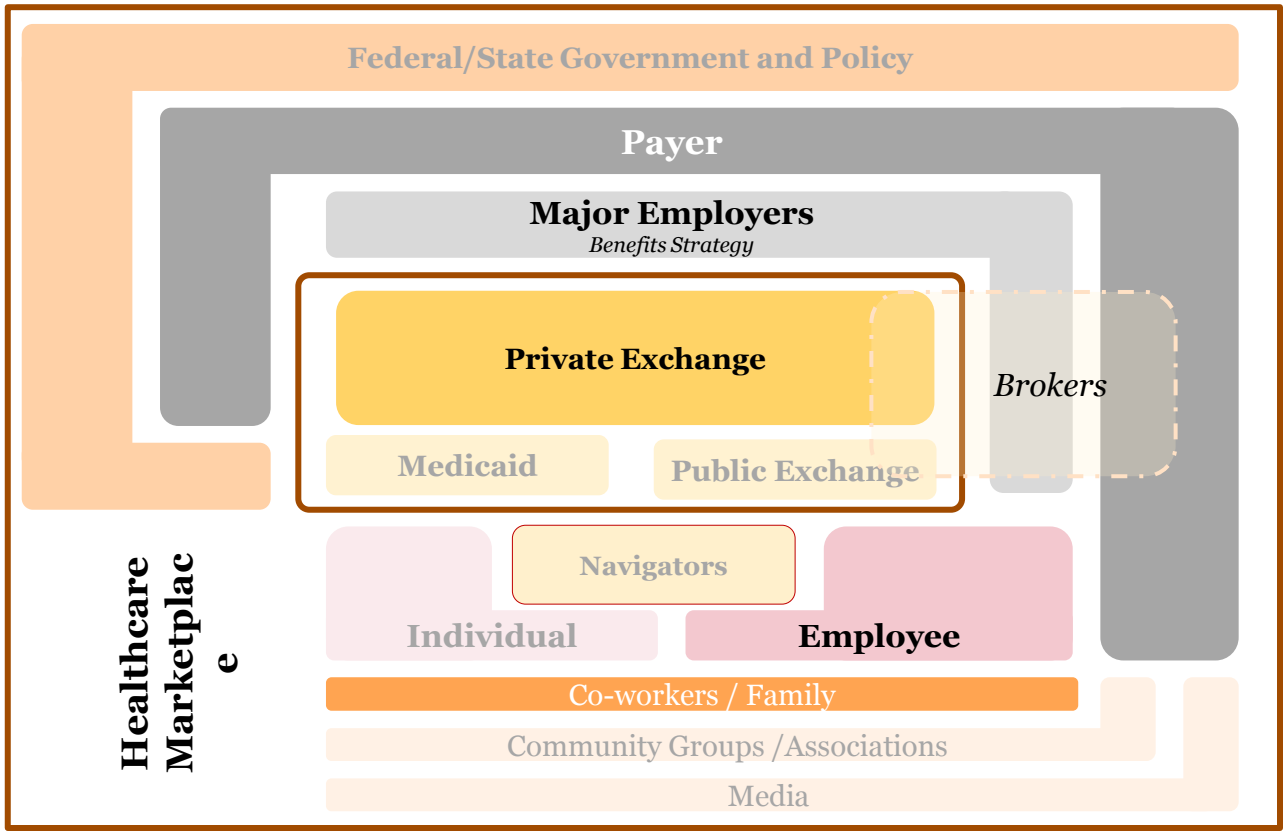
Analyze

- Develop strategic alternatives by key population segment
- Perform broad cost-benefit analysis of alternatives
- Score alternatives against goals and priorities

Path Forward - Health Benefits Strategy



Can a private exchange provide superior stewardship, coordination and advocacy for major employers?



