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The National Commission on

PHYSICIAN PAYMENT REFORM

Seeking Cost-Conscious Changes to Improve Patient Care by Assessing How Physicians are Paid

WHO ARE WE?

The National Commission on Physician Payment Reform was created by the Society of General Internal Medicine (SGIM) to assess how physicians are paid, and how pay incentives are linked to patient care. The independent commission includes physicians from a wide range of medical specialties, representatives from health care, insurance, a state health department, health policy leaders and a consumer representative. *(See right for list of commissioners.)*

WHAT IS THE PROBLEM?

There is an escalating need to curtail skyrocketing health care costs in the U.S. Without major changes to the current system, the nation is on track to spend $4.5 trillion on health care by 2019. Contributing drivers include:

- The current fee-for-service system which rewards doctors for quantity not quality. Physicians are paid more to perform more procedures and order more tests, instead of better overall care.
- The lack of care coordination among providers. This results in duplication of services and tests, overtreatment, errors, and excessive administrative costs.
- An increasing number of patients accessing the health care system more often. They are older, have more chronic diseases, and often have more complex health problems.
- Physicians and patients continue to utilize high tech interventions that may or may not be necessary.

*Without major changes, the nation is on track to spend **$4.5 trillion** on health care by 2019.*

WHAT WILL WE DO?

The Commission will issue an analysis and recommendations on how to reform the physician payment system in an effort to rein in health care costs while at the same time optimizing outcomes for patients. The Commission expects to issue a full report in early 2013.

How physicians are paid is a major driver of health care costs. The Commission will assess payment and delivery models in place, efforts to incorporate quality into the current pay system, and the opportunities and risks of the coming payment configurations in the Affordable Care Act, including:

- Accountable care organizations (ACO's)
- Patient-centered medical homes
- Value-based purchasing

SGIM
Society of General Internal Medicine

Report of the

The National Commission on PHYSICIAN PAYMENT REFORM

March 2013

EMBARGOED. Not for release before 12:01am ET on Monday, March 4, 2013.

"Our nation cannot control runaway medical spending without *fundamentally changing how physicians are paid.*"

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Heart transplant surgeon; former Senate Majority Leader

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* Position held at time of appointment to the commission.

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EXECUTIVE SUMMARY

The United States spends nearly three trillion dollars a year on health care—more than any other developed country—yet provides care of uneven quality.

Recognizing that the level of spending on health care in the United States is unsustainable, the return on investment is generally poor, and the way that physicians are paid contributes substantially to the high cost of health care, The Society of General Internal Medicine (SGIM) convened The National Commission on Physician Payment Reform in March 2012 to recommend new ways to pay physicians that will ultimately improve patient outcomes but also rein in health care costs.

The commission was charged with assessing current physician payment systems, the incentives that drive physicians' care recommendations, and exploring new payment systems to yield better results for both payers and patients.

Chaired by Steven A. Schroeder, MD, with former Senator William H. Frist, MD, serving as the honorary chair, the 14-member commission comprised physicians from a variety of specialties, as well as others who are expert in health care policy, delivery, and payment.

The United States health care system is plagued by the twin ills of high cost and uneven quality. Health care spending in the U.S. represents 18 percent of gross domestic product or $8,000 per person annually. As a proportion of the federal budget, the cost of Medicare has risen from 3.5 percent in 1975 to 15.1 percent in 2010. In 2020, it is projected to consume 17 percent of the federal budget. This enormous investment has not produced a commensurate improvement in the nation's health. In fact, the health status of Americans pales in comparison to other nations, with the U.S. ranking 37th in health status.

Many factors drive the high level of expenditures in our health care system, yet several stand out:

- **Fee-for-service reimbursement.** Under this model, physicians are reimbursed for each service they provide. Pay is not necessarily linked to outcomes.
- **Reliance on technology and expensive care.** The federal government and private insurers reimburse technology-intensive procedures—such as imaging or surgery—at higher rates than services focused on evaluating patients or managing the care for chronic conditions over time, such as an appointment to discuss diabetes management.
- **Reliance on a high proportion of specialists.** The U.S. has a high ratio of specialists to primary care physicians. The higher-intensity, higher-cost practice of specialists makes their care particularly expensive. The current payment system favors high-cost procedures over time spent on evaluation or management of care.

- **Paying more for the same service or procedure when done in a hospital setting as opposed to an outpatient setting.** For example, Medicare pays $450 for an echocardiogram done in a hospital and only $180 for the same procedure in a physician's office.

HOW PHYSICIANS ARE PAID DRIVES HEALTH CARE EXPENDITURES

The commission examined the factors that contribute to high cost and uneven quality, and the consequences to society and individuals, examining the role of physician payment. While physician salary and related expenses account for 20 percent of health care spending, the decisions they make influence an additional 60 percent of spending.[1] The commission reviewed the ways in which physicians are compensated, focusing on the incentives of fee-for-service payment toward more—and more expensive—care and the potential for fixed payment mechanisms such as capitation and bundling of fees to promote more prudent, high value health care. The commission concluded that our nation cannot control runaway medical spending without fundamentally changing how physicians are paid, including the inherent incentives built into the current fee-for-service pay system.

The issues currently facing physician payment fall into two general categories:

- **Systemic issues**—specifically, the skewed incentives of fee-for-service payment.
- **Medicare issues**—in particular, the sustainable growth rate (SGR) and the operation of the Relative Value Scale Update Committee (RUC).

COMMISSION RECOMMENDATIONS

The commission's recommendations focus on the near-term, calling for drastic changes to the current fee-for-service payment system and a five-year transition to a physician-payment system that rewards quality and value-based care. The recommendations pertain to the way physicians are paid throughout the health care system—both public and private payers.

The commission adopted twelve recommendations.

Our nation cannot control runaway medical spending without fundamentally changing how physicians are paid.

The recommendations stress the importance of eliminating the current fee-for-service payment system and provide a blueprint for transitioning to new systems over a five-year-period. They also call for transparency in determining how physicians are paid and services reimbursed, and offer suggestions for how to eliminate the SGR and its associated "doc-fix."

Transitioning from fee-for-service

The first three recommendations propose a rapid transition away from fee-for-service payment, yet recognize the need to fix current fee-for-service system inequities while the system is still in place. It is likely that fee-for-service will remain relevant for some time given that many delivery and payment models being tested under the Affordable Care Act, such as accountable care organizations (ACOs) and bundled payments, still pay individual doctors on a fee-for-service basis.

1. Over time, payers should largely eliminate stand-alone fee-for-service payment to medical practices because of its inherent inefficiencies and problematic financial incentives.

2. The transition to an approach based on quality and value should start with the testing of new models of care over a 5-year time period, incorporating them into increasing numbers of practices, with the goal of broad adoption by the end of the decade.

3. Because fee-for-service will remain an important mode of payment into the future, even as the nation shifts toward fixed-payment models, it will be necessary to continue recalibrating fee-for-service payments to encourage behavior that improves quality and cost-effectiveness and penalize behavior that misuses or overuses care.

Recalibrating fee-for-service and advancing fixed payment models

The next six recommendations provide a blueprint for transitioning to a value-based blended payment model over a five-year period, focusing on increasing reimbursement for evaluation and management services, reducing gaps in payment for the same physician services regardless of specialty or setting, and advancing bundled payment and capitation:

4. For both Medicare and private insurers, annual updates should be increased for evaluation and management codes, which are currently undervalued. Updates for procedural diagnosis codes should be frozen for a period of three years, except for those that are demonstrated to be currently undervalued.

5. Higher payment for facility-based services that can be performed in a lower-cost setting should be eliminated.

6. Fee-for-service contracts should always incorporate quality metrics into the negotiated reimbursement rates.

7. Fee-for-service reimbursement should encourage small practices (those having fewer than five providers) to form virtual relationships and thereby share resources to achieve higher quality care.

8. Fixed payments should initially focus on areas where significant potential exists for cost savings and higher quality, such as care for people with multiple chronic conditions, and in-hospital procedures and their follow-up.

9. Measures to safeguard access to high quality care, assess the adequacy of risk-adjustment indicators, and promote strong physician commitment to patients should be put into place for fixed payment models.

Medicare payment

The final three recommendations focus on ways to improve physician payment within the Medicare program:

10. The Sustainable Growth Rate (SGR) should be eliminated.

11. Repeal of the SGR should be paid for with cost-savings from the Medicare program as a whole, including both cuts to physician payments and reductions in inappropriate utilization of Medicare services.

12. The Relative Value Scale Update Committee (RUC) should make decision-making more transparent and diversify its membership so that it is more representative of the medical profession as a whole. At the same time, CMS should develop alternative open, evidence-based, and expert processes to validate the data and methods it uses to establish and update relative values.

There is no question that we need to reform our physician payment system. Both private and public payers must take steps now to move the U.S. toward a physician payment system that drives higher quality and more cost-effective care, and helps improve not only individual health but that of the nation.

The Commission is funded in part by the Robert Wood Johnson Foundation and the California HealthCare Foundation.

THE COMMISSION'S RECOMMENDATIONS WERE BASED ON THESE PRINCIPLES:

- Payment reform should result in a decreased rate of growth in total per capita expenditures and improve the efficiency, effectiveness, and quality of health care delivery systems.
- Payment reform should encourage the routine delivery of evidence-based care and discourage inappropriate care or care that adds minimal value.
- Payment reform should encourage caring for and managing those with complex medical problems, multiple social support needs, and those who are traditionally medically disadvantaged.
- Recalibrating physician reimbursement should be done by considering total medical expenses not just as a zero-sum game of current physician-related expenses. Supplementation of incomes of specialists with high proportions of evaluation and management services can come from reducing marginal, ineffective and harmful services.
- Payment reform should be transparent to patients and the public. Interested patients should have access to easily understood summary-level information about how physicians are paid.
- Payment reform should reward patient-centered comprehensive care that manages transitions between sites of care and among providers of care.

BACKGROUND

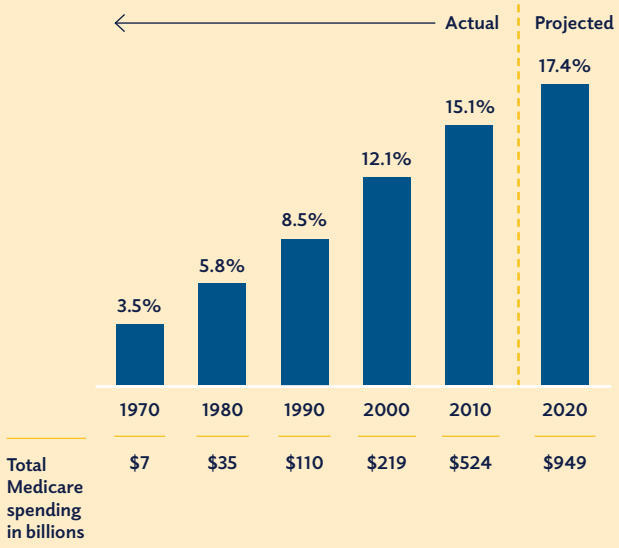
The United States health care system is plagued by the twin ills of high cost and uneven quality.

At the national level, high spending on health care—especially within the Medicare program—threatens to crowd out other social expenditures and contributes significantly to the national deficit. Expenditures for Medicaid are squeezing the budget of nearly every state.[2] For businesses—especially small ones—and individuals, high premiums make health insurance virtually unaffordable. Although the Affordable Care Act promises some relief, more action is needed to address the high and rising cost of care.

At nearly three trillion dollars a year—18 percent of gross domestic product or $8,000 per person annually—expenditures on health care in the U.S. exceed those of any other developed country.[3] As a proportion of the federal budget, the cost of Medicare has risen from 3.5 percent in 1975 to 15.1 percent in 2010 ($524 billion in 2010). In 2020, it is projected to consume 17 percent of the federal budget (4 percent of GDP).[4]

This enormous investment of resources has not produced a commensurate improvement in the nation's health. At its best, American health care is unsurpassed anywhere in the world. However, the health status of Americans pales in comparison to other nations. The World Health Organization ranked the U.S. 37th in health status—behind, among others, Oman, Morocco, and Paraguay.[5] A recent Institute of Medicine study concluded, "Americans… are, on average, in worse health than people in other high-income countries."[6]

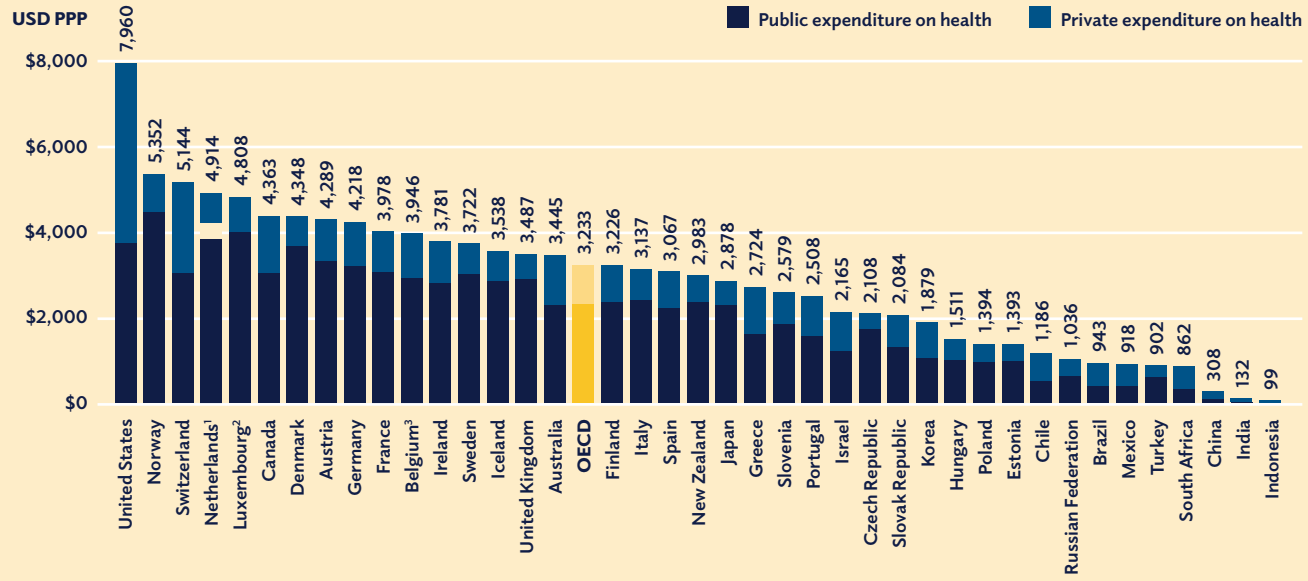
MEDICARE SPENDING AS A SHARE OF FEDERAL BUDGET OUTLAYS, 1970–2020



Source: Henry J. Kaiser Family Foundation and Congressional Budget Office, Budget and Economic Outlook, January 2010 (for 1970 data) and January 2011 (for 1980–2020 data, except 2010 which comes from CBO August 2010 Baseline: Medicare). Historical total spending for 1970–2000 from 2010 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds.

* Estimates for 1970–2010 represent total Medicare outlays, estimate for 2020 represents projection of mandatory Medicare outlays. CBO (August 2010) projects discretionary Medicare outlays will be $9 billion in 2020.

TOTAL HEALTH EXPENDITURE PER CAPITA, PUBLIC AND PRIVATE, 2009 (OR NEAREST YEAR)



1. In the Netherlands, it is not possible to clearly distinguish the public and private share related to investments.
2. Health expenditure is for the insured population rather than the resident population.
3. Total expenditure excluding investments.

Source: OECD Health Data 2011; WHO Global Health Expenditure Database.

Recognizing that the level of spending on health care in the United States cannot be sustained indefinitely, that the return on investment is generally poor, and that the way in which physicians are paid contributes substantially to the high cost of health care, the Society of General Internal Medicine (SGIM) convened The National Commission on Physician Payment Reform in March 2012, chaired by Steven Schroeder, MD, with former Senator William Frist, MD, serving as honorary chair.

The commissioners agreed upon a set of six principles and twelve recommendations to guide physician payment reform.

WHY THE UNITED STATES SPENDS SO MUCH ON HEALTH CARE

Although no single aspect of the U.S. health care system explains why the country spends so much on health care, several features of our delivery and financing of care drive costs higher and set the U.S. apart from other developed nations.

Fee-for-service reimbursement

The basic payment model in the U.S. is fee-for-service, which reimburses physicians for each service they deliver. This creates a financial incentive to provide more—and more costly—services. Physicians determine the kind and quality of care patients receive and can be influenced by the incentives for costly care that the system offers.

Reliance on technology and expensive care

The federal government, through Medicare and Medicaid, and private insurers, which tend to follow the federal government's lead, reimburse technology-intensive procedures at higher rates than cognitive services—that is, those services requiring time for evaluation and management of patients.

A high proportion of specialists

The United States has a comparatively high ratio of specialists to primary care physicians, and most patients can self-refer directly to those specialists. The higher-intensity, higher-cost practice of specialists makes their care particularly expensive. Systems with a greater emphasis on primary care have been shown to deliver better outcomes at a lower cost.[7]

The disproportionately high number of procedural specialists and the relative lack of cognitively focused physicians is a direct result of a payment system adopted by Medicare and mimicked by private insurers that values time for services provided under procedure codes more highly than time provided under evaluation and management (E &M) codes. High reimbursement for procedures also subtly nudges specialists such as gastroenterologists and pulmonologists away from E& M services and toward doing procedures.

As a result, physicians doing diagnostic or therapeutic procedures earn considerably more than physicians who mainly evaluate and manage patients—even those with multiple chronic conditions. In 2011, a radiologist, on average, earned $315,000 a year, while a family doctor on average earned $158,000.[8] This has led medical students—many of whom leave school heavily in debt—away from the E & M specialties and toward the higher paying procedural and imaging specialties.

Consolidation in the health care industry

In recent years, the pace of hospital-system consolidation has accelerated. Because of their increased market share, large health care systems can negotiate higher reimbursement for services provided by their physicians than can physicians working independently or in smaller practices—leading the larger systems to acquire physicians' practices. For their part, physicians are banding together in larger groups to increase their own bargaining power and gain higher reimbursement.[12] This has led to a situation where private payers often pay different rates for the same service, depending on the negotiating power of the provider.