Open Discussion

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Public and Private Health Insurance Exchanges - PBGH

Appendices
- ACA Implemention 2013-2018
- Private Exchange Market Scan

February, 2012

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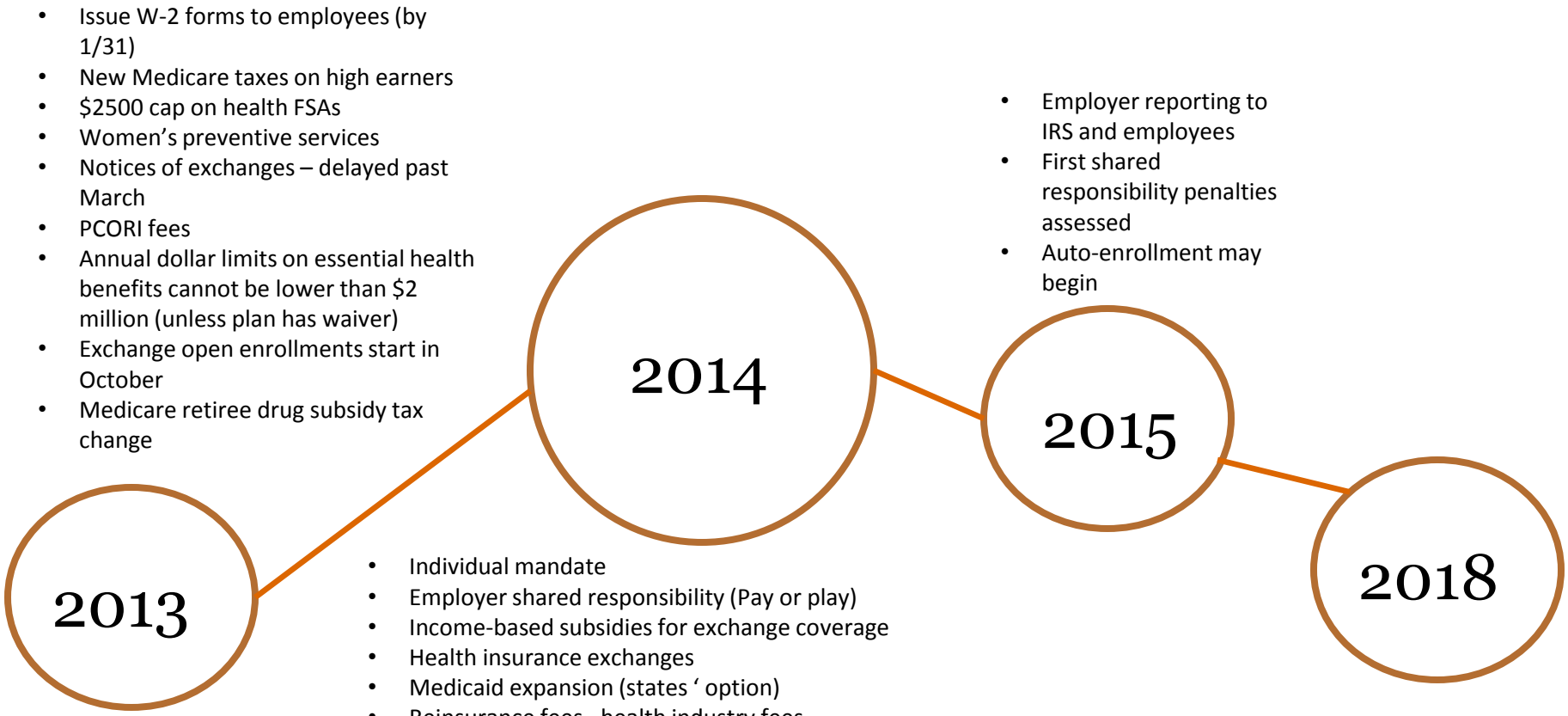
Appendix 1 – ACA Implementation 2013-2018

ACA implementation will reach its stride in 2014, when additional key provisions take effect



- Issue W-2 forms to employees (by 1/31)
- New Medicare taxes on high earners
- $2500 cap on health FSAs
- Women's preventive services
- Notices of exchanges – delayed past March
- PCORI fees
- Annual dollar limits on essential health benefits cannot be lower than $2 million (unless plan has waiver)
- Exchange open enrollments start in October
- Medicare retiree drug subsidy tax change

- Individual mandate
- Employer shared responsibility (Pay or play)
- Income-based subsidies for exchange coverage
- Health insurance exchanges
- Medicaid expansion (states ' option)
- Reinsurance fees , health industry fees
- Enhanced wellness incentives
- Additional reporting
- New health plan mandates: no pre-existing condition exclusions, no annual dollar limits on essential health benefits, no waiting period over 90 days, and for nongrandfathered plans - caps on out-of pocket maximums, coverage for certain clinical trial patient expenses, and provider nondiscrimination

- Employer reporting to IRS and employees
- First shared responsibility penalties assessed
- Auto-enrollment may begin

- Excise tax on high cost "Cadillac" plans

2013 Health Care Reform Action Items
January 1 plan year

January – March

- Ensure payroll is set up for new Medicare taxes
- Distribute W-2 forms with value of health care (by 1/ 31)
- Cover women's preventive services
- SBC must be given to new hires, special enrollees after start of plan year
- Consider performing pay or play analysis
- Review essential health benefit definition if benefit caps in place (for 2013, no annual dollar caps exceeding $2M unless waiver in place)

April – June

- Select approach for determining FT employees for pay or play (measurement period must be at least 6 may begin no later than 7/1/13)
- Select approach for counting covered lives for PCORI
- Plan for open enrollment (SBCs, review wellness incentives for 2014 and other new plan mandates)

July – September

- Receive and apply MLR rebates , if any (by August)
- Pay PCORI fees by July 31
- Create and distribute notices of exchanges (timing is uncertain, but delayed until regulations are issued and applicable)
- Continue planning for renewal, compliance with 2014 plan mandates

October - December

- Conduct open enrollment for 2014
- Exchange open enrollment begins
- Measuring period for full-time employee status may end and administrative period begin (depends on administrative period)
- Adjust various dollar thresholds for 2014 indexing

ACA regulations are moving at a breakneck pace

Over the past few months, significant ACA-related guidance and regulation has been released

November-December 2012	Summary
Insurance market reforms	• Rating restrictions for age, tobacco use, and family size • Risk pooling, open enrollment guidance
Essential health benefits	• Defined EHB categories, benchmark plan options • Actuarial value calculator • Important for employer dollar caps, whether plan meets minimum value
Fees	• Transitional reinsurance fees in 2014 up to $63 per covered individual • Additional fees to support comparative effectiveness research • Anticipated impact of health insurer fees
Employer shared responsibility (pay or play)	• Employer obligations to provide coverage to full-time employees or pay up to $2000 per FT employee
Additional Medicare taxes	• Individuals with income over $200,00 (joint filers with income over $250,000) must have additional Medicare taxes withheld from wages starting 1/1/13
Wellness incentives	• Wellness incentives linked to outcomes can be up to 30% of cost of coverage (50% if related to tobacco use), but reasonable alternatives required for people who fail to achieve the targets
Tax on medical devices	• 2.3% excise tax that will be levied on the total revenues of a company, and likely will be passed through to payers

ACA regulations are moving at a breakneck pace

Over the past few months, significant ACA-related guidance and regulation has been released.