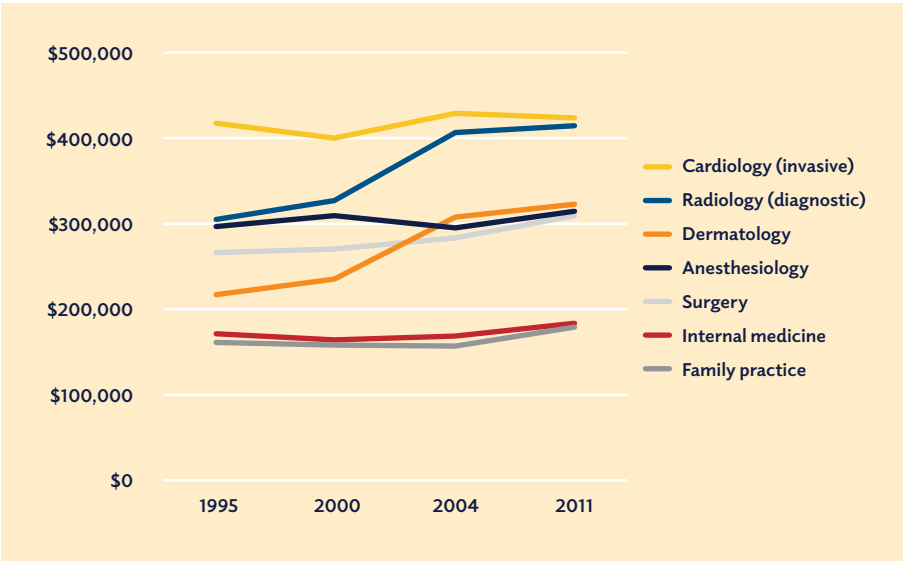
A disproportionate percentage of health care spending directed to a small number of people who are very sick and costly to treat

The distribution of spending on health care in the U.S. is skewed toward a small number of people who are extremely expensive to treat—many of them frail, elderly, and with four or five chronic illnesses. Five percent of patients account for nearly half of all health care expenditures.[13]

High administrative costs

Although Medicare's administrative costs are only 2 percent,[14] those of private insurance companies and health plans routinely reach 13 percent or more.[15] Administrative costs are expected to diminish in the future with the Affordable Care Act's requirement that at least 85 percent (80 percent for individual products) of premiums be devoted to health care.[16]

ANNUAL PHYSICIAN COMPENSATION BY SPECIALTY (IN $2004)



Source: Bodenheimer 2007[9], AMGA 2011 [10], Bureau of Labor Statistics[11].

Fear of malpractice lawsuits

Although major studies have demonstrated that malpractice is not a significant driver of health care costs,[17] the fear of lawsuits does influence physician behavior. Under the threat of lawsuits, physicians may practice defensive medicine, ordering unnecessary tests and providing unnecessary medical services.[18]

Fraud and abuse

The Institute of Medicine estimated that in 2009 health care fraud accounted for $75 billion, or 3 percent of the nation's $2.5 trillion health care budget that year.[19] Former CMS Administrator Donald Berwick and RAND Corporation analyst Andrew Hackbarth estimated that Medicare and Medicaid fraud and abuse could account for up to $98 billion and that system-wide, the cost of fraud and abuse could be $272 billion.[20] While the exact dollar amount may not be known, fraud and abuse clearly contribute to high health care costs.

THE CONSEQUENCES OF HIGH HEALTH CARE EXPENDITURES

The high and rising expenditures for health care affect society at large as well as individuals and families. Government spending on health care limits the amount available for education, transportation infrastructure, and other societal needs, and it threatens financial wellbeing at every level of government. Premiums are often so high that small businesses do not insure their employees and people choose to take their chances and go without insurance.[21] And uninsured people delay going to the doctor until they are very sick—and expensive to treat.[22]

The high and rising expenditures for health care affect society at large as well as individuals and families.

Even with the expansion of coverage under the Affordable Care Act, expenditures for health care will remain high unless action is taken to lower them.

HOW PHYSICIANS IN THE U.S. ARE COMPENSATED

Physicians in the United States are generally compensated in three ways: fee-for-service, fixed payment, and salary. In an effort to curb costs and improve quality of care—especially the care of those with multiple chronic conditions—other approaches to physician payment are being tried.

Fee-for-service

Fee-for-service is the predominant way of compensating physicians and, despite its problems, appears likely to remain so for the foreseeable future.[23] Fee-for-service arrangements have many advantages and are popular with the public. In practice, fee-for-service allows people to go to the physician of their choice and creates incentives for those physicians to be accessible. It does not restrict physicians from referring patients to specialists and for tests, which many patients desire and believe to be in their best interest. Moreover, it allows payers to know what they are buying and provides a handy way of auditing.

Fee-for-service also has many disadvantages. Most significantly, it provides an incentive to increase volume—especially for highly reimbursed care. Fee-for-service payments also disadvantage physicians who primarily deliver evaluation and management services because they can only increase volume by scheduling more and shorter appointments. Many health policy analysts consider fee-for-service to be the single most important driver of the high cost of health care.[24]

Fixed payment

Payment to physicians of a set amount can come in a variety of forms—two of the most common being capitation and bundling. A distinguishing factor of fixed payment is that physicians may bear some or all of the financial risk of patient care, that is, they may either share in the savings as compared to historical charges or market rates, or bear part or all of the increased cost.

Capitation

Under capitation, physicians are paid a specified amount, often on a monthly basis, per patient they agree to serve. The capitation model has a number of advantages. One of them is that it is agnostic about what services a patient receives and where they are delivered—a capitated provider can deliver care by phone, at home, or any way that is deemed most effective and efficient. A second advantage is its focus on primary care and prevention. A third is that since physicians may themselves bear the risk for the cost of care, it creates incentives for cost-efficient services, keeping people healthy, and reducing spending on unnecessary care.

Capitation also has disadvantages, particularly its implicit restriction of patients' choice of physician and the incentive it offers physicians to limit access to expensive downstream services, such as referrals to specialists and imaging, in order to maximize financial returns. These negative aspects surfaced during the late-1990s, leading to a backlash against managed care and a subsequent retreat from its more restrictive elements.

Bundling by episode or event

Under this payment mechanism, a fixed price is paid in return for care related to a specific condition, event, or episode such as a hip replacement or a heart attack. Similar to diagnostic-related groups that Medicare uses to pay hospitals, this payment mechanism should encourage better coordination within physician teams and among physicians, hospitals, and others involved in patient care. With a fixed price for the total episode, physicians have a financial incentive to be more prudent than they would under fee-for-service.

However, bundled payment faces a number of practical difficulties: defining what is in the bundle; finding ways to divide payment among participating physicians; determining what to do when some physicians involved in the care do not share in the bundled payment; and factoring in the health status of patients (risk-adjustment).[25]

Salary

Salaried payment alone does not explicitly encourage either overuse or withholding of expensive services. A salaried physician (without bonuses or other performance incentives) might tend to over-refer complex patients, however, because there is no reward for managing such patients on one's own. In general, incentives associated with salaried payment are less "high-powered" than either fee-for-service or fixed fee arrangements. Salary is typically only found in larger employment arrangements, however, because other management mechanisms must take the place of incentives in aligning medical practice with the payer's goals.

A growing number of physicians are forgoing independent practice entirely and choosing to practice medicine as paid employees. The national physician search firm, Merritt Hawkins, found that in 2011, 56 percent of their searches assignments were for hospital-based jobs, which often are salaried employment positions—up from 23 percent five years earlier.[26]

As is the case with fee-for-service and fixed payment mechanisms, salaried physicians can receive additional compensation for meeting financial or quality targets.

With a fixed price for the total episode, physicians have a financial incentive to be more prudent than they would under fee-for-service.

For example, Geisinger Health System has developed a physician compensation plan that pays 80 percent of salary based on work effort, mainly measured by relative value units, and 20 percent on individual and group performance, as measured by a proprietary survey.

HYBRID PAYMENT MODELS

Many health policy experts believe that alternative delivery and payment systems, such as accountable care organizations with shared savings and patient-centered medical homes with care coordination fees,

represent promising approaches to reducing cost and improving quality.

Accountable Care Organizations

Spurred by the Affordable Care Act, accountable care organizations (ACOs) are viewed as a way to shift financial incentives away from fee-for-service and, through sharing of financial savings or risk, toward a system that emphasizes prevention, care coordination, quality, and value. ACOs are integrated networks of providers—often hospital systems and physician groups—that, in theory, assume financial risk for the quality and total cost of the care they provide. CMS has established several programs to test the concept—the Medicare Shared Savings Program, the Pioneer Accountable Care Program, and the Physician Group Practice Transition Demonstration Program. Additionally, private health insurers have been actively organizing ACOs in many locations around the country.[27]

Currently, most physicians in ACOs are reimbursed by fee-for-service and can share in cost savings if specified quality and financial benchmarks are met. Very few physicians have, to date, agreed to accept the downside risk of potential financial loss should expenditures exceed budget. Whether ACOs save money and improve quality is uncertain; results to date are mixed.[28]

The Patient-Centered Medical Home

The Patient-Centered Medical Home (PCMH—sometimes called Primary Care Medical Home) model has the goal of transforming care from a volume-based model to a value-based one that rewards quality and efficiency and compensates doctors for care that has not traditionally been reimbursed, such as disease management and clinical interventions outside of office visits. Believed to be particularly effective for coordinating the care of individuals with several chronic conditions, the model is built around a primary care physician who coordinates patient care and is often paid by capitation or a global budget (though care coordination fees or other bonus arrangements are sometimes included).[29] Although still unproven in large-scale demonstrations,[30] results from some early PCMH experiments have shown cost savings and improved quality of care.[31]

PAYING PHYSICIANS UNDER MEDICARE

Fee-for-service

Medicare pays physicians primarily by fee-for-service. Under the current system, a relative value unit (RVU) is assigned to every medical service that physicians carry out and that will be reimbursed by Medicare.* The RVU is then converted into a monetary value based on a conversion factor and the geographic location of the physician.**

Since the RVU system was first instituted in 1992, it has been the subject of criticism. Some of the criticism has been conceptual, for example:

- The payment system values the time for procedures that require surgery or technology (such as interpreting CT scans or inserting a stent) more highly than those requiring evaluation and management (for example, an office visit to educate a patient about a new diagnosis such as diabetes). It has skewed the field toward high-cost, high-tech medicine and away from evaluative medicine and primary care.

* The Centers for Medicare and Medicaid Services (CMS) uses Current Procedural Terminology (CPT) codes to determine services that it will reimburse for Medicare enrollees, and each CPT code has an assigned relative value unit.

** The relative value unit is based on the RVRBS, which defines the value of a service. It is based on cost and has three components. Physician work accounts for the time, skill, physical effort and mental judgment involved in providing a service and is approximately 52% of the relative value unit. Practice expense refers to direct costs incurred by the physician and includes the cost of maintaining an office, staff and supplies and accounts for 44%. Practice liability expense takes into account the malpractice insurance essential for maintaining a practice and is 4% of the calculation.

- Since the physician payment system is based on the resources physicians use, order, and prescribe rather than the outcomes their patients experience, it encourages practitioners to provide more, and more expensive, services, thus potentially rewarding overtreatment and waste. It does nothing to encourage physicians to improve either the efficiency or the quality of care.

Other criticism is leveled at the way the Medicare physician payment system works in practice. Critics charge that the AMA/Medical Specialties Societies Relative Value Scale Update Committee (RUC), which advises CMS on updating the amounts paid by Medicare for every procedure, is dominated by specialists at the expense of primary care; meets generally out of the public eye; does not disclose individual votes on recommendations; and fails to release the transcripts of meetings.

The Sustainable Growth Rate

Established by the 1997 Balanced Budget Act, the Sustainable Growth Rate (SGR) is the method that Congress established to control the growth of physician reimbursement under Medicare. It basically pegs payment for physicians' services to the growth of gross domestic product (GDP).*** If the cumulative rate of spending for physicians' services under Medicare exceeds the target SGR in a given year, payments for physicians' services the following year are supposed to be reduced, and vice-versa.

Every year, Congress is advised on a fee schedule for physicians' services for the coming year based on the estimated payments to physicians compared with the target SGR in the current year. In 2002, payments for physicians' services exceeded the SGR. This resulted in a 4.8 percent reduction in Medicare reimbursement to physicians, which caused an outcry in the physician community. Every year since then, payments for physicians' services have exceeded the SGR, and every year Congress has stepped in to prevent cuts in payments for physicians. This is the "doc-fix," and it has taken place 15 times over the past decade, most recently in January 2013. Overall, since 2002, physicians' reimbursement under Medicare has increased only 3 percent while the consumer price index rose 20 percent during the same time.

*** In reality, the SGR is somewhat more complicated. The rate is determined by four factors: (1) the estimated percentage change in fees for physicians' services; (2) the estimated percentage change in the average number of Medicare fee-for-service beneficiaries; (3) the estimated ten-year average annual percentage change in GDP per capita; (4) the estimated percentage change in expenditures for physicians' services due to changes in law or regulation.

PRINCIPLES

The issues currently facing physician payment fall into two general categories:

- **Systemic issues**—the skewed incentives of fee-for-service payment and the proposed system-wide changes that would shift to a physician-payment system that offers incentives to provide value-based care.
- **Medicare issues**—the SGR and doc-fix, RVUs as a way of determining physician payment, and the operation of the RUC.

The commission agreed upon recommendations that address both these categories. But first, however, the commission adopted six principles that should guide any system of physician payment reform. The principles are:

- Payment reform should result in a decreased rate of growth in total per capita expenditures and improve the efficiency, effectiveness, and quality of health care delivery systems.
- Payment reform should encourage the routine delivery of evidence-based care and discourage inappropriate care or care that adds minimal value.
- Payment reform should encourage caring for and managing those with complex medical problems, multiple social support needs, and those who are traditionally medically disadvantaged.
- Recalibrating physician reimbursement should be done by considering total medical expenses not just as a zero-sum game of physician-related expenses. Supplementation of incomes of physicians with high proportion of evaluation and management services can come from a reduction in the utilization of marginal, harmful, ineffective, or unnecessary medical or other services.
- Payment reform should be transparent to patients and the public. Interested patients should have access to easily understood summary-level information about how physicians are paid.
- Payment reform should reward patient-centered comprehensive care that includes management of transitions between sites of care and among providers of care.

RECOMMENDATIONS

The commission adopted twelve specific recommendations for reforming physician payment. These are listed below, along with explanations and justifications.

RECOMMENDATIONS PERTAINING TO PHYSICIAN PAYMENT THROUGHOUT THE HEALTH CARE SYSTEM

1 Over time, payers should largely eliminate stand-alone fee-for-service payment to medical practices because of its inherent inefficiencies and problematic financial incentives.

As this report has made clear, the fee-for-service mechanism of paying physicians is a major driver of higher health care costs in the U.S.[32] It contains incentives for increasing the volume and cost of services, whether appropriate or not; encourages duplication; discourages care coordination, and promotes inefficiency in the delivery of medical services. In light of these factors, the commission believes that fee-for-service should eventually disappear as the predominant mode of compensating physicians.

The long-range solution is a system that provides appropriate, high-quality care that emphasizes disease prevention rather than treatment of illness and that values examination and diagnosis as much as medical procedures. This implies a shift from a payment system based on fee-for-service to one based on value through mechanisms such as bundled payment, capitation, and increased financial risk sharing.

2 The transition to an approach based on quality and value should start with the testing of new models of care over a 5-year time period and incorporating them into increasing numbers of practices, with the goal of broad adoption by the end of the decade.

Changing from the current model of care to one that is value-based cannot be accomplished overnight. It will require a transition period—and even then, the likely end point will be a blended system with some payment based on fee-for-service and other payment based on capitation or salary.

The commissioners judged that five years would be an appropriate length of time for a transition period. It would give physicians and health care organizations the time to make changes in their models of care—for example, to install electronic medical records and to change billing systems—and would allow time to evaluate the experiments currently underway to test ACOs, medical homes, and other delivery and payment mechanisms.

3 Because fee-for-service will remain an important mode of payment into the future, even as the nation shifts to fixed payment models, it will be necessary to continue recalibrating fee-for-service payments.

Whatever system reforms are ultimately adopted—be they ACOs, bundled payments, patient-centered medical homes, capitation—the commission recognizes that fee-for-service payment will remain an integral part of physician payment for a long time.[33] While paying a fixed payment through bundling or capitation is reasonable, appropriate, and desirable for acute episodes of care requiring hospitalization, many issues remain as the concept is expanded outside of hospitals. Some services are not appropriate for bundling. And the optimal ways that bundled payments are allocated to individual physicians remain to be clarified.

In all cases, payment—whether it be fee-for-service, fixed payment, or salary payment models—should reward behavior that improves quality, care coordination, and cost-effectiveness and/or penalize behavior that misuses or overuses care that does not add benefits to patients but simply adds to the cost.

4 For both Medicare and private insurers, annual updates should be increased for evaluation and management codes, which are currently undervalued. Updates for procedural diagnosis codes, which are generally overvalued and thus create incentives for overuse, should be frozen for a period of three years. During this time period, efforts should continue to improve the accuracy of relative values, which may result in some increases as well as some decreases in payments for specific services.

Time spent on services performed under evaluation and management (E&M) codes is reimbursed at lower rates than time spent providing services under procedure codes. The undervalued E&M services at issue are often those that provide preventive health and wellness care, address new or undiagnosed problems, and manage chronic illnesses.

The current skewed physician payment system causes a number of problems, such as creating a disincentive to spend time with patients with complex chronic conditions; leading physicians to offer care for highly reimbursed procedures rather than lower-reimbursed cognitive care;[34] neglecting illness prevention and disease management, which tend to be cognitive in nature; and inducing medical students to choose procedural specialties over evaluative ones.