January 2013	Summary
ACA FAQs	• Health reimbursement arrangements not paired with group health coverage won't be permitted – forecloses certain defined contribution/private exchange approaches • Fixed indemnity products under new scrutiny
Exchanges and verification of employer-sponsored coverage	• Still uncertain linkage between employers and exchanges • If FT employee receives subsidy, employer is penalized • Complex employer appeal process
Exemptions from penalties	• Employer obligations to provide coverage to full-time employees or pay up to $2000 per FT employee
Health premium tax credits	• Confirmation that an employee's family members won't be considered to have "unaffordable" coverage entitling them to premium tax credits to buy coverage on an exchange if the cost of self-only coverage doesn't exceed 9.5% of the employee's household income • Means that family members may not be eligible for subsidized exchange coverage, regardless of how much an employer charges for covering them
Minimum essential coverage	• Any employer-sponsored coverage will be minimum essential coverage that will satisfy the individual mandate • Retirees and COBRA beneficiaries under employer-sponsored plans deemed to have minimum essential coverage • Exchanges will generally be responsible for granting individual exemptions from penalties for failing to maintain minimum essential coverage (e.g., hardships, religious conscience, employer or other coverage costs more than 8% of household income)

Appendix 2 – Private Exchange Market Scan

Mass multi-channel and Platform Partnership Exchanges

HealthPlanOne

Company Name

Overview:

- Web based health insurance brokerage focused on individual/family health insurance, and SHOP customers
- Carrier & agent focuses, has relationship with all national carriers

Demographic Information

Revenue: 1.6mil ***Location:*** National
***Owner*:** Pequot Ventures, Greycroft Partners
# of participants: N/A ***Carrier:*** Multiple
Products: Medicare, Individual, SG, Ancillary

Exchange Capabilities	
Eligibility	Yes☑ No☐
Interface Cust.	n/a
Mobile	Yes☑ No☐ Agent tool
Billing	Exchange ☐ Carrier ☑
Sales	Open ☑ Restricted ☐ Commission based
Communication	Call Center Online Chat Social Media

Participant Services	
Employee	Employer
• Wiki & articles • Glossary • Search filters & quotes • Shop & Compare • "Most Popular" Rating	• No information available, assumed to have basic admin support for SHOP employers

GoHealth

Company Name

Overview:

- Found in 2002 in Chicago, focus on improving exchange technology solutions for end users
- Consists of 20K agents, performed 18mil quotes, named one of the fastest growing companies in America by Inc. 500

Demographic Information

Revenue: 13 mil ***Location:*** National
***Owner*:** Norvax Inc., Norwest Equity Partners
# of participants: 52K ***Carrier:*** Multiple
Products: Medicare, Individual, Ancillary

Exchange Capabilities	
Eligibility	Yes☑ No☐
Interface Cust.	n/a
Mobile	Yes☑ No☐
Billing	Exchange ☐ Carrier ☑
Sales	Open ☑ Restricted ☐ Commission based
Communication	Call Center Online Chat Social Media

Participant Services	
Employee	Employer
• Wiki & articles • Glossary • Search filters & quotes • Shop & Compare • Coverage Blog • State Insurance comparison Map • Direct agent contact	• N/A

HealthInsurance.com

Company Name

Overview:

- Developed in partnership with Kelsey National foundation-broker and administrator of fully insured group and HMO benefit plans
- Focuses solely on individuals and small businesses

Demographic Information

Revenue: 5 mil ***Location:*** National
***Owner*:** Kelsey National Corporation
# of participants: N/A ***Carrier:*** Multiple
Products: Medicare, Medicare, SG, Ancillary

Exchange Capabilities	
Eligibility	Yes☑ No☐
Interface Cust.	n/a
Mobile	Yes☐ No☑
Billing	Exchange ☐ Carrier ☑
Sales	Open ☑ Restricted ☐ Commission based
Communication	Call Center

Participant Services	
Employee	Employer
• Wiki & articles • Glossary • Search filters & quotes • Shop & Compare	• No information available, assumed to have basic admin support for SHOP employers

Extend Health

Company Name

Overview:

- Target retirees primarily
- Largest private Medicare exchange, serving 250k retirees with 5% market penetration
- Acquired by Towers Watson recently

Demographic Information

Revenue: 51.13 mil ***Location:*** National
***Owner*:** Towers Watson
# of participants: 300k ***Carrier:*** Multiple
Products: Medicare, Individual, LG, Ancillary

Exchange Capabilities	
Eligibility	Yes☑ No☐
Interface Cust.	n/a
Mobile	Yes☐ No☑
Billing	Exchange ☐ Carrier ☑
Sales	Open ☑ Restricted ☐ Commission based
Communication	Call Center Social Media

Participant Services	
Employee	Employer
• Wiki & articles • Glossary • Search filters & quotes • Prescription Profiler • Recomm . survey • Similar Plan • Shop & Compare	• FASB & GASB analysis • HRA mgmt • Budget determination • Education, admin, communications, implementation specialists

InsureMonkey

Company Name

Overview:

- Nevada firm found in 2009 , leverages superior API data connection to ensure accurate and real-time quote updates from carriers
- Receives 15%-28% commission from direct-to-consumer sales

Demographic Information

Revenue: 5 mil ***Location:*** National (40+ States)
Owner: Nevada based ventures
# of participants: 100K ***Carrier:*** Multiple
Products: Individual, Medicare, Ancillary

Exchange Capabilities	
Eligibility	Yes☑ No☐
Interface Cust.	n/a
Mobile	Yes☐ No☑
Billing	Exchange ☐ Carrier ☑
Sales	Open ☑ Restricted ☐ Commission based
Communication	Call Center Online Chat Social Media

Participant Services	
Employee	Employer
• Wiki & articles • Glossary • Search filters & quotes • Shop & Compare • Video tutorials • Integrated HSA acct • Plan & carrier ratings • Live blog & reviews • Savings Alert	• N/A

Vimo (Getinsured.com)

Company Name

Overview:

- In operation since 2005; focus on appealing to individuals and States for Health Reform, does not have a specific section for corporate employers.
- Designed like an Expedia for health insurance

Demographic Information

Revenue: 11.5 mil ***Location:*** National (48)
***Owner*:** Bessemer VC ,Trinity Ventures, Partech International, River Street Management
# of participants: 50k ***Carrier:*** Multiple
Products: Individual, Medicare, Ancillary

Exchange Capabilities	
Eligibility	Yes☑ No☐
Interface Cust.	n/a
Mobile	Yes☐ No☑
Billing	Exchange ☐ Carrier ☑
Sales	Open ☑ Restricted ☐ Commission based
Communication	Call Center Social Media Online Chat

Participant Services	
Employee	Employer*
• Wiki & articles • Glossary • Search filters & quotes • AM Best Rating • NCQA report card • Similar Plan • Shop & Compare	• Financial reporting • Compliance dashboard • Education, admin, communications, implementation specialists • Modular architecture

eHealth

Company Name

Overview:

- Public since 2006, 635 employees, 300mil market cap
- Most comprehensive ancillary products, offers deductible credit for selected policies (Decrease next year deduct or cash credits)

Demographic Information

Revenue: 151.65 mil ***Location:*** National
***Owner*:** BCBS Mn, RS Investment, Wellington Mgmt Company, HealthCor Mgmt
# of participants: 3 mil ***Carrier:*** Multiple
Products: Medicare, SG, Individual, Ancillary

Exchange Capabilities	
Eligibility	Yes☑ No☐
Interface Cust.	n/a
Mobile	Yes☑ No☐
Billing	Exchange ☐ Carrier ☑
Sales	Open ☑ Restricted ☐ Commission based
Communication	Call Center Social Media Online Chat

Participant Services	
Employee	Employer
• Wiki & articles • Glossary • Search filters & quotes • Customer rating & reviews • Recomm. survey • Best seller stamp • Similar Plan • Shop & Compare • Provider Plan	• Financial reporting • Compliance dashboard • Education, admin, communications, implementation specialists

Bloom Health

Company Name

Overview:

- Innovative with its recommendation tools
- Friendly user interface
- Quoted in a Booz & Company /National Institute for Health Care Management webinar

Demographic Information

Revenue: 1.9 mil ***Location:*** National (19)
***Owner*:** HCSC, Wellpoint, BCBS Michigan
# of participants: 40K ***Carrier:*** Multiple
Products: Medicare, LG, SG, Individual, Ancillary