While the discussion about reimbursement has generally focused on services performed by primary care physicians, the commission believes that the real issue is not one of relative payment of specialists versus primary care physicians but, rather, of payment for E&M services as contrasted with procedural services. These include E&M services provided by, among others, cardiologists, endocrinologists, hematologists, infectious disease specialists, neurologists, psychiatrists, and rheumatologists.

5 Higher payment for facility-based services that can be performed in a lower-cost setting should be eliminated. Additionally, the payment mechanism for physicians should be transparent, and it should reimburse physicians roughly equally for equivalent services, regardless of specialty or setting.

Over the past years, there has been a trend to reimburse medical services performed in outpatient facilities at a lower rate than those same services when provided in hospitals. In its March 2012 report, MedPAC noted that the previous year, Medicare paid 80 percent more for a 15-minute office visit in an outpatient department than in a freestanding physician office.[35]

The disparity is having a negative effect on the way health care services are delivered. In addition to paying extra for an in-hospital procedure that can be done more cheaply in an ambulatory facility, large hospital systems are buying up independent practices. This threatens the viability of independent physicians and raises the cost of health care. Cardiology presents a telling example. Medicare pays $450 for an echocardiogram done in a hospital and only $180 for the same procedure in a physician's office.[36] The

New York Times reported in 2010 that practices around the country were selling out to health systems or hospitals; the CEO of the American College of Cardiology was quoted as saying, "the share of cardiologists working in private practice had dropped by half in a year."[37]

Moreover, private payers negotiate payment for services with individual groups, often resulting in different payment levels for the same physician services, depending on the market power of the physician group. Payments by private payers for medical services should be transparent to the public.

These payment differentials are difficult to justify in concept or in practice.

6 Fee-for-service contracts should always include a component of quality or outcome-based performance reimbursement at a level sufficient to motivate substantial behavior change.

The inherent incentive in fee-for-service payment arrangements to increase volume can be mitigated by incorporating quality metrics into the negotiated reimbursement rates. This is already being done in many places, including programs carried out by the federal government and private insurers. For example, the Affordable Care Act created a "value-based modifier" under the Medicare physician fee schedule. It will go into effect in 2015. On a budget-neutral basis, the modifier will increase or decrease payment rates to physicians on the measures of quality and cost.[38]

Although the overall evidence of the effectiveness of pay-for-performance programs based on quality measures is mixed to date,[39] some programs are demonstrating positive results. UnitedHealthcare, for example, reports that the 250,000 physicians participating in its Premium Designation program—whose compensation depends in part on their meeting quality measures—have significantly lower complication rates for, among others, stent placement procedures and for knee arthroscopic surgery, and have 14 percent lower costs than specialists not in the program.[40] WellPoint has obtained similar results in its pilot programs.

7 In practices having fewer than five providers, changes in fee-for-service reimbursement should encourage methods for the practices to form virtual relationships and thereby share resources to achieve higher quality care.

Large, integrated networks of providers dominate health service provision in some areas of the country, but small, independent providers provide care for nine out of ten Americans, including millions living in rural and underserved areas.[41] Fee-for-service models that fail to reimburse care that is not delivered in person (for example, by telephone or email) or for coordination among providers puts patients in these areas at a continuing disadvantage.

Telemedicine and other forms of remote communication have improved outcomes for many types of patients, including those in remote, scattered intensive care units,[42] the frail elderly,[43] and those experiencing depression in clinics not served by a psychiatrist.[44] These interventions have demonstrated reduced costs in some populations and in these circumstances should be reimbursed appropriately.[45]

8 As the nation moves from a fee-for-service system toward one that pays physicians through fixed payments, initial payment reforms should focus on areas where significant potential exists for cost savings and better quality.

This recommendation refers largely to the clinical circumstances where 5 percent of the sickest patients consume half of the nation's health care resources. Many of these people have multiple chronic conditions, including behavioral health disorders. Improving care for people with these conditions offers significant potential for cost savings and improved quality of care. They are a logical place to start a transition period.

Another logical place is in-hospital procedures and their follow-up. There are many conditions whose treatment lends itself to payment by means of a fixed payment.

Treatment of heart attacks and joint replacements are two obvious examples.

Additionally, examples abound of care whose benefits are unproven or which are unnecessary that is given to (and sometimes demanded by) patients. The Affordable Care Act created a new Patient-Centered Outcomes Research Institute (PCORI) to conduct research evaluating and comparing health outcomes and assessing the clinical effectiveness, risks and benefits of medical treatments. Implementation of PCORI results should be expeditious.

9 Measures should be put into place to safeguard access to high quality care, assess the adequacy of risk-adjustment indicators, and promote strong physician commitment to patients.

This recommendation acknowledges that any prospective payment system adopted should be accompanied by adequate protections for patients and recognition of the centrality of patient care. While the main body of this report deals with ways to reduce spending on health care, the commission recognizes that:

A physician's commitment to his or her patient has traditionally been—and remains—paramount.

Quality measures are necessary to assure that evidence-based care is not denied as a cost-saving mechanism. A body of evidence now demonstrates that prevention, care coordination, and the prudent practice of medicine will not only save money but will also lead to better outcomes.

Risk adjustment is important for any type of fixed payment to avoid physicians and other providers cherry-picking the healthiest patients and avoiding the sickest ones. This recommendation is a reminder that the sickest and neediest members of our society—who are often the poorest as well—deserve the same attention as the more advantaged members of society, and that where patients with more complex illnesses need more resources, payment should be adjusted to reflect those needs.

RECOMMENDATIONS PERTAINING SPECIFICALLY TO MEDICARE

10 The SGR adjustment should be eliminated

Simply stated, the SGR has not worked in practice and shows no prospect of ever working. The practice of setting expenditure targets one year and ignoring the consequences of exceeding them the next year makes no sense. Moreover, setting a spending cap without addressing the underlying issues of the volume and price of services and health outcomes is a short-term answer to a problem that requires a long-term solution. And since the SGR is based on the aggregate payment for physicians' services by Medicare, there is no incentive for individual physicians to try to hold down costs, and those who do are, in effect, penalized. It is the Tragedy of the Commons.

Rather than tinkering with the SGR, the Commission recommends abolishing it and replacing it with a physician payment system that strengthens the doctor-patient relationship and emphasizes appropriate, cost-effective care. This recommendation is consistent with the recommendations of other bodies (for example MedPAC and the AMA) that have looked at physician-payment reform for the Medicare program and proposals by Representatives Allyson Schwartz (D-Pennsylvania) and Joe Heck (R-Nevada), that directly address the SGR.

11 **Recovering the revenues that would have been in the SGR should come not just from reduced physician payment but from the Medicare program as a whole. Medicare should not cut just physician payments, but should also look for savings from reductions in inappropriate utilization of Medicare services.**

The question of where to find the $138 billion over ten years that the Congressional Budget Office estimates it will take to eliminate the SGR is a thorny one that has generated a wide variety of responses.

The commission believes that the $138 billion needed to eliminate the SGR can be found entirely by reducing overutilization of medical services within Medicare. In a 2011 report, the Institute of Medicine found more than *three-quarters of a trillion* dollars in excess medical costs annually, as follows:

Unnecessary services	$210 billion
Inefficiently delivered services	$130 billion
Excess administrative costs	$190 billion
Prices that are too high	$105 billion
Missed prevention opportunities	$55 billion
Fraud	$75 billion [46]

12 **The Relative Value Scale Update Committee (RUC) should continue to make changes to become more representative of the medical profession as a whole and to make its decision making more transparent. CMS has a statutory responsibility to ensure that the relative values it adopts are accurate and therefore it should develop additional open, evidence-based, and expert processes beyond the recommendations of the RUC to validate the data and methods it uses to establish and update relative values.**

The RUC, which is managed by the American Medical Association (AMA) and composed of members named by national medical specialty societies, makes recommendations to CMS regarding updates to the relative value scale on which physician payment is based. Both its composition and its operations are seriously flawed.

The composition of the RUC, which is skewed toward the procedural and highly technological specialties, has led to concern that it overvalues those specialties and undervalues the cognitive specialties. Currently, six seats on the 31-member RUC are reserved for the chairman and representatives of the AMA, the American Osteopathic Association, the CPT Editorial Panel representative, the Health Care Professionals Advisory Committee representative, and the Practice Expense Review Committee representative. The remaining 25 seats are held by representatives of the various specialties. Of these, 16 are currently held by specialties whose physicians do procedures or highly technical work—such as cardiology, dermatology, plastic surgery, radiology,

and vascular surgery. Nine are held by specialties whose physicians' practices consist largely of examination and management of patients: emergency medicine, family medicine, geriatrics, internal medicine, neurology, pediatrics, primary care, psychiatry, and rheumatology.[47] Earlier versions of the RUC were even more heavily dominated by procedural-oriented specialties.

While the composition of the RUC has come under scrutiny, so too have its operating procedures. Critics observe that meetings are largely closed to the public; RUC members sign confidentiality agreements; individual voting records are not made public; and transcripts of meetings are not published. Moreover, critics contend that since nearly 90 percent of the RUC's recommendations have historically been adopted by CMS,[48] it should be considered a Federal Advisory Committee and subject to the sunshine requirements and the oversight mandated by the Federal Advisory Committee Act.

Others, while strongly agreeing that the RUC needs to be improved, note recent positive changes in both the composition and the operations of the RUC and suggest that an additional problem lies with CMS. Recent improvements in the RUC include the addition of new primary care and geriatrics seats as of 2012 and the requirement that vote totals for all recommendations be published. Moreover, supporters of improving rather than abolishing the RUC state that individuals who ask can be invited to attend RUC meetings if the RUC chair approves their request. They further note that the RUC is constituted as a private organization and therefore should not be considered a federal advisory committee, and that CMS should look more widely for alternate sources of relative value and other payment recommendations.

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The Relationship Between Commercial Website Ratings and Traditional Hospital Performance Measures

Naomi Bardach, Renée Asteria-Peñaloza, et al.

As more consumers turn to social media to research purchasing decisions, how do sites like Yelp.com compare with traditional sites for hospital quality information?

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March 2013

Thanks to explosive growth in the popularity of social media, millions of consumers routinely use sites like Yelp.com and Facebook.com to research restaurants, retail stores, and even physicians and hospitals.

Researchers from the University of California, San Francisco, were curious whether there was a correlation between these consumer reviews and more traditional measures of hospital quality, such as patient satisfaction surveys, mortality rates, and readmissions.

With support from CHCF, the authors focused on 270 hospitals across the United States with at least five reviews on Yelp.com. The authors compared the hospitals' scores on Yelp with those from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey, a more familiar industry benchmark, available on the federal government site, HospitalCompare.hhs.gov.

Their research, published in the November 2012 issue of *British Medical Journal Quality and Safety*, found that hospitals which did the best on Yelp — garnering four or five stars — also tended to have high HCAHPS scores, and better mortality rates and readmission outcomes. This suggests that the crowd-sourced reviews may tell stories that relate both to the experience of being a patient at the hospital and how well patients do during the hospitalization and after discharge.

See the complete article in ~~British Medical Journal Quality and Safety~~.

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EDITORIAL

Inadequate Treatment of Ovarian Cancer

By THE EDITORIAL BOARD
Published: March 13, 2013 89 Comments

A new study has found widespread failure among doctors to follow clinical guidelines for treating ovarian cancer, which kills 15,000 women a year in this country. This disturbing news shows the kind of challenge that health care reformers are up against in improving medical care — even when cost is not the issue.

The study, presented at a conference on gynecologic cancers on Monday, analyzed the treatment of more than 13,000 women with ovarian cancer who received their diagnoses between 1999 and 2006. Only 37 percent received the care recommended in guidelines set by the National Comprehensive Cancer Network, an alliance of 21 major cancer centers.

This kind of failure is not uncommon in American medicine. A decade ago, RAND Corporation researchers reported that just 55 percent of a large sample of patients suffering from a broad range of diseases received care that met quality guidelines. Numerous studies since then focusing on specific diseases have found similar problems.

In the case of ovarian cancer, the consequences of inadequate care are tragic. The recommended guidelines specify combinations of surgery and chemotherapy, depending on the stage of the disease including debulking surgery to remove all visible traces of the tumor and aggressive chemotherapy that can prolong life. Women who received the recommended treatment were 30 percent less likely to die than those who did not. Among those with advanced cancer, the stage at which ovarian cancer is usually first found, 35 percent of the women treated in accordance with the guidelines survived at least five years compared with 25 percent for those whose care fell short.

Lack of experience with ovarian cancer among many doctors may be a factor in poor treatment. But even patients treated by surgeons with 10 or more ovarian-cancer patients a year, or in hospitals with 20 or more such patients a year, received the recommended therapy only about half the time.

The poor showing raises perplexing issues for health care reform. The Affordable Care Act has many provisions intended to improve the quality of care. They include new research organizations to help doctors and patients understand which treatments work best as well as pilot projects to test new ways of paying for and organizing health care delivery to reduce costs and improve quality.

However, such measures won't accomplish much if doctors continue to ignore the recommendations made by experts from their own professional societies. One of the surest ways to improve performance would be to analyze and make public how well individual doctors and hospitals do in treating various diseases. This is controversial among many doctors, who question the accuracy of measures used or fear their records will look bad. While some data are kept on a fragmented basis around the country, the reform law gives doctors incentives to report various quality measures to the federal government

The law promotes treatment based on sound evidence and electronic health records (which allow for data collection), two advances that could make it easier for patients and their primary-care doctors to find specialists who have had superior results.

A version of this editorial appeared in print on March 14, 2013, on page A34 of the New York edition with the headline: Inadequate Treatment of Ovarian Cancer.

Customer Service Principles and Performance Standards for Exchange Call Centers

March 11, 2013

The Affordable Care Act (ACA) commits to giving consumers applying for affordable health coverage a seamless, top-flight experience. Turning that lofty goal into reality will require performance standards to assure the expectation is met. In some instances, for example, consumers calling an Exchange (Federally Facilitated Exchange also known as an "FFE", or a state Exchange) may be transferred to another entity such as a state or county agency to make a full Medicaid eligibility determination. Hand-offs between agencies can result in a frustrating consumer experience. Clear performance guidelines are essential to optimize the possibility of a smooth, satisfactory experience.

In California, policymakers and advocates are immersed in developing the transition to a new unified application structure coordinated between the state's Exchange, Covered California, and the "single state agency" for Medicaid, the Department of Health Care Services. Further complexity exists in California, as in many states, because counties also play an important role as agents of the state responsible for making final Medicaid eligibility determinations. Consumers calling to apply for affordability program coverage may thus find themselves interacting with more than one agency, with potential transfers of callers between federal and state, or between state and county, agencies.

The principles and performance standards below by advocacy organizations in California were developed to ensure those who telephone Exchange Call Centers, whether at the FFE or state Exchanges, have a consumer-friendly, successful experience applying for coverage over the telephone. These suggested principles and standards are not intended to be all-inclusive, and do not cover web-based or walk-in applications. *Note that Covered California's "Service Center" is a centralized, multi-site hub that will receive applicants' phone calls, as well as perform other service functions. In this memo we use the term "Service Center" to indicate any Exchange entity that receives telephone applications.*

For further information contact Betsy Imholz, Special Projects Director at Consumers Union's West Coast Office, 415-431-6747, bimholz@consumer.org. *Thanks to Maureen Mahoney, Public Policy Fellow at Consumers Union, for her helpful research on customer service standards.*

I. General Principles:

1. **Seamless intake** -- Screening calls to the Service Center for possible Medicaid eligibility adds a potential additional step for callers to be transferred during phone-in applications. This complicates and lengthens the eligibility determination process. Safeguards, including clear performance standards, are critically important to ensure the overall experience is seamless to the caller and does not result in delays in enrollments.

2. **Parity for all consumer experiences** -- Policies and performance standards should be the same whether application processing is done by a Service Center, state Medicaid agency, a county, or any other entity. In order to ensure a uniform consumer experience, the standards for how applications are processed should be the same whether calls are handled by the original Service Center representative or by an entity that receives a transferred call.

3. **Consumer's first call allows for a completed application and final determination** -- The first call should result in an open application and a final determination made in "real-time," whenever possible ("real-time determinations" should occur in cases where the person can provide, or the data system obtain, all necessary information by telephone or electronic means during the first call).

4. **Consumers required to make only one call --** If transfers of callers are made, the transferred consumer should not then be required to call back or call another number (unless the consumer requests a call back due to lack of application information, e.g. information not electronically available). Rather, the agency to which the consumer has been transferred must have the capacity to follow through with the application on that same call.

5. **Consumer information provided one time only** -- Consumers should not have to provide their information more than once (even if transferred); all data given by the consumer during the initial call should be entered into the computer system, then transferred or made visible in real time to the transferee agency.

6. **Performance standards measured on an individual consumer basis, broken out by language spoken --** Performance standards, e.g. required phone pick-up times, need to apply to each caller to ensure a uniform customer experience across multiple languages. Aggregate, periodic (e.g. weekly) reports are useful for monitoring and determining whether structural adjustments are necessary, but do not ensure a real-time, satisfactory consumer experience.

7. **Accountability standards and enforcement mechanisms required --** There must be adequate accountability standards and enforcement mechanisms in place for all calls routed to non-Exchange entities, including state and county agencies, so that Exchanges remain responsible for the handling of all callers to their Service Centers.

II. Performance Standards for Starting an Application for "Affordability Programs"

All the recommended standards below should apply equally to Exchanges and any agencies to which their callers are transferred. And these standards should apply equally to English-speaking, Limited English Proficient (LEP), and hearing impaired callers.

1. **Calls need to be answered quickly** -- A predominant industry standard requires that incoming calls be answered **within 20-30 seconds.** North American Quitline Consortium (NAQC) notes that this "is a common goal for centers in the health care field"[1]; Covered California proposed 30 seconds as the standard for call handling at its "Service Center," as well as for counties and health plans.[2] There may be additional state law requirements to consider for state agencies answering telephones.