Exchange Capabilities	
Eligibility	Yes☑ No☐
Interface Cust.	n/a
Mobile	Yes☐ No☑
Billing	No Information
Sales	Open ☐Restricted ☑ Assumed BCBS channel
Communication	Call Center Social Media Online Chat

Participant Services	
Employee	Employer
• Glossary • Bloom Recomm. Survey * • Personality Report • Shop & Compare • Search filter & quotes	• Budget determination • COBRA & part-time employee solution • Employee welcome kit • Education, admin, communications, implementation specialists

Aon Hewitt

Company Name

Overview:

- Target large companies with 1000+ employees; found interest in 19 companies with a total insureds of 600,000, expecting 3.5bn in net premium

Demographic Information

Revenue: 1.4bn ***Location:*** National
Owner: Aon Hewitt (Aon Corp.)
# of participants: 2.4mil ***Carrier:*** Multiple
Products: LG, Medicare, Ancillary

Exchange Capabilities	
Eligibility	Yes☑ No☐
Interface Cust.	n/a
Mobile	Yes☐ No☑
Billing	No Information
Sales	Open ☑ Restricted ☐ Commission based
Communication	Call Center Social Media Online Chat

Participant Services	
Employee	Employer
• No information, assumed to have basic services comparable to Bloom Health	• No information, assumed to have basic admin, financial, education, communications, and implementation services

Appendix 2 – Private Exchange Market Scan

Technology Solution Companies

Liazon

Company Name

Overview:

- Started in 2007 , largest private exchange for small and mid sized businesses, serving 2200 companies (micro employers to companies with over 2500 employees)

Demographic Information

Revenue: 1.3mil ***Location:*** National
***Owner*:** Bain Capital, Besemer Venture, Rand Capital
# of participants: N/A ***Carrier:*** Multiple
Products: SG, LG, individual, Ancillary

Exchange Capabilities	
Eligibility	Yes☑ No☐ *No subsidy determination
Interface Cust.	Yes☑ No☐
Mobile	Yes☐ No☑
Billing	Exchange ☑ Carrier ☐
Sales	Open ☑ Restricted ☐ Service based
Communication	Call Center Social Media Online Chat

Participant Services	
Employee	Employer
• Wiki & articles • Glossary • Search filters & quotes • Stats analysis (superior) • Videos • Similar Plan • Shop & Compare • Recomm. survey	• Financial reporting • Budget determination • Analytics • Education, admin, communications, implementation specialists

Array Health

Company Name

Overview:

- Found in 2006, specializes in health insurance exchanges for payers. Platform used by employers ranging in size from 5 – 1,000 employee.
- Current partnership with Highmark

Demographic Information

Revenue: 0.39mil ***Location:*** National
***Owner*:** Independent
# of participants: N/A ***Carrier:*** Multiple
Products: SG, LG, individual, Medicare, Ancillary

Exchange Capabilities	
Eligibility	Yes☑ No☐
Interface Cust.	Yes☑ No☐
Mobile	Yes☐ No☑
Billing	Exchange ☑ Carrier ☐
Sales	Open ☑ Restricted ☑ Highmark partnership could bring restrictions
Communication	Call Center Social Media Online Chat

Participant Services	
Employee	Employer
• Wiki & articles • Glossary • Search filters & quotes • Recomm . Tool • Similar Plan • Shop & Compare • Integrated HAS, HRA, FSA accts	• Financial reporting • Accounting module • Compliance dashboard • Analytics • Education, admin, communications, implementation specialists • Modular platform*

Bswift

Company Name

Overview:

- Found in 1996, created the first web-based consumer driven health plan. 3 areas of focus: employer, broker, and exchange
- 1 million consumers using its various systems
- Manage Utah's health exchange