2. **Hold times must be minimized** -- The answer rate is less significant if an automated voice system picks up a call; the more important indicator is how long it takes to get a live agent on the phone, i.e. hold time. Hold times should be limited to less than 2 minutes for all callers, including LEP and hearing impaired consumers. If hold time will be greater than 2 minutes, the consumer should be able to choose to be called back by an agent when their call is next in the queue from when they called. The NAQC encourages call centers to keep these times as short as possible.[3]

3. **No one should experience a busy signal --** The standard of "no busy signals" should apply to calls to the Exchanges and to transferee agencies. NAQC states that the general benchmark is 2% (at most) of calls unable to get through, noting that this would be unacceptable for 911 or a similar service.[4] The Exchanges must have a process in place to retain and fully process calls if the Service Center staff gets a busy signal when attempting to transfer a call. Covered California has proposed a "no busy signals" goal for calls to its Service Center requiring transfers.[5]

4. **Use of voice mail should be avoided** -- Voice mail is never consumer-friendly and cannot by its nature accomplish immediate "real time" coverage. But if customers must leave a voice mail at the Service Center, 90% of the callers should hear back from an agent within one business day.[6]

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1 NAQC, "Call Center Metrics: Best Practices in Performance Measurement and Management to Maximize Quitline Efficiency and Quality," 2010, p. 10, calls for 80% of incoming calls to be answered in 20-30 seconds.

2 Covered California "Customer Service Center Updates," pp. 15 and 16, accessed Jan. 30, 2013, http://www.healthexchange.ca.gov/StakeHolders/Documents/CA%20Service%20Center%20Protocols%20Presentation.pdf ; Covered California, Qualified Health Plan Contract ("QHPC"), Attachment 3: "Performance Guarantees," p. 90.

3 NAQC, p. 15.

4 NAQC, pp. 8-9.

5 Covered California "Customer Service Center Updates," p. 15, accessed Jan. 30, 2013, http://www.healthexchange.ca.gov/StakeHolders/Documents/CA%20Service%20Center%20Protocols%20Presentation.pdf; see also QHPC, p. 91.

6 Covered California has suggested two business days for QHPs. QHPC, p. 91.

5. **Call "abandonment rates" must be minimal and are a key measure** -- The "abandonment rate," or rate at which frustrated callers hang up because they can't get through to an agent or because an interactive voice response (IVR) system does not provide the needed connection, should be lower than 3%.[7] The NAQC recommends that call centers strive to achieve a 0% abandonment rate, but notes that 10-20% is common.[8]

6. **Automated systems should be limited** -- **No more than two automated questions** should be asked before customers are guided to the most knowledgeable, available agent.[9] The customer also should be able to opt out of the automated system and be routed to an agent.

III. Additional Standards for Ongoing Performance Assessment

1. **Aim for a zero error rate on eligibility determinations for affordability programs --** Callers to Exchanges will be unlikely to know which, if any, of the affordability programs they qualify for. The Exchange will be responsible for assuring the proper eligibility assignment to Medicaid, subsidized Exchange products, and unsubsidized Exchange products, regardless of whether the Exchange or a delegated agency does the final determination, and the goal should be for a correct determination, most favorable to each consumer each time.

2. **Aim high on customer satisfaction** -- Approval rates for the application experience through Exchanges should be 95% or above.[10]

3. **Have 24/7 phone access to apply, at least during the first open enrollment period** -- As Turbo Tax provides during tax filing season, 24/7 enrollment assistance should be available when enrollment first begins.[11] After hours calls (e.g. voicemail messages) should be monitored to determine if hours need to be extended during any period without 24/7 access.[12]

4. **Respond to consumer inquiries quickly** -- Standards for telephone application responses are described in detail above. Emails and letters should receive a 90% response rate within two business days.[13]

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7 NAQC, p. 9; QHPC, p. 91.

8 NAQC, p. 9.

9 See Genesys, "Customer Service Strategies for the Healthcare Industry," 2008, p. 12, advocating for skills-based routing and encouraging use of automation. We believe, however, that for the population applying for Affordability Programs access to a live agent will be especially important.

10 Covered California has proposed customer satisfaction standards for Qualified Health Plans, as determined through customer surveys, of 92%. QHPC, p. 91.

11 The Kaiser Commission on Medicaid and the Uninsured suggests as a performance measure whether 24/7 customer assistance is available at call centers. "Performance Measurement Under Health Reform: Proposed Measures for Eligibility and Enrollment Systems and Key Issues and Trade-offs to Consider," December 2011, p. 8.

12 NAQC, p. 11.

13 Covered California has suggested this timeframe for QHPs. QHPC, p. 91.

5. **Monitor social media** (e.g. Yelp) **for uncensored feedback --** In order for Service Center managers to continuously identify problems in service and address them in the system, user experience should be reviewed periodically through social media.[14]

6. **Seek multi-lingual customer feedback** -- To ascertain the consumer experience, as well as which standards customers value, feedback should be regularly sought from all consumers, including non-English speakers. After evaluating the feedback, performance standards should be adjusted accordingly.[15] Surveys should measure not only speed, but also quality and accuracy of service provided.

7. **Regularly compare all performance standards** -- Review performance standards, including customer satisfaction, among the various Exchange Service Center components and delegated entities (e.g. counties), to raise the bar for all.

8. **Require random monitoring by Exchange staff --** Have staff listen in on calls in progress (both calls to the Service Center and transferred calls, if technologically possible) to hear how calls are handled and the information is given. This is a fairly common tracking process in the commercial world.

9. **Require each Exchange to have an ombudsman** -- Having a party to whom people can go if they have had a problem with customer service, e.g. their call got dropped or they were on hold for excessive time, is an important check and balance. Ombudsman programs in public agencies and private endeavors are quite common and successful, allowing for resolution of individual complaints as well as tracking recurring problems that warrant systemic change. For example, seeking to improve its customer service the California State Controller's Office established an ombudsman office for its Unclaimed Property Division and has found it helpful in reducing errors and improving quality of service.

10. **Ensure employees** (at Exchange Service Centers and other agencies handling phone applications) **all have the continuous training and tools needed** to provide quality service for applicants -- Having ongoing training and a communication feedback loop for telephone agents to note problems and successes will allow Exchanges to troubleshoot and provide a more uniform, high quality consumer experience. Also, providing Service Center employees incentives based on accurate work and satisfied customers will promote a positive consumer experience, as well as create job growth opportunities for employees that will, in turn, improve the consumer experience.[16]

11. **If performance standards are not met, institute a corrective action plan --** Any sub-contractor or agent agreements should ensure there are effective corrective actions plans, including termination and penalty clauses for breach of performance standards.

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[14] Tim Montgomery, "Five Attributes of the Best 'Real Time Customer' Call Centers," Contact Center Pipeline, April 2009, pp. 1- 2.

[15] NAQC, p. 7.

[16] See generally, Montgomery, p. 2, and NAQC, pp. 6-7.

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http://www.healthexchange.ca.gov/Solicitations/Documents/1st%20DRAFT%20QHP%20Model%20Contract%20%201%2011%2013.pdf

Genesys, "Customer Service Strategies for the Healthcare Industry," 2008.

Kaiser Commission on Medicaid and the Uninsured, "Performance Measurement Under Health Reform: Proposed Measures for Eligibility and Enrollment Systems and Key Issues and Trade-offs to Consider," (sets out six metrics by which the user experience should be judged for eligibility and enrollment systems: whether they are available at all times (24/7), the number of "completed contacts," "average wait time," "number of complaints," the "percentage of enrollees highly satisfied with application/renewal process," and "number of appeals submitted related to program eligibility"), Table 2, p.8, December 2011.

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SPECIAL REPORT

TIME

ONE ACETAMINOPHEN TABLET COSTS 1.5¢. YOUR HOSPITAL MARKS IT UP 10,000%

WHY MEDICAL BILLS ARE KILLING US

BY STEVEN BRILL

TIME

VOL. 181, NO. 8 | 2013

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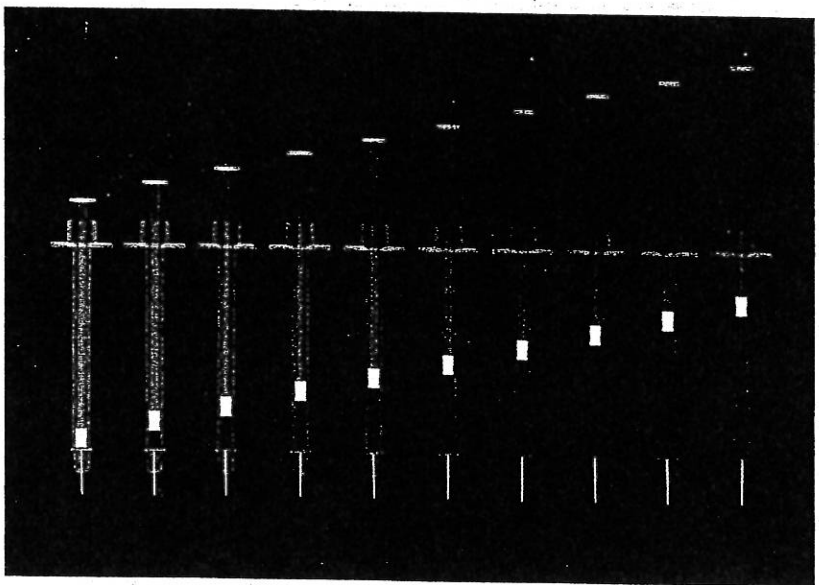

Health care providers have the power to bring down U.S. medical spending, but they're not going to change without a fight. Photograph by Nick Veasey for TIME

Nigella Lawson, page 68

LAWSON: JAVIER SIRVENT FOR TIME

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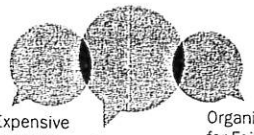
TIME stories that elicited the most mail



The Most Expensive Weapon Ever Built

Second Act: Benedict XVI

Organizing for Failure

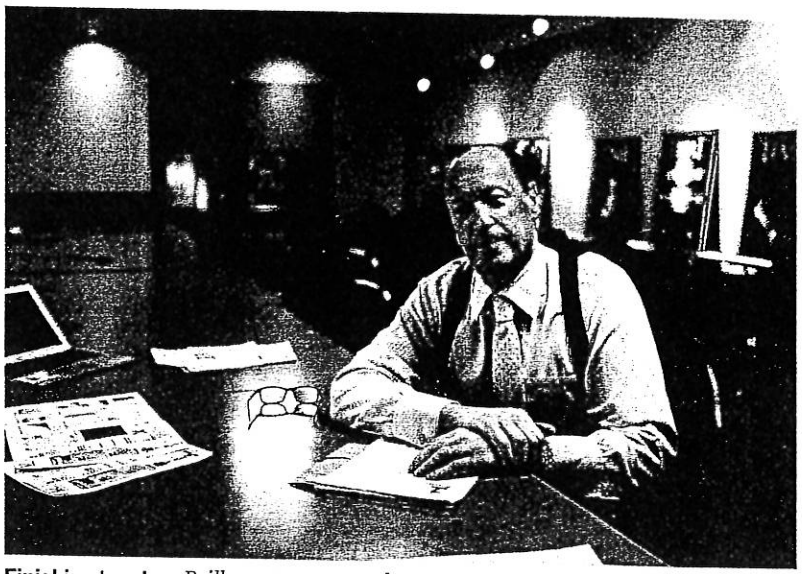
The High Cost of Care

FOR THE FIRST TIME IN OUR HISTORY, we are devoting the entire feature section of the magazine to a single story by one writer: a powerful examination of America's health care costs. The 24,105-word story, reported and written by Steve Brill, inverts the standard question of who should pay for health care and asks instead, Why are we paying so much? Why do we spend nearly 20% of our gross domestic product on health care, twice as much as most other developed countries, which get the same or better health outcomes? Why, Brill asks, does America spend more on health care than the next 10 highest-spending countries combined?

One answer is that health care is a seller's market and we're all buyers—buyers with little knowledge and no ability to negotiate. It's a $2.8 trillion market, but it's not a free one. Hospitals and health care providers offer services at prices that very often bear little relationship to costs. They charge what they want to, and mostly—because it's a life-and-death issue—we have to pay. Have you actually looked at your hospital bill? It's largely indecipherable, but Brill meticulously dissects bills and calculates the true costs. He employs a classic journalistic practice: he follows the money, and he does it right down to the 10,000% markup that hospitals put on acetaminophen. He explains why about one-fourth of our bloated health care spending is overpayment and strips the veneer from of a vital American industry that is not always what it seems to be.

Brill, the founder of Court TV and *American Lawyer* and the CEO of Journalism Online, is one of America's premier—and most dogged—journalists. Brill, who will be talking about health care on CNN all this week, has worked on this story for the past seven months. "What I learned in doing the piece," he says, "is what I always tell my journalism students: opinions and policy debates are boring and meaningless without looking at the facts, without doing the grunt work of real reporting."

If the piece has a villain, it's something you've probably never heard of: the chargemaster, the mysterious internal price list for products and services that every hospital in the U.S. keeps. If the piece has a hero, it's an unlikely one: Medicare, the government program that by law can pay hospitals only the approximate costs of care. It's Medicare, not Obamacare, that is bending the curve in terms of costs and efficiency. Brill's story is resolutely nonideological, but it resets the terms of one of our most important policy debates. Both sides of the aisle are culpable, as our elected leaders refuse to rein in hospitals and health care providers. According to Brill, there are things that can be done. He argues that lowering the age of Medicare entry, not raising it, would lower costs. And that allowing Medicare to competitively price and assess drugs would save billions of dollars. Asking wealthy Medicare recipients for higher co-pays would make sense. Most of all, health care must be a market in which patients can help control costs by understanding them better. And make sure you look at your hospital bill.



Finishing touches *Brill spent seven months deciphering the hidden costs in hospital bills*

Richard Stengel, MANAGING EDITOR

STENGEL: MARTIN SCHOELLER; BRILL: ELIZABETH D. HERMAN FOR TIME

Tell your side of the story

CNN iReport

Share your experience with high medical bills by adding video or photos to **cnnireport.com/bitterpill**, or visit **time.com/bitterpill** to join the conversation on our live blog. **#BITTERPILL**

Steven Brill discusses his investigation into the high costs of American health care in a video for the iPad

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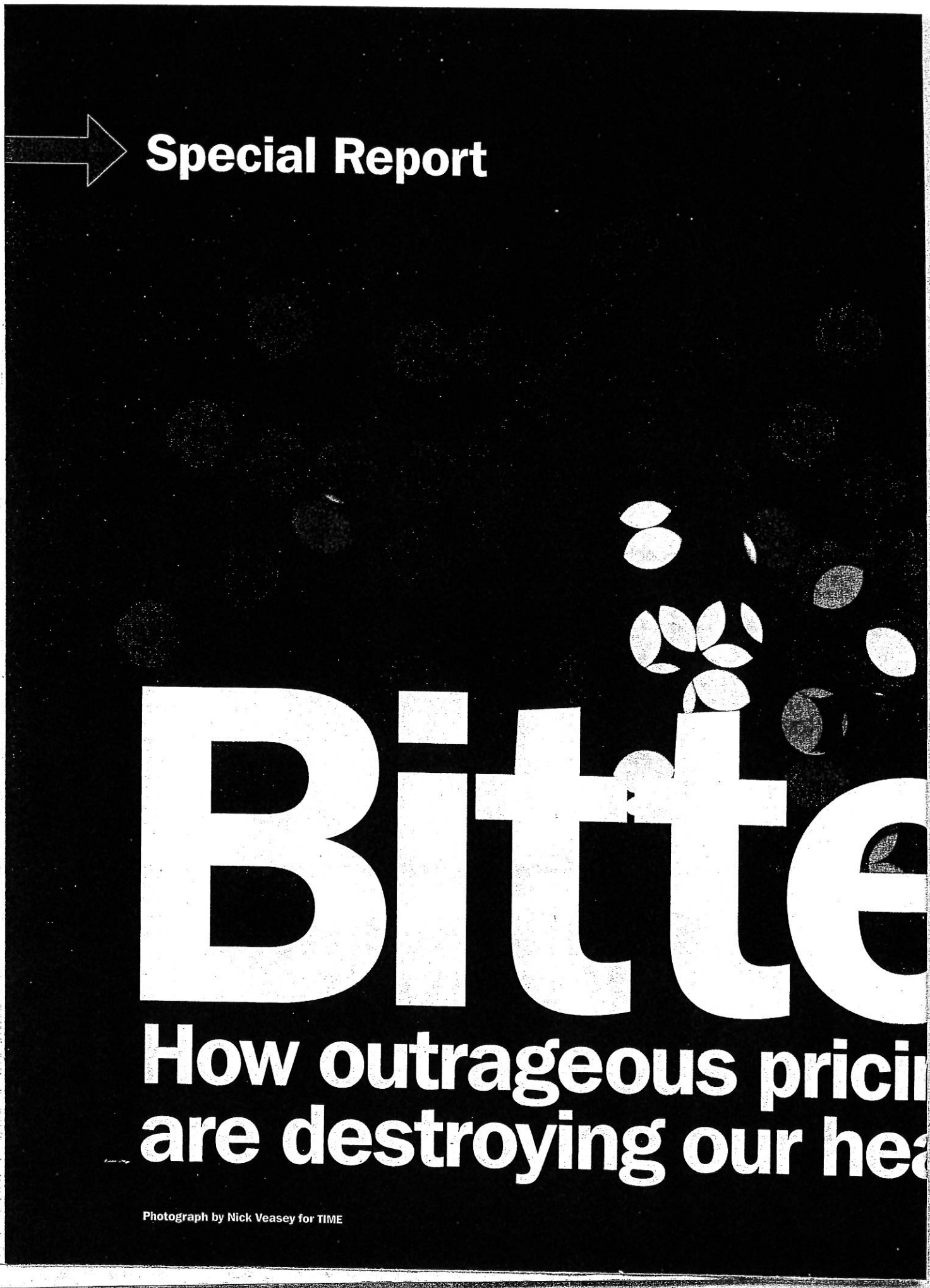

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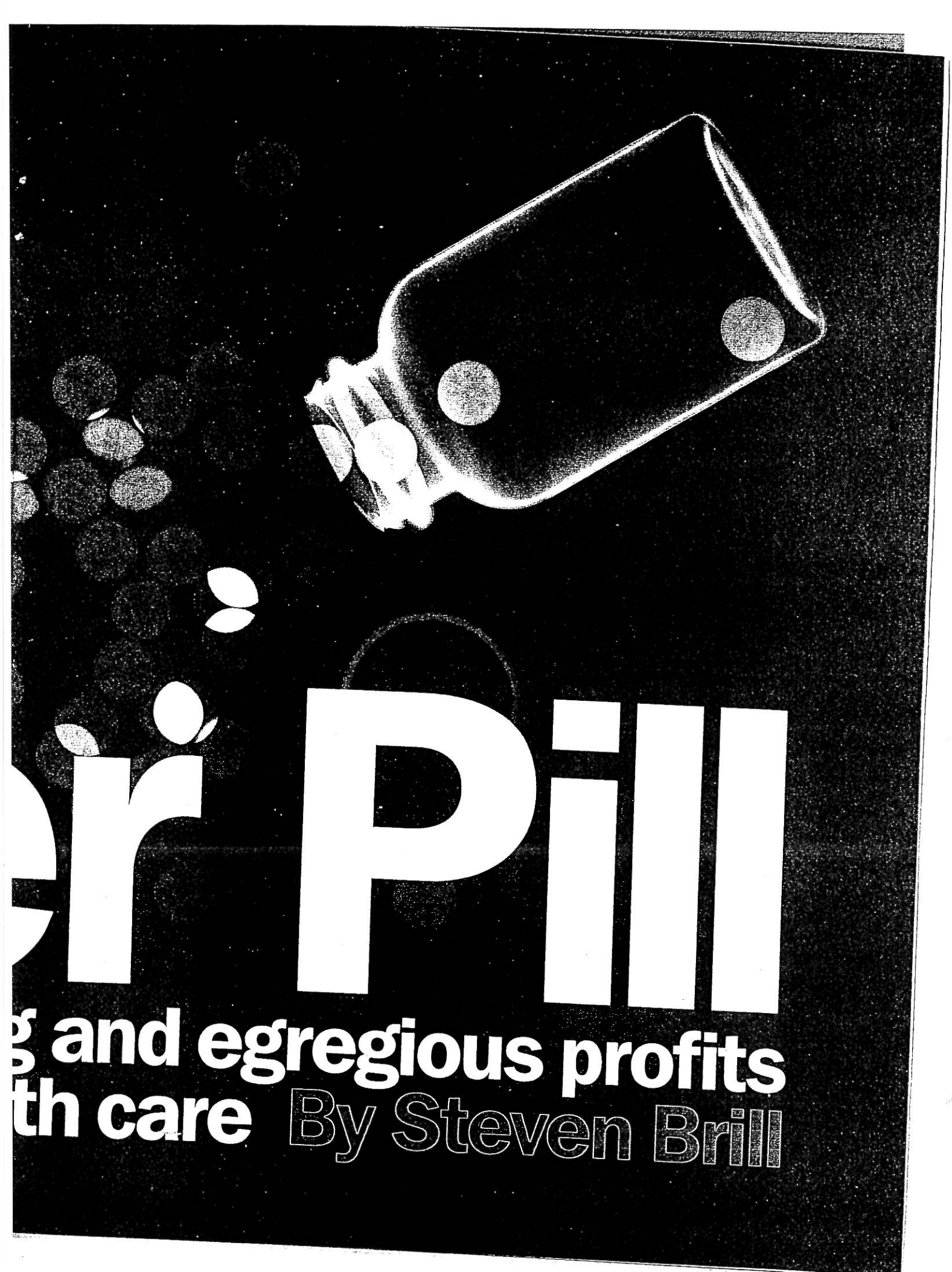
How outrageous pricin are destroying our hea

Photograph by Nick Veasey for TIME



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By Steven Brill

1

Routine Care, Unforgettable Bills

WHEN SEAN RECCHI, A 42-YEAR-OLD FROM LANCASTER, Ohio, was told last March that he had non-Hodgkin's lymphoma, his wife Stephanie knew she had to get him to MD Anderson Cancer Center in Houston. Stephanie's father had been treated there 10 years earlier, and she and her family credited the doctors and nurses at MD Anderson with extending his life by at least eight years.

Because Stephanie and her husband had recently started their own small technology business, they were unable to buy comprehensive health insurance. For $469 a month, or about 20% of their income, they had been able to get only a policy that covered just $2,000 per day of any hospital costs. "We don't take that kind of discount insurance," said the woman at MD Anderson when Stephanie called to make an appointment for Sean.

Stephanie was then told by a billing clerk that the estimated cost of Sean's visit—just to be examined for six days so a treatment plan could be devised—would be $48,900, due in advance. Stephanie got her mother to write her a check. "You do anything you can in a situation like that," she says. The Recchis flew to Houston, leaving Stephanie's mother to care for their two teenage children.

About a week later, Stephanie had to ask her mother for $35,000 more so Sean could begin the treatment the doctors had decided was urgent. His condition had worsened rapidly since he had arrived in Houston. He was "sweating and shaking with chills and pains," Stephanie recalls. "He had a large mass in his chest that was ... growing. He was panicked."

Nonetheless, Sean was held for about 90 minutes in a reception area, she says, because the hospital could not confirm that the check had cleared. Sean was allowed to see the doctor only after he advanced MD Anderson $7,500 from his credit card. The hospital says there was nothing unusual about how Sean was kept waiting. According to MD Anderson communications manager Julie Penne, "Asking for advance payment for services is a common, if unfortunate, situation that confronts hospitals all over the United States."

The total cost, in advance, for Sean to get his treatment plan and initial doses of chemotherapy was $83,900.

Why?

The first of the 344 lines printed out across eight pages of his hospital bill—filled with indecipherable numerical codes and acronyms—seemed innocuous. But it set the tone for all that followed. It read, "1 ACETAMINOPHE TABS 325 MG." The charge was only $1.50, but it was for a generic version of a Tylenol pill. You can buy 100 of them on Amazon for $1.49 even without a hospital's purchasing power.

Dozens of midpriced items were embedded with similarly aggressive markups, like $283.00 for a "CHEST, PA AND LAT 71020." That's a simple chest X-ray, for which MD Anderson is routinely paid $20.44 when it treats a patient on Medicare, the government health care program for the elderly.

Every time a nurse drew blood, a "ROUTINE VENIPUNCTURE" charge of $36.00 appeared, accompanied by charges of $23 to $78 for each of a dozen or more lab analyses performed on the blood sample. In all, the charges for blood and other lab tests done on Recchi amounted to more than $15,000. Had Recchi been old enough for Medicare, MD Anderson would have been paid a few hundred dollars for all those tests. By law, Medicare's payments approximate a hospital's cost of providing a service, including overhead, equipment and salaries.

On the second page of the bill, the markups got bolder. Recchi was charged $13,702 for "1 RITUXIMAB INJ 660 MG." That's an injection of 660 mg of a cancer wonder drug called Rituxan. The average price paid by all hospitals for this dose is about $4,000, but MD Anderson probably gets a volume discount that would make its cost $3,000 to $3,500. That means the nonprofit cancer center's paid-in-advance markup on Recchi's lifesaving shot would be about 400%.

When I asked MD Anderson to comment on the charges on Recchi's bill, the cancer center released a written statement that said in part, "The issues related to health care finance are complex for patients, health care providers, payers and government entities alike ... MD Anderson's clinical billing and collection practices are similar to those of other major hospitals and academic medical centers."

The hospital's hard-nosed approach pays off. Although it is officially a nonprofit unit of the University of Texas, MD Anderson has revenue that exceeds the cost of the world-class care it provides by so much that its operating profit for the fiscal year 2010, the most recent annual report it filed with the U.S. Department of Health and Human Services, was $531 million. That's a profit margin of 26% on revenue of $2.05 billion, an astounding result for such a service-intensive enterprise.[1]

THE PRESIDENT OF MD ANDERSON IS PAID LIKE SOMEONE running a prosperous business. Ronald DePinho's total compensation last year was $1,845,000. That does not count outside earnings derived from a much publicized waiver he

1. Here and elsewhere I define *operating profit* as the hospital's excess of revenue over expenses, plus the amount it lists on its tax return for depreciation of assets—because depreciation is an accounting expense, not a cash expense. John Gunn, chief operating officer of Memorial Sloan-Kettering Cancer Center, calls this the "fairest way" of judging a hospital's financial performance

Photograph by Claudia Susana for TIME

Sean Recchi

Diagnosed with non-Hodgkin's lymphoma at age 42. Total cost, in advance, for Sean's treatment plan and initial doses of chemotherapy: $83,900. Charges for blood and lab tests amounted to more than $15,000; with Medicare, they would have cost a few hundred dollars

received from the university that, according to the Houston *Chronicle*, allows him to maintain unspecified "financial ties with his three principal pharmaceutical companies."

DePinho's salary is nearly triple the $674,350 paid to William Powers Jr., the president of the entire University of Texas system, of which MD Anderson is a part. This pay structure is emblematic of American medical economics and is reflected on campuses across the U.S., where the president of a hospital or hospital system associated with a university—whether it's Texas, Stanford, Duke or Yale—is invariably paid much more than the person in charge of the university.

I got the idea for this article when I was visiting Rice University last year. As I was leaving the campus, which is just outside the central business district of Houston, I noticed a group of glass skyscrapers about a mile away lighting up the evening sky. The scene looked like Dubai. I was looking at the Texas Medical Center, a nearly 1,300-acre, 280-building complex of hospitals and related medical facilities, of which MD Anderson is the lead brand name. Medicine had obviously become a huge business. In fact, of Houston's top 10 employers, five are hospitals, including MD Anderson with 19,000 employees; three, led by ExxonMobil with 14,000 employees, are energy companies. How did that happen, I wondered. Where's all that money coming from? And where is it going? I have spent the past seven months trying to find out by analyzing a variety of bills from hospitals like MD Anderson, doctors, drug companies and every other player in the American health care ecosystem.

WHEN YOU LOOK BEHIND THE BILLS THAT SEAN RECCHI AND other patients receive, you see nothing rational—no rhyme or reason—about the costs they faced in a marketplace they enter through no choice of their own. The only constant is the sticker shock for the patients who are asked to pay.

Yet those who work in the health care industry and those who argue over health care policy seem inured to the shock. When we debate health care policy, we seem to jump right to the issue of who should pay the bills, blowing past what should be the first question: Why exactly are the bills so high?

What are the reasons, good or bad, that cancer means a half-million- or million-dollar tab? Why should a trip to the emergency room for chest pains that turn out to be indigestion bring a bill that can exceed the cost of a semester of college? What makes a single dose of even the most wonderful wonder drug cost thousands of dollars? Why does simple lab work done during a few days in a hospital cost more than a car? And what is so different about the medical ecosystem that causes technology advances to drive bills up instead of down?

Recchi's bill and six others examined line by line for this article offer a closeup window into what happens when powerless buyers—whether they are people like Recchi or big health-insurance companies—meet sellers in what is the ultimate seller's market.

The result is a uniquely American gold rush for those who provide everything from wonder drugs to canes to high-tech implants to CT scans to hospital bill-coding and collection services. In hundreds of small and midsize cities across the country—from Stamford, Conn., to Marlton, N.J., to Oklahoma City—the American health care market has transformed tax-exempt "nonprofit" hospitals into the towns' most profitable businesses and largest employers, often presided over by the regions' most richly compensated executives. And in our largest cities, the system offers lavish paychecks even to midlevel hospital managers, like the 14 administrators at New York City's Memorial Sloan-Kettering Cancer Center who are paid over $500,000 a year, including six who make over $1 million.

For every member of Congress, there are more than seven lobbyists working for various parts of the health care industry

Taken as a whole, these powerful institutions and the bills they churn out dominate the nation's economy and put demands on taxpayers to a degree unequaled anywhere else on earth. In the U.S., people spend almost 20% of the gross domestic product on health care, compared with about half that in most developed countries. Yet in every measurable way, the results our health care system produces are no better and often worse than the outcomes in those countries.

According to one of a series of exhaustive studies done by the McKinsey & Co. consulting firm, we spend more on health care than the next 10 biggest spenders combined: Japan, Germany, France, China, the U.K., Italy, Canada, Brazil, Spain and Australia. We may be shocked at the $60 billion price tag for cleaning up after Hurricane Sandy. We spent almost that much last week on health care. We spend more every year on artificial knees and hips than what Hollywood collects at the box office. We spend two or three times that much on durable medical devices like canes and wheelchairs, in part because a heavily lobbied Congress forces Medicare to pay 25% to 75% more for this equipment than it would cost at Walmart.

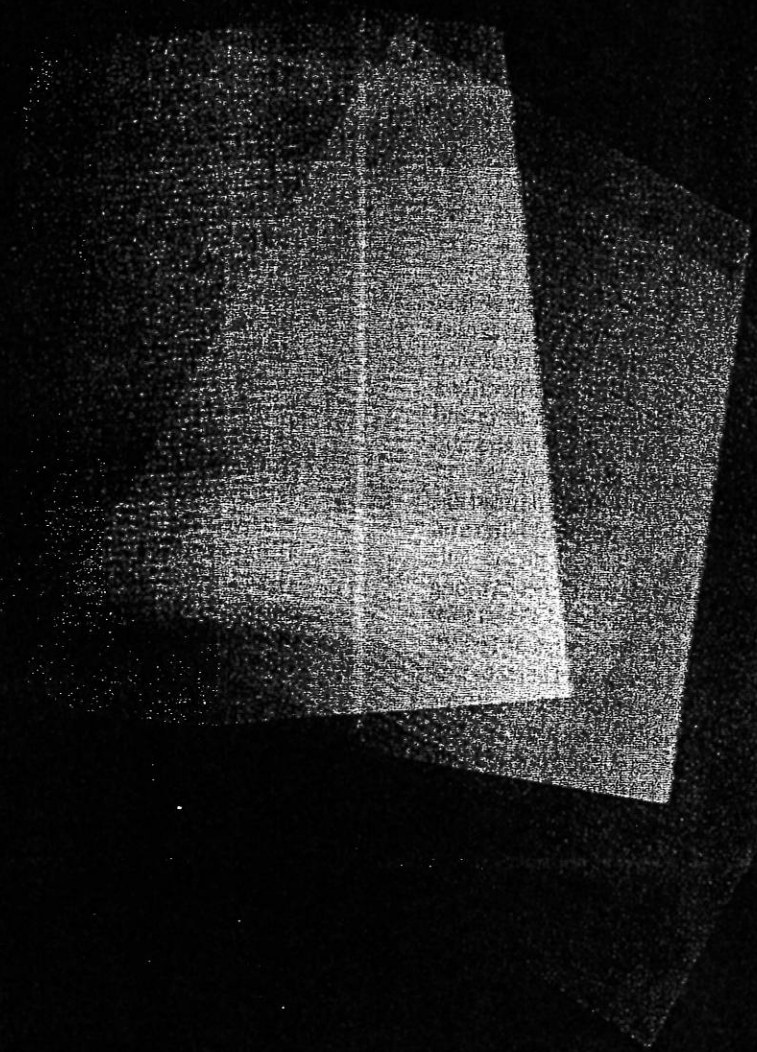
The Bureau of Labor Statistics projects that 10 of the 20 occupations that will grow the fastest in the U.S. by 2020 are related to health care. America's largest city may be commonly thought of as the world's financial-services capital, but of New York's 18 largest private employers, eight are hospitals and four are banks. Employing all those people in the cause of curing the sick is, of course, not anything to be ashamed of. But the drag on our overall economy that comes with taxpayers, employers and consumers spending so much more than is spent in any other country for the same product is unsustainable. Health care is eating away at our economy and our treasury.

The health care industry seems to have the will and the means to keep it that way. According to the Center for Responsive Politics, the pharmaceutical and health-care-product industries, combined with organizations representing doctors, hospitals, nursing homes, health services and HMOs, have spent $5.36 billion since 1998 on lobbying in Washington. That dwarfs the $1.53 billion spent by the defense and aerospace industries and the $1.3 billion spent by oil and gas interests over the same period. That's right: the health-care-industrial complex spends more than three times what the military-industrial complex spends in Washington.