Demographic Information

Revenue: 0.89mil ***Location:*** National
***Owner*:** Various partnerships
# of participants: N/A ***Carrier:*** Multiple
Products: SG, LG, individual, Medicare, Ancillary

Exchange Capabilities	
Eligibility	Yes☑ No☐
Interface Cust.	Yes☑ No☐
Mobile	Yes☐ No☑
Billing	Exchange ☑ Carrier ☐
Sales	Open ☑ Restricted ☐ Service based
Communication	Call Center Social Media Online Chat

Participant Services	
Employee	Employer
• Wiki & articles • Glossary • Search filters & quotes • Recomm . survey • Similar Plan • Shop & Compare • Spanish translation • Videos	• Financial reporting • Accounting module • Compliance dashboard • Analytics • Education, admin, communications, implementation specialists

hCentive

Company Name

Overview:

- First organization to build an exchange solution from the ground-up post the PPACA.
- Presented at AHIP Institute 2012 Exchange Conference, appeals to State govts
- Found in 2009, 52 employees , R&D in India

Demographic Information

Revenue: 5.3 mil ***Location:*** National
***Owner*:** Independent
# of participants: N/A ***Carrier:*** Multiple
Products: SG, LG, individual, Medicare, Ancillary

Exchange Capabilities	
Eligibility	Yes☑ No☐ *Most Comprehensive
Interface Cust.	Yes☑ No☐
Mobile	Yes☐ No☑
Billing	Exchange ☑ Carrier ☐
Sales	Open ☑ Restricted ☐ Service based
Communication	Call Center Social Media Online Chat Service Ticket

Participant Services	
Employee	Employer
• Wiki & articles • Glossary • Search filters & quotes • Recomm . survey • Life event tracking • Shop & Compare • Integrated HAS, HRA, FSA accts	• Financial reporting • Accounting module • Participant Mgmt • Compliance dashboard • Analytics • Education, admin, communications, implementation specialists • Modular architecture*

Connectedhealth

Company Name

Overview:

•Very small team led former founders of Subimo, a decision support company. Subimo created out of pocket health cost modeling application for 60mil people and was later acquired by WebMD in 2006

Demographic Information

Revenue: 0.14mil ***Location:*** National
***Owner*:** Independent
# of participants: N/A ***Carrier:*** Multiple
Products: SG, LG, individual, Medicare, Ancillary

Exchange Capabilities	
Eligibility	Yes☑ No☐ *No subsidy determination
Interface Cust.	Yes☑ No☐
Mobile	Yes☐ No☑
Billing	Exchange ☑ Carrier ☐
Sales	Open ☑ Restricted ☐ Service based
Communication	Call Center Social Media Online Chat

Participant Services	
Employee	Employer
• Wiki & articles • Glossary • Search filters & quotes • Recomm . survey • Similar Plan • Shop & Compare • Integrated HAS, HRA, FSA accts	• Financial reporting • COBRA & part-time employee solution • Analytics

Connextions

Company Name

Overview:

- Technology solution that helps healthcare organizations acquire, serve, retain customers
- Known for it's bConnected consumer engagement platform
- Acquired by Optum Health in 2011

Demographic Information

Revenue: 210.8 mil ***Location:*** National
***Owner*:** Optum Health/UnitedHealth Group
# of participants: N/A ***Carrier:*** Multiple
Products: SG, LG, individual, Medicare, Ancillary

Exchange Capabilities	
Eligibility	Yes☑ No☐
Interface Cust.	Yes☑ No☐
Mobile	Yes☐ No☑
Billing	Exchange ☑ Carrier ☐
Sales	Open ☑ Restricted ☐ Service based
Communication	Call Center Social Media Online Chat

Participant Services	
Employee	Employer
• Wiki & articles • Glossary • Search filters & quotes • Recomm . survey • Life event tracking • Shop & Compare • Integrated HAS, HRA, FSA accts	• Financial reporting • Accounting module • Participant Mgmt • Analytics • Education, admin, communications, implementation specialists