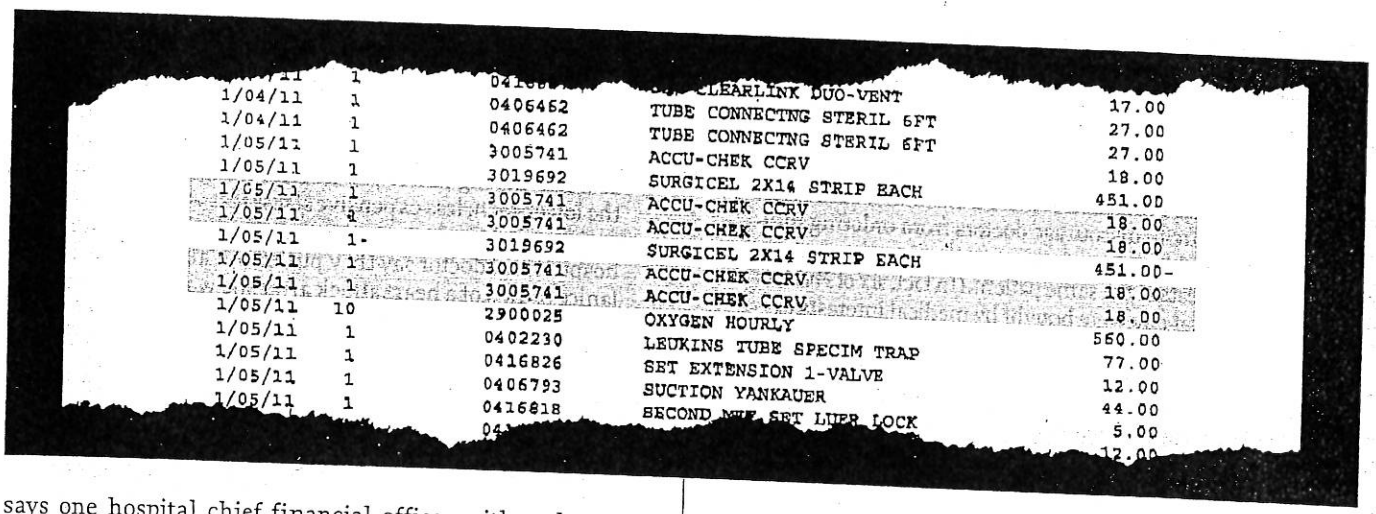
WHEN YOU CRUNCH DATA COMPILED BY MCKINSEY AND OTHER researchers, the big picture looks like this: We're likely to spend $2.8 trillion this year on health care. That $2.8 trillion is likely to be $750 billion, or 27%, more than we would spend if we spent the same per capita as other developed countries, even after adjusting for the relatively high per capita income in the U.S. vs. those other countries. Of the total $2.8 trillion that will be spent on health care, about $800 billion will be paid by the federal government through the Medicare insurance program for the disabled and those 65 and older

Photograph by Nick Veasey for TIME

Gauze Pads



$77 Charge for each of four boxes of sterile gauze pads, as itemized in a $348,000 bill following a patient's diagnosis of lung cancer



	1	[illegible]	[illegible] CLEARLINK DUO-VENT	
1/04/11	1	0406462	TUBE CONNECTNG STERIL 6FT	17.00
1/04/11	1	0406462	TUBE CONNECTNG STERIL 6FT	27.00
1/05/11	1	3005741	ACCU-CHEK CCRV	27.00
1/05/11	1	3019692	SURGICEL 2X14 STRIP EACH	18.00
1/05/11	1	3005741	ACCU-CHEK CCRV	451.00
1/05/11	1	3005741	ACCU-CHEK CCRV	18.00
1/05/11	1-	3019692	SURGICEL 2X14 STRIP EACH	18.00
1/05/11	1	3005741	ACCU-CHEK CCRV	451.00-
1/05/11	1	3005741	ACCU-CHEK CCRV	18.00
1/05/11	10	2900025	OXYGEN HOURLY	18.00
1/05/11	1	0402230	LEUKINS TUBE SPECIM TRAP	560.00
1/05/11	1	0416826	SET EXTENSION 1-VALVE	77.00
1/05/11	1	0406793	SUCTION YANKAUER	12.00
1/05/11	1	0416818	SECOND [illegible] SET LUER LOCK	44.00
		04[illegible]		5.00
				12.00

says one hospital chief financial officer with a shrug.

At Stamford Hospital I got the first of many brush-offs when I asked about the chargemaster rates on Janice S.'s bill. "Those are not our real rates," protested hospital spokesman Orstad when I asked him to make hospital CEO Brian Grissler available to explain Janice S.'s bill, in particular the blood-test charges. "It's a list we use internally in certain cases, but most people never pay those prices. I doubt that Brian [Grissler] has even seen the list in years. So I'm not sure why you care."

Orstad also refused to comment on any of the specifics in Janice S.'s bill, including the seemingly inflated charges for all the lab work. "I've told you I don't think a bill like this is relevant," he explained. "Very few people actually pay those rates."

But Janice S. was asked to pay them. Moreover, the chargemaster rates are relevant, even for those unlike her who have insurance. Insurers with the most leverage, because they have the most customers to offer a hospital that needs patients, will try to negotiate prices 30% to 50% above the Medicare rates rather than discounts off the sky-high chargemaster rates. But insurers are increasingly losing leverage because hospitals are consolidating by buying doctors' practices and even rival hospitals. In that situation—in which the insurer needs the hospital more than the hospital needs the insurer—the pricing negotiation will be over discounts that work down from the chargemaster prices rather than up from what Medicare would pay. Getting a 50% or even 60% discount off the chargemaster price of an item that costs $13 and lists for $199.50 is still no bargain. "We hate to negotiate off of the chargemaster, but we have to do it a lot now," says Edward Wardell, a lawyer for the giant health-insurance provider Aetna Inc.

That so few consumers seem to be aware of the chargemaster demonstrates how well the health care industry has steered the debate from why bills are so high to who should pay them.

The expensive technology deployed on Janice S. was a bigger factor in her bill than the lab tests. An "NM MYO REST/SPEC EJCT MOT MUL" was billed at $7,997.54. That's a stress test using a radioactive dye that is tracked by an X-ray computed tomography, or CT, scan. Medicare would have paid Stamford $554 for that test.

JANICE S. WAS CHARGED AN ADDITIONAL $872.44 JUST FOR the dye used in the test. The regular stress test patients are more familiar with, in which arteries are monitored electronically with an electrocardiograph, would have cost far less—$1,200 even at the hospital's chargemaster price. (Medicare would have paid $96 for it.) And although many doctors view the version using the CT scan as more thorough, others consider it unnecessary in most cases.

Test Strips PATIENT WAS CHARGED $18 EACH FOR ACCU-CHEK DIABETES TEST STRIPS. AMAZON SELLS BOXES OF 50 FOR ABOUT $27, OR 55¢ EACH

According to Jack Lewin, a cardiologist and former CEO of the American College of Cardiology, "It depends on the patient, of course, but in most cases you would start with a standard stress test. We are doing too many of these nuclear tests. It is not being used appropriately ... Sometimes a cardiogram is enough, and you don't even need the simpler test. But it usually makes sense to give the patient the simpler one first and then use nuclear for a closer look if there seem to be problems."

We don't know the particulars of Janice S.'s condition, so we cannot know why the doctors who treated her ordered the more expensive test. But the incentives are clear. On the basis of market prices, Stamford probably paid about $250,000 for the CT equipment in its operating room. It costs little to operate, so the more it can be used and billed, the quicker the hospital recovers its costs and begins profiting from its purchase. In addition, the cardiologist in the emergency room gave Janice S. a separate bill for $600 to read the test results on top of the $342 he charged for examining her.

According to a McKinsey study of the medical marketplace, a typical piece of equipment will pay for itself in one year if it carries out just 10 to 15 procedures a day. That's a terrific return on capital equipment that has an expected life span of seven to 10 years. And it means that after a year, every scan ordered by a doctor in the Stamford Hospital emergency room would mean pure profit, less maintenance costs, for the hospital. Plus an extra fee for the doctor.

Another McKinsey report found that health care providers in the U.S. conduct far more CT tests per capita than those in any other country—71% more than in Germany, for example, where the government-run health care system offers none of those incentives for overtesting. We also pay a lot more for each test, even when it's Medicare doing the paying. Medicare reimburses hospitals and clinics an average of four times as much as Germany does for CT scans, according to the data gathered by McKinsey.

Medicare's reimbursement formulas for these tests are regulated by Congress. So too are restrictions on what Medicare can do to limit the use of CT and magnetic resonance imaging

(MRI) scans when they might not be medically necessary. Standing at the ready to make sure Congress keeps Medicare at bay is, among other groups, the American College of Radiology, which on Nov. 14 ran a full-page ad in the Capitol Hill–centric newspaper *Politico* urging Congress to pass the Diagnostic Imaging Services Access Protection Act. It's a bill that would block efforts by Medicare to discourage doctors from ordering multiple CT scans on the same patient by paying them less per test to read multiple tests of the same patient. (In fact, six of *Politico*'s 12 pages of ads that day were bought by medical interests urging Congress to spend or not cut back on one of their products.)

The costs associated with high-tech tests are likely to accelerate. McKinsey found that the more CT and MRI scanners are out there, the more doctors use them. In 1997 there were fewer than 3,000 machines available, and they completed an average of 3,800 scans per year. By 2006 there were more than 10,000 in use, and they completed an average of 6,100 per year.

According to a study in the *Annals of Emergency Medicine*, the use of CT scans in America's emergency rooms "has more than quadrupled in recent decades." As one former emergency-room doctor puts it, "Giving out CT scans like candy in the ER is the equivalent of putting a 90-year-old grandmother through a pat-down at the airport: Hey, you never know."

Selling this equipment to hospitals—which has become a key profit center for industrial conglomerates like General Electric and Siemens—is one of the U.S. economy's bright spots. I recently subscribed to an online headhunter's listings for medical-equipment salesmen and quickly found an opening in Connecticut that would pay a salary of $85,000 and sales commissions of up to $95,000 more, plus a car allowance. The only requirement was that applicants have "at least one year of experience selling some form of capital equipment."

In all, on the day I signed up for that jobs website, it carried 186 listings for medical-equipment salespeople just in Connecticut.

2

Medical Technology's Perverse Economics

UNLIKE THOSE OF ALMOST ANY OTHER AREA WE CAN THINK of, the dynamics of the medical marketplace seem to be such that the advance of technology has made medical care more expensive, not less. First, it appears to encourage more procedures and treatment by making them easier and more convenient. (This is especially true for procedures like arthroscopic surgery.) Second, there is little patient pushback against higher costs because it seems to (and often does) result in safer, better care and because the customer getting the treatment is either not going to pay for it or not going to know the price until after the fact.

Hurricane Sandy is costing $60 billion to clean up. We spend nearly that much on health care every week

Beyond the hospitals' and doctors' obvious economic incentives to use the equipment and the manufacturers' equally obvious incentives to sell it, there's a legal incentive at work. Giving Janice S. a nuclear-imaging test instead of the lower-tech, less expensive stress test was the safer thing to do—a belt-and-suspenders approach that would let the hospital and doctor say they pulled out all the stops in case Janice S. died of a heart attack after she was sent home.

"We use the CT scan because it's a great defense," says the CEO of another hospital not far from Stamford. "For example, if anyone has fallen or done anything around their head—hell, if they even say the word *head*—we do it to be safe. We can't be sued for doing too much."

His rationale speaks to the real cost issue associated with medical-malpractice litigation. It's not as much about the verdicts or settlements (or considerable malpractice-insurance premiums) that hospitals and doctors pay as it is about what they do to avoid being sued. And some no doubt claim they are ordering more tests to avoid being sued when it is actually an excuse for hiking profits. The most practical malpractice-reform proposals would not limit awards for victims but would allow doctors to use what's called a safe-harbor defense. Under safe harbor, a defendant doctor or hospital could argue that the care provided was within the bounds of what peers have established as reasonable under the circumstances. The typical plaintiff argument that doing something more, like a nuclear-imaging test, might have saved the patient would then be less likely to prevail.

When Obamacare was being debated, Republicans pushed this kind of commonsense malpractice-tort reform. But the stranglehold that plaintiffs' lawyers have traditionally had on Democrats prevailed, and neither a safe-harbor provision nor any other malpractice reform was included.

Nonprofit Profitmakers

TO THE EXTENT THAT THEY DEFEND THE CHARGEMASTER rates at all, the defense that hospital executives offer has to do with charity. As John Gunn, chief operating officer of Sloan-Kettering, puts it, "We charge those rates so that when we get paid by a [wealthy] uninsured person from overseas, it allows us to serve the poor."

A closer look at hospital finance suggests two holes in that argument. First, while Sloan-Kettering does have an aggressive financial-assistance program (something Stamford Hospital lacks), at most hospitals it's not a Saudi sheik but the *almost* poor—those who don't qualify for Medicaid and don't have insurance—who are most often asked to pay those exorbitant chargemaster prices. Second, there is the jaw-dropping difference between those list prices and the hospitals' costs, which enables these ostensibly nonprofit institutions to produce high profits even after all the discounts. True, when the discounts to Medicare and private insurers are applied, hospitals end up being paid a lot less overall than what is itemized on the original bills. Stamford ends up receiving about 35% of what it bills, which is the yield for most hospitals. (Sloan-Kettering and

MD Anderson, whose great brand names make them tough negotiators with insurance companies, get about 50%).

However, no matter how steep the discounts, the chargemaster prices are so high and so devoid of any calculation related to cost that the result is uniquely American: thousands of nonprofit institutions have morphed into high-profit, high-profile businesses that have the best of both worlds. They have become entities akin to low-risk, must-have public utilities that nonetheless pay their operators as if they were high-risk entrepreneurs. As with the local electric company, customers must have the product and can't go elsewhere to buy it. They are steered to a hospital by their insurance companies or doctors (whose practices may have a business alliance with the hospital or even be owned by it). Or they end up there because there isn't any local competition. But unlike with the electric company, no regulator caps hospital profits.

Yet hospitals are also beloved local charities.

The result is that in small towns and cities across the country, the local nonprofit hospital may be the community's strongest business, typically making tens of millions of dollars a year and paying its nondoctor administrators six or seven figures. As nonprofits, such hospitals solicit contributions, and their annual charity dinner, a showcase for their good works, is typically a major civic event. But charitable gifts are a minor part of their base; Stamford Hospital raised just over 1% of its revenue from contributions last year. Even after discounts, those $199.50 blood tests and multithousand-dollar CT scans are what really count.

Thus, according to the latest publicly available tax return it filed with the IRS, for the fiscal year ending September 2011, Stamford Hospital—in a midsize city serving an unusually high 50% share of highly discounted Medicare and Medicaid patients—managed an operating profit of $63 million on revenue actually received (after all the discounts off the chargemaster) of $495 million. That's a 12.7% operating profit margin, which would be the envy of shareholders of high-service businesses across other sectors of the economy.

Its nearly half-billion dollars in revenue also makes Stamford Hospital by far the city's largest business serving only local residents. In fact, the hospital's revenue exceeded all money paid to the city of Stamford in taxes and fees. The hospital is a bigger business than its host city.

There is nothing special about the hospital's fortunes. Its operating profit margin is about the same as the average for all nonprofit hospitals, 11.7%, even when those that lose money are included. And Stamford's 12.7% was tallied after the hospital paid a slew of high salaries to its management, including $744,000 to its chief financial officer and $1,860,000 to CEO Grissler.

In fact, when McKinsey, aided by a Bank of America survey, pulled together all hospital financial reports, it found that the 2,900 nonprofit hospitals across the country, which are exempt from income taxes, actually end up averaging higher operating profit margins than the 1,000 for-profit hospitals after the for-profits' income-tax obligations are deducted. In health care, being nonprofit produces more profit.

Nonetheless, hospitals like Stamford are able to use their sympathetic nonprofit status to push their interests. As the debate over deficit-cutting ideas related to health care has heated up, the American Hospital Association has run daily ads on Mike Allen's Playbook, a popular Washington tip sheet, urging that Congress not be allowed to cut hospital payments because that would endanger the "$39.3 billion" in care for the poor that hospitals now provide. But that $39.3 billion figure is calculated on the basis of chargemaster prices. Judging from the difference I saw in the bills examined between a typical chargemaster price and what Medicare says the item cost, this would mean that this $39.3 billion in charity care cost the hospitals less than $3 billion to provide. That's less than half of 1% of U.S. hospitals' annual revenue and includes bad debt that the hospitals did not give away willingly in any event.

25% of Americans surveyed said they or a household member have skipped a recommended medical test or treatment because of the cost

Under Internal Revenue Service rules, nonprofits are not prohibited from taking in more money than they spend. They just can't distribute the overage to shareholders—because they don't have any shareholders.

So, what do these wealthy nonprofits do with all the profit? In a trend similar to what we've seen in nonprofit colleges and universities—where there has been an arms race of sorts to use rising tuition to construct buildings and add courses of study—the hospitals improve and expand facilities (despite the fact that the U.S. has more hospital beds than it can fill), buy more equipment, hire more people, offer more services, buy rival hospitals and then raise executive salaries because their operations have gotten so much larger. They keep the upward spiral going by marketing for more patients, raising prices and pushing harder to collect bill payments. Only with health care, the upward spiral is easier to sustain. Health care is seen as even more of a necessity than higher education. And unlike in higher education, in health care there is little price transparency—and far less competition in any given locale even if there were transparency. Besides, a hospital is typically one of the community's larger employers if not the largest, so there is unlikely to be much local complaining about its burgeoning economic fortunes.

In December, when the New York *Times* ran a story about how a deficit deal might threaten hospital payments, Steven Safyer, chief executive of Montefiore Medical Center, a large nonprofit hospital system in the Bronx, complained, "There is no such thing as a cut to a provider that isn't a cut to a beneficiary ... This is not crying wolf."

Actually, Safyer seems to be crying wolf to the tune of about $196.8 million, according to the hospital's latest publicly available tax return. That was his hospital's operating profit, according to its 2010 return. With $2.586 billion in revenue—of which 99.4% came from patient bills and 0.6% from fundraising events and other charitable contributions—Safyer's business is more than six times as large as that of the Bronx's most famous enterprise, the New York Yankees. Surely, without cutting services to beneficiaries, Safyer could cut what have to be some of the Bronx's better non-Yankee salaries: his own, which was $4,065,000, or those of his chief financial officer ($3,243,000), his executive vice president ($2,220,000) or the head of his dental department ($1,798,000).

SHOCKED BY HER BILL FROM STAMFORD HOSPITAL AND unable to pay it, Janice S. found a local woman on the Internet who is part of a growing cottage industry of people who call themselves medical-billing advocates. They help people read and understand their bills and try to reduce them. "The hospitals all know the bills are fiction, or at least only a place

to start the discussion, so you bargain with them," says Katalin Goencz, a former appeals coordinator in a hospital billing department who negotiated Janice S.'s bills from a home office in Stamford.

Goencz is part of a trade group called the Alliance of Claim Assistant Professionals, which has about 40 members across the country. Another group, Medical Billing Advocates of America, has about 50 members. Each advocate seems to handle 40 to 70 cases a year for the uninsured and those disputing insurance claims. That would be about 5,000 patients a year out of what must be tens of millions of Americans facing these issues—which may help explain why 60% of the personal bankruptcy filings each year are related to medical bills.

"I can pretty much always get it down 30% to 50% simply by saying the patient is ready to pay but will not pay $300 for a blood test or an X-ray," says Goencz. "They hand out blood tests and X-rays in hospitals like bottled water, and they know it."

After weeks of back-and-forth phone calls, for which Goencz charged Janice S. $97 an hour, Stamford Hospital cut its bill in half. Most of the doctors did about the same, reducing Janice S.'s overall tab from $21,000 to about $11,000.

But the best the ambulance company would offer Goencz was to let Janice S. pay off its $995 ride in $25-a-month installments. "The ambulances never negotiate the amount," says Goencz.

A manager at Stamford Emergency Medical Services, which charged Janice S. $958 for the pickup plus $9.38 per mile, says that "our rates are all set by the state on a regional basis" and that the company is independently owned. That's at odds with a trend toward consolidation that has seen several private-equity firms making investments in what Wall Street analysts have identified as an increasingly high-margin business. Overall, ambulance revenues were more than $12 billion last year, or about 10% higher than Hollywood's box-office take.

It's not a great deal to pay off $1,000 for a four-mile ambulance ride on the layaway plan or receive a 50% discount on a $199.50 blood test that should cost $15, nor is getting half off on a $7,997.54 stress test that was probably all profit and may not have been necessary. But, says Goencz, "I don't go over it line by line. I just go for a deal. The patient usually is shocked by the bill, doesn't understand any of the language and has bill collectors all over her by the time they call me. So they're grateful. Why give them heartache by telling them they still paid too much for some test or pill?"

A Slip, a Fall And a $9,400 Bill

THE BILLING ADVOCATES AREN'T ALWAYS SUCCESSFUL. JUST ask Emilia Gilbert, a school-bus driver who got into a fight with a hospital associated with Connecticut's most venerable nonprofit institution, which racked up quick profits on multiple CT scans, then refused to compromise at all on its chargemaster prices.

Gilbert, now 66, is still making weekly payments on the bill she got in June 2008 after she slipped and fell on her face one summer evening in the small yard behind her house in Fairfield, Conn. Her nose bleeding heavily, she was taken to the emergency room at Bridgeport Hospital.

In 2010, 45% of working adults in small firms had problems paying medical bills or accrued medical debt

Along with Greenwich Hospital and the Hospital of St. Raphael in New Haven, Bridgeport Hospital is now owned by the Yale New Haven Health System, which boasts a variety of gleaming new facilities. Although Yale University and Yale New Haven are separate entities, Yale–New Haven Hospital is the teaching hospital for the Yale Medical School, and university representatives, including Yale president Richard Levin, sit on the Yale New Haven Health System board.

"I was there for maybe six hours, until midnight," Gilbert recalls, "and most of it was spent waiting. I saw the resident for maybe 15 minutes, but I got a lot of tests."

In fact, Gilbert got three CT scans—of her head, her chest and her face. The last one showed a hairline fracture of her nose. The CT bills alone were $6,538. (Medicare would have paid about $825 for all three.) A doctor charged $261 to read the scans.

Gilbert got the same troponin blood test that Janice S. got—the one Medicare pays $13.94 for and for which Janice S. was billed $199.50 at Stamford. Gilbert got just one. Bridgeport Hospital charged 20% more than its downstate neighbor: $239.

Also on the bill were items that neither Medicare nor any insurance company would pay anything at all for: basic instruments and bandages and even the tubing for an IV setup. Under Medicare regulations and the terms of most insurance contracts, these are supposed to be part of the hospital's facility charge, which in this case was $908 for the emergency room.

Gilbert's total bill was $9,418.

"We think the chargemaster is totally fair," says William Gedge, senior vice president of payer relations at Yale New Haven Health System. "It's fair because everyone gets the same bill. Even Medicare gets exactly the same charges that this patient got. Of course, we will have different arrangements for how Medicare or an insurance company will not pay some of the charges or discount the charges, but everyone starts from the same place." Asked how the chargemaster charge for an item like the troponin test was calculated, Gedge said he "didn't know exactly" but would try to find out. He subsequently reported back that "it's an historical charge, which takes into account all of our costs for running the hospital."

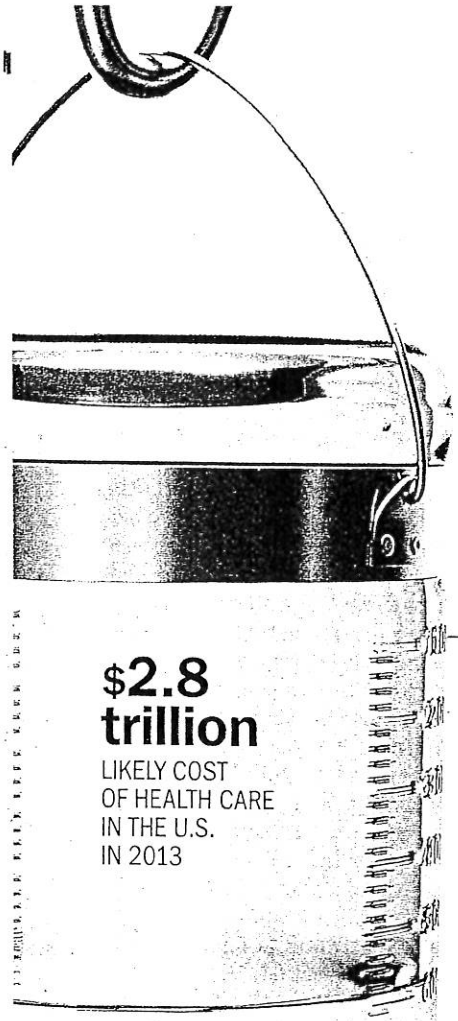
Bridgeport Hospital had $420 million in revenue and an operating profit of $52 million in 2010, the most recent year covered by its federal financial reports. CEO Robert Trefry, who has since left his post, was listed as having been paid $1.8 million. The CEO of the parent Yale New Haven Health System, Marna Borgstrom, was paid $2.5 million, which is 58% more than the $1.6 million paid to Levin, Yale University's president.

"You really can't compare the two jobs," says Yale–New Haven Hospital senior vice president Vincent Petrini. "Comparing hospitals to universities is like apples and oranges. Running a hospital organization is much more complicated." Actually, the four-hospital chain and the university have about the same operating budget. And it would seem that Levin deals with what most would consider complicated challenges in overseeing 3,900 faculty members, corralling (and complying with the terms of) hundreds of millions of dollars in government research grants and presiding over a $19 billion endowment, not to mention admitting and educating 14,000 students spread across Yale College and a

Photograph by Javier Sirvent for TIME

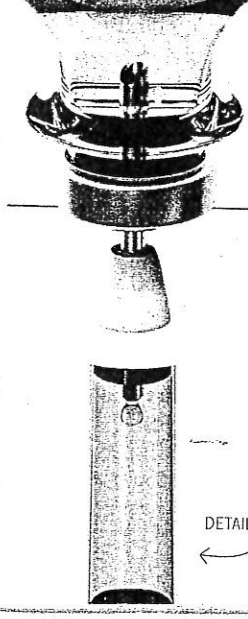
Emilia Gilbert

Slipped and fell in June 2008 and was taken to the emergency room. She is still paying off the $9,418 bill from that hospital visit in weekly installments. Her three CT scans cost $6,538. Medicare would have paid about $825 for all three



$2.8 trillion
LIKELY COST OF HEALTH CARE IN THE U.S. IN 2013

$750 billion
ADDITIONAL AMOUNT SPENT ANNUALLY FOR HEALTH CARE IN THE U.S. COMPARED WITH OTHER DEVELOPED NATIONS
(adjusted for relative income and cost of living)

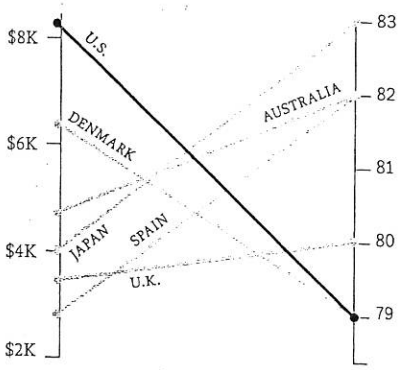


1
The Mess We're In

The U.S.'s uniquely high health care spending, which has been rising disproportionately to the economy, is not reflected in outcomes

Annual health care spending
per person in U.S. dollars, 2010

Life expectancy
at birth, in years



Infant mortality is relatively high

NO. **50**
U.S. RANK IN THE WORLD, NINE SPOTS BELOW CUBA, 2012

2
What Makes Health Care So Expensive

Average drug prices are sky-high

THE PRICE OF ...
One Lipitor pill in the U.S.

is the same as that of three in **Argentina**

One Plavix pill in the U.S.

is the same as that of four in **Spain**

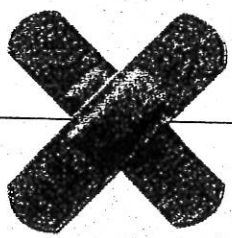
One Nexium pill in the U.S.

is the same as that of eight in **France**

Procedure costs are higher in the U.S. than in most other countries

	CT SCAN (HEAD)	APPENDECTOMY	CORONARY BYPASS
ARGENTINA	$78	$1,030	$9,319
AUSTRALIA	$254	$4,926	$38,891
CANADA	$122	$5,606	$40,954
CHILE	$184	$5,509	$20,505
FRANCE	$141	$3,164	$16,140
GERMANY	$272	$3,093	$16,578
INDIA	$43	$254	$4,525
SPAIN	$123	$2,615	$17,908
SWITZERLAND	$319	$5,840	$25,486
U.S.	$510	$13,003	$67,583

Average cost, 2011

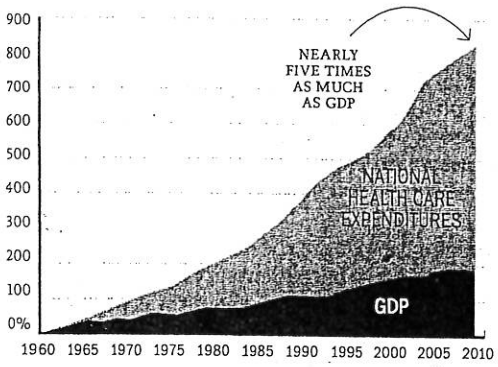


3
What We Can Do About It

Drawing on previous studies, ***Steven Brill*** *has estimated potential savings in the nation's health care system. Americans' bills tell us we don't have anything approaching a free market. The changes Brill suggests would allow the U.S. to provide better care at lower costs without substituting the kind of government-provider system typical in comparison countries*

Health spending has maintained a steep climb

Percentage growth since 1960



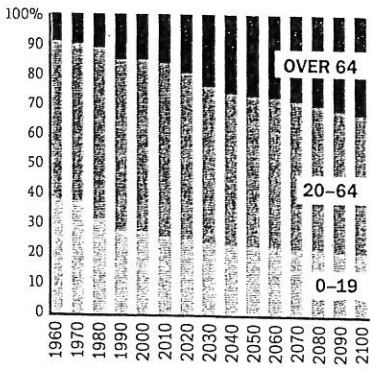
Adjusted for inflation and population growth

Health care is a major factor in personal finance

69% of those who've experienced medically related bankruptcy were insured at the time of their filing

62% of bankruptcies are related to illness or medical bills

The aging U.S. population will require more care



Percentage of total population

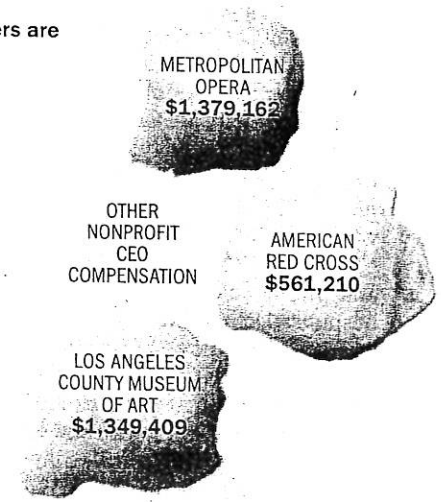
Nonprofit hospitals are making big bucks ...

Top 10 largest nonprofit hospitals*

HOSPITAL NAME	OPERATING PROFIT	CEO COMPENSATION
University of Pittsburgh Medical Center Presbyterian	$769,700,054	$5,975,462
Cleveland Clinic	$572,298,875	$2,564,214
Barnes-Jewish Hospital, St. Louis	$489,696,091	$2,335,882
New York–Presbyterian/Weill Cornell Medical Center	$383,477,548	$4,356,039
Indiana University Health Methodist Hospital, Indianapolis	$360,836,468	$2,080,779
Florida Hospital Orlando	$352,017,588	$2,925,356
Orlando Regional Medical Center	$250,843,745	$2,244,110
Montefiore Medical Center–Moses Division Hospital, Bronx, N.Y.	$196,868,926	$4,065,194
Methodist University Hospital, Memphis	$151,910,728	$2,180,962
Norton Hospital, Louisville, Ky.	$118,101,911	$2,206,401

*Hospital size by number of beds. Most recent available profits and salaries. Operating profit is defined as excess of revenue over expenses, plus the amount listed on tax returns for depreciation of assets. In some cases, salaries refer to those of the president or CEO of the parent health system

... and hospital leaders are receiving big pay



Includes all salaries, bonuses, deferred compensation and other payments, most recent available

The industry spends heavily on lobbying Congress

Total, 1998–2012

$5.36 billion

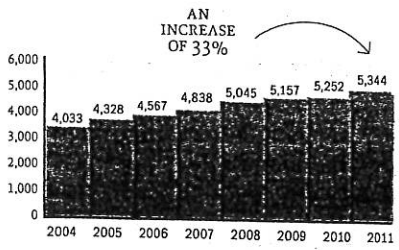
Lobbying by the pharmaceutical and health-care-products industries and organizations representing doctors, hospitals, nursing homes, health services and HMOs

$1.53 billion

Amount spent on lobbying by defense interests in the same period

More outpatient care allows for more procedures

Number of ambulatory surgery centers



$94 billion

Control prescription-drug prices, which make up 10% of U.S. health care costs. Studies show that drug prices in the U.S. are, on average, 50% higher than in other developed nations

$84 billion

Recapture 75% of profits from hospitals, whose expenses are about a third of health care costs, by taxing them and regulating their prices or ensuring real competition and transparency and the end of the chargemaster

$74 billion

Cut 5% from hospital and physician costs by reducing the overordering of tests and other procedures—sometimes used only to prevent medical-malpractice lawsuits

$50 billion

Spending on outpatient clinics and labs owned by doctors could be cut by a third by regulating fees or taxing profits

$30 billion

Use transparency, price controls and whatever else it takes—the Affordable Care Act included a 2.3% tax on medical devices—to bring the overall gross profit margins of medical-device makers like Medtronic down to 50%

$28 billion

Allow and fund comparative-effectiveness evaluations in decisions to prescribe drugs, tests and medical devices

Sources, these pages: World Bank; *CIA World Factbook*; McKinsey & Co.; *American Journal of Medicine*; U.N. Population Division; International Federation of Health Plans; *Becker Hospital Review*; IRS; Center for Responsive Politics; Centers for Medicare and Medicaid Services; Kaiser Family Foundation

Sources, other pages: Center for Responsive Politics; Kaiser Family Foundation; Commonwealth Fund; *Journal of Family Practice*; Employee Benefit Research Institute; McKinsey & Co.; ADP Research Institute

GRAPHIC BY ANDREA FORD, HEATHER JONES, CLAIRE MANIBOG AND LON TWEETEN

PHOTOS: GETTY IMAGES (29); CORBIS (2)

variety of graduate schools, professional schools and foreign-study outposts. And surely Levin's responsibilities are as complicated as those of the CEO of Yale New Haven Health's smallest unit—the 184-bed Greenwich Hospital, whose CEO was paid $112,000 more than Levin.

"WHEN I GOT THE BILL, I ALMOST HAD TO GO BACK TO THE hospital," Gilbert recalls. "I was hyperventilating." Contributing to her shock was the fact that although her employer supplied insurance from Cigna, one of the country's leading health insurers, Gilbert's policy was from a Cigna subsidiary called Starbridge that insures mostly low-wage earners. That made Gilbert one of millions of Americans like Sean Recchi who are routinely categorized as having health insurance but really don't have anything approaching meaningful coverage.

Starbridge covered Gilbert for just $2,500 per hospital visit, leaving her on the hook for about $7,000 of a $9,400 bill. Under Connecticut's rules (states set their own guidelines for Medicaid, the federal-state program for the poor), Gilbert's $1,800 a month in earnings was too high for her to qualify for Medicaid assistance. She was also turned down, she says, when she requested financial assistance from the hospital. Yale New Haven's Gedge insists that she never applied to the hospital for aid, and Gilbert could not supply me with copies of any applications.

In September 2009, after a series of fruitless letters and phone calls from its bill collectors to Gilbert, the hospital sued her. Gilbert found a medical-billing advocate, Beth Morgan, who analyzed the charges on the bill and compared them with the discounted rates insurance companies would pay. During two court-required mediation sessions, Bridgeport Hospital's attorney wouldn't budge; his client wanted the bill paid in full, Gilbert and Morgan recall. At the third and final mediation, Gilbert was offered a 20% discount off the chargemaster fees if she would pay immediately, but she says she responded that according to what Morgan told her about the bill, it was still too much to pay.

"We probably could have offered more," Gedge acknowledges. "But in these situations, our bill-collection attorneys only know the amount we are saying is owed, not whether it is a chargemaster amount or an amount that is already discounted."

On July 11, 2011, with the school-bus driver representing herself in Bridgeport superior court, a judge ruled that Gilbert had to pay all but about $500 of the original charges. (He deducted the superfluous bills for the basic equipment.) The judge put her on a payment schedule of $20 a week for six years. For her, the chargemaster prices were all too real.

The One-Day, $87,000 Outpatient Bill

GETTING A PATIENT IN AND OUT OF A HOSPITAL THE SAME day seems like a logical way to cut costs. Outpatients don't take up hospital rooms or require the expensive 24/7 observation and care that come with them. That's why in the 1990s Medicare pushed payment formulas on hospitals that paid them for whatever ailment they were treating (with more added for documented complications), not according to the number of days the patient spent in a bed. Insurance companies also pushed incentives on hospitals to move patients out faster or not admit them for overnight stays in the first place. Meanwhile, the introduction of procedures like noninvasive laparoscopic surgery helped speed the shift from inpatient to outpatient.

By 2010, average days spent in the hospital per patient had declined significantly, while outpatient services had increased even more dramatically. However, the result was not the savings that reformers had envisioned. It was just the opposite.

Experts estimate that outpatient services are now packed with so much hidden profit that about two-thirds of the $750 billion annual U.S. overspending identified by the McKinsey research on health care comes in payments for outpatient services. That includes work done by physicians, laboratories and clinics (including diagnostic clinics for CT scans or blood tests) and same-day surgeries and other hospital treatments like cancer chemotherapy. According to a McKinsey survey, outpatient emergency-room care averages an operating profit margin of 15% and nonemergency outpatient care averages 35%. On the other hand, inpatient care has a margin of just 2%. Put simply, inpatient care at nonprofit hospitals is, in fact, almost nonprofit. Outpatient care is wildly profitable.

"An operating room has fixed costs," explains one hospital economist. "You get 10% or 20% more patients in there every day who you don't have to board overnight, and that goes straight to the bottom line."

The 2011 outpatient visit of someone I'll call Steve H. to Mercy Hospital in Oklahoma City illustrates those economics. Steve H. had the kind of relatively routine care that patients might expect would be no big deal: he spent the day at Mercy getting his aching back fixed.

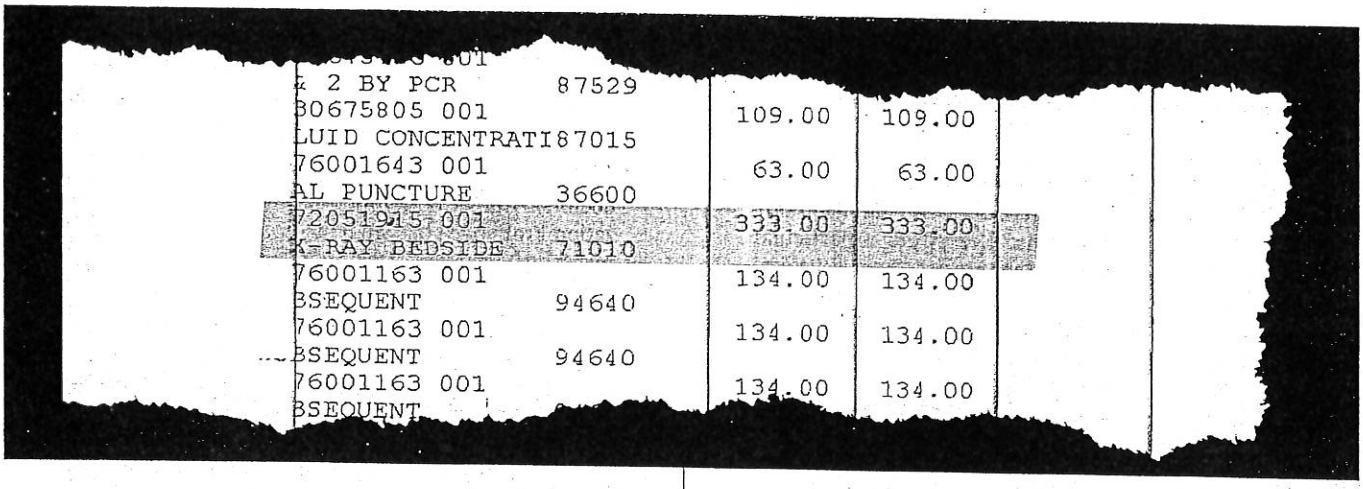
A blue collar worker who was in his 30s at the time and worked at a local retail store, Steve H. had consulted a specialist at Mercy in the summer of 2011 and was told that a stimulator would have to be surgically implanted in his back. The good news was that with all the advances of modern technology, the whole process could be done in a day. (The latest federal filing shows that 63% of surgeries at Mercy were performed on outpatients.)

Steve H.'s doctor intended to use a RestoreUltra neurostimulator manufactured by Medtronic, a Minneapolis-based company with $16 billion in annual sales that bills itself as the world's largest stand-alone medical-technology company. "RestoreUltra delivers spinal-cord stimulation through one or more leads selected from a broad portfolio for greater customization of therapy," Medtronic's website promises.

I was not able to interview Steve H., but according to Pat Palmer, a medical-billing specialist based in Salem, Va., who consults for the union that provides Steve H.'s health insurance, Steve H. didn't ask how much the stimulator would cost because he had $45,181 remaining on the $60,000 annual payout limit his union-sponsored health-insurance plan imposed. "He figured, How much could a day at Mercy cost?" Palmer says. "Five thousand? Maybe 10?"

Steve H. was about to run up against a seemingly irrelevant footnote in millions of Americans' insurance policies: the limit, sometimes annual or sometimes over a lifetime, on what the insurer has to pay out for a patient's claims.

23% of patients surveyed reported missing doses of medication because of difficulties related to insurance



& 2 BY PCR	87529		
30675805 001		109.00	109.00
LUID CONCENTRATI	87015		
76001643 001		63.00	63.00
AL PUNCTURE	36600		
72051915 001		333.00	333.00
X-RAY BEDSIDE	71010		
76001163 001		134.00	134.00
BSEQUENT	94640		
76001163 001		134.00	134.00
BSEQUENT	94640		
76001163 001		134.00	134.00
BSEQUENT			

Chest X-Ray PATIENT WAS CHARGED $333. THE NATIONAL RATE PAID BY MEDICARE IS $23.83

Under Obamacare, those limits will not be allowed in most health-insurance policies after 2013. That might help people like Steve H. but is also one of the reasons premiums are going to skyrocket under Obamacare.

Steve H.'s bill for his day at Mercy contained all the usual and customary overcharges. One item was "MARKER SKIN REG TIP RULER" for $3. That's the marking pen, presumably reusable, that marked the place on Steve H.'s back where the incision was to go. Six lines down, there was "STRAP OR TABLE 8X27 IN" for $31. That's the strap used to hold Steve H. onto the operating table. Just below that was "BLNKT WARM UPPER BDY 42268" for $32. That's a blanket used to keep surgery patients warm. It is, of course, reusable, and it's available new on eBay for $13. Four lines down there's "GOWN SURG ULTRA XLG 95121" for $39, which is the gown the surgeon wore. Thirty of them can be bought online for $180. Neither Medicare nor any large insurance company would pay a hospital separately for those straps or the surgeon's gown; that's all supposed to come with the facility fee paid to the hospital, which in this case was $6,289.

In all, Steve H.'s bill for these basic medical and surgical supplies was $7,882. On top of that was $1,837 under a category called "Pharmacy General Classification" for items like bacitracin ($108). But that was the least of Steve H.'s problems.

The big-ticket item for Steve H.'s day at Mercy was the Medtronic stimulator, and that's where most of Mercy's profit was collected during his brief visit. The bill for that was $49,237.

According to the chief financial officer of another hospital, the wholesale list price of the Medtronic stimulator is "about $19,000." Because Mercy is part of a major hospital chain, it might pay 5% to 15% less than that. Even assuming Mercy paid $19,000, it would make more than $30,000 selling it to Steve H., a profit margin of more than 150%. To the extent that I found any consistency among hospital chargemaster practices, this is one of them: hospitals routinely seem to charge 2½ times what these expensive implantable devices cost them, which produces that 150% profit margin.

As Steve H. found out when he got his bill, he had exceeded the $45,000 that was left on his insurance policy's annual payout limit just with the neurostimulator. And his total bill was $86,951. After his insurance paid that first $45,000, he still owed more than $40,000, not counting doctors' bills. (I did not see Steve H.'s doctors' bills.)

Mercy Hospital is owned by an organization under the umbrella of the Catholic Church called Sisters of Mercy. Its mission, as described in its latest filing with the IRS as a tax-exempt charity, is "to carry out the healing ministry of Jesus by promoting health and wellness." With a chain of 31 hospitals and 300 clinics across the Midwest, Sisters of Mercy uses a bill-collection firm based in Topeka, Kans., called Berlin-Wheeler Inc. Suits against Mercy patients are on file in courts across Oklahoma listing Berlin-Wheeler as the plaintiff.

According to its most recent tax return, the Oklahoma City unit of the Sisters of Mercy hospital chain collected $337 million in revenue for the fiscal year ending June 30, 2011. It had an operating profit of $34 million. And that was after paying 10 executives more than $300,000 each, including $784,000 to a regional president and $438,000 to the hospital president.

That report doesn't cover the executives overseeing the chain, called Mercy Health, of which Mercy in Oklahoma City is a part. The overall chain had $4.28 billion in revenue that year. Its hospital in Springfield, Mo. (pop. 160,660), had $880.7 million in revenue and an operating profit of $319 million, according to its federal filing. The incomes of the parent company's executives appear on other IRS filings covering various interlocking Mercy nonprofit corporate entities. Mercy president and CEO Lynn Britton made $1,930,000, and an executive vice president, Myra Aubuchon, was paid $3.7 million, according to the Mercy filing. In all, seven Mercy Health executives were paid more than $1 million each.

A note at the end of an Ernst & Young audit that is attached to Mercy's IRS filing reported that the chain provided charity care worth 3.2% of its revenue in the previous year. However, the auditors state that the value of that care is based on the charges on all the bills, not the actual cost to Mercy of providing those services—in other words, the chargemaster value. Assuming that Mercy's actual costs are a tenth of these chargemaster values—they're probably less—all of this charity care actually cost Mercy about three-tenths of 1% of its revenue, or about $13 million out of $4.28 billion.

Mercy's website lists an 18-member media team; one member, Rachel Wright, told me that neither CEO Britton nor anyone else would be available to answer questions about compensation, the hospital's bill-collecting activities through Berlin-Wheeler or Steve H.'s bill, which I had sent her (with his name and the date of

his visit to the hospital redacted to protect his privacy).

Wright said the hospital's lawyers had decided that discussing Steve H.'s bill would violate the federal HIPAA law protecting the privacy of patient medical records. I pointed out that I wanted to ask questions only about the hospital's charges for standard items—such as surgical gowns, basic blood tests, blanket warmers and even medical devices—that had nothing to do with individual patients. "Everything is particular to an individual patient's needs," she replied. Even a surgical gown? "Yes, even a surgical gown. We cannot discuss this with you. It's against the law." She declined to put me in touch with the hospital's lawyers to discuss their legal analysis.

Hiding behind a privacy statute to avoid talking about how it prices surgeons' gowns may be a stretch, but Mercy might have a valid legal reason not to discuss what it paid for the Medtronic device before selling it to Steve H. for $49,237. Pharmaceutical and medical-device companies routinely insert clauses in their sales contracts prohibiting hospitals from sharing information about what they pay and the discounts they receive. In January 2012, a report by the federal Government Accountability Office found that "the lack of price transparency and the substantial variation in amounts hospitals pay for some IMD [implantable medical devices] raise questions about whether hospitals are achieving the best prices possible."

A lack of price transparency was not the only potential market inefficiency the GAO found. "Although physicians are not involved in price negotiations, they often express strong preferences for certain manufacturers and models of IMD," the GAO reported. "To the extent that physicians in the same hospitals have different preferences for IMDs, it may be difficult for the hospital to obtain volume discounts from particular manufacturers."

"Doctors have no incentive to buy one kind of hip or other implantable device as a group," explains Ezekiel Emanuel, an oncologist and a vice provost of the University of Pennsylvania who was a key White House adviser when Obamacare was created. "Even in the most innocent of circumstances, it kills the chance for market efficiencies."

The circumstances are not always innocent. In 2008, Gregory Demske, an assistant inspector general at the Department of Health and Human Services, told a Senate committee that "physicians routinely receive substantial compensation from medical-device companies through stock options, royalty agreements, consulting agreements, research grants and fellowships."

The assistant inspector general then revealed startling numbers about the extent of those payments: "We found that during the years 2002 through 2006, four manufacturers, which controlled almost 75% of the hip- and knee-replacement market, paid physician consultants over $800 million under the terms of roughly 6,500 consulting agreements."

Other doctors, Demske noted, had stretched the conflict of interest beyond consulting fees: "Additionally, physician ownership of medical-device manufacturers and related businesses appears to be a growing trend in the medical-device sector ... In some cases, physicians could receive substantial returns while contributing little to the venture beyond the ability to generate business for the venture."

In 2010, Medtronic, along with several other members of a medical-technology trade group, began to make the potential conflicts transparent by posting all payments to physicians on a section of its website called Physician Collaboration. The voluntary move came just before a similar disclosure regulation promulgated by the Obama Administration went into effect governing any doctor who receives funds from Medicare or the National Institutes of Health (which would include most doctors). And the nonprofit public-interest-journalism organization ProPublica has smartly organized data on doctor payments on its website (http://projects.propublica.org/docdollars). The conflicts have not been eliminated, but they are being aired, albeit on searchable websites rather than through a requirement that doctors disclose them to patients directly.

But conflicts that may encourage devices to be overprescribed or that lead doctors to prescribe a more expensive one instead of another are not the core problem in this marketplace. The more fundamental disconnect is that there is little reason to believe that what Mercy Hospital paid Medtronic for Steve H.'s device would have had any bearing on what the hospital decided to charge Steve H. Why would it? He did not know the price in advance.

Besides, studies delving into the economics of the medical marketplace consistently find that a moderately higher or lower price doesn't change consumer purchasing decisions much, if at all, because in health care there is little of the price sensitivity found in conventional marketplaces, even on the rare occasion that patients know the cost in advance. If you were in pain or in danger of dying, would you turn down treatment at a price 5% or 20% higher than the price you might have expected—that is, if you'd had any informed way to know what to expect in the first place, which you didn't?

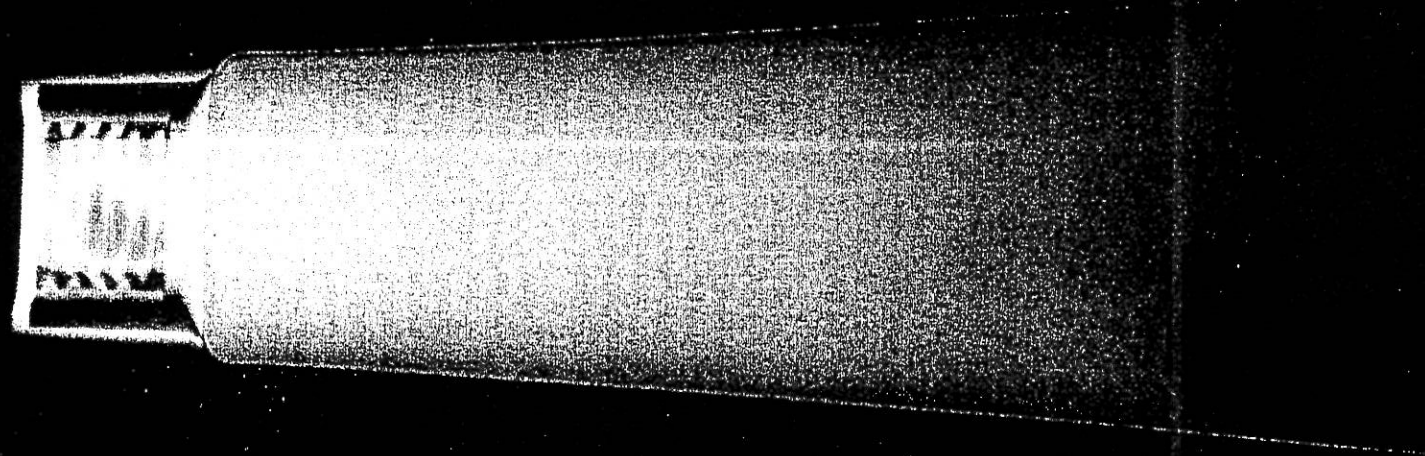
The question of how sensitive patients will be to increased prices for medical devices recently came up in a different context. Aware of the huge profits being accumulated by devicemakers, Obama Administration officials decided to recapture some of the money by imposing a 2.39% federal excise tax on the sales of these devices as well as other medical technology such as CT-scan equipment. The rationale was that getting back some of these generous profits was a fair way to cover some of the cost of the subsidized, broader insurance coverage provided by Obamacare—insurance that in some cases will pay for more of the devices. The industry has since geared up in Washington and is pushing legislation that would repeal the tax. Its main argument is that a 2.39% increase in prices would so reduce sales that it would wipe out a substantial portion of what the industry claims are the 422,000 jobs it supports in a $136 billion industry.

That prediction of doom brought on by this small tax contradicts the reams of studies documenting consumer price insensitivity in the health care marketplace. It also ignores profit-margin data collected by McKinsey that demonstrates that devicemakers have an open field in the current medical ecosystem. A 2011 McKinsey survey for medical-industry clients reported that devicemakers are superstar performers in a booming medical economy. Medtronic, which performed in the middle of the group, delivered an amazing compounded annual return of 14.95% to shareholders from 1990 to 2010. That means $100 invested in the company in 1990 was worth $1,622 20 years later. So if the extra 2.39% would be so disruptive to the market for products like Medtronic's that it would kill sales, why would the industry

Photograph by Nick Veasey for TIME

$108

Charge for the common antibiotic ointment that appeared on a patient's bill under the hard-to-parse category "Pharmacy General Classification"



Bacitracin

pass it along as a price increase to consumers? It hardly has to, given its profit margins.

Medtronic spokeswoman Donna Marquad says that for competitive reasons, her company will not discuss sales figures or the profit on Steve H.'s neurostimulator. But Medtronic's October 2012 quarterly SEC filing reported that its spine "products and therapies," which presumably include Steve H.'s device, "continue to gain broad surgeon acceptance" and that its cost to make all of its products was 24.9% of what it sells them for.

That's an unusually high gross profit margin—75.1%—for a company that manufactures real physical products. Apple also produces high-end, high-tech products, and its gross margin is 40%. If the neurostimulator enjoys that company-wide profit margin, it would mean that if Medtronic was paid $19,000 by Mercy Hospital, Medtronic's cost was about $4,500 and it made a gross profit of about $14,500 before expenses for sales, overhead and management—including CEO Omar Ishrak's compensation, which was $25 million for the 2012 fiscal year.

Mercy's Bargain

WHEN PAT PALMER, THE MEDICAL-BILLING SPECIALIST WHO advises Steve H.'s union, was given the Mercy bill to deal with, she prepared a tally of about $4,000 worth of line items that she thought represented the most egregious charges, such as the surgical gown, the blanket warmer and the marking pen. She restricted her list to those she thought were plainly not allowable. "I didn't dispute nearly all of them," she says. "Because then they get their backs up."

The hospital quickly conceded those items. For the remaining $83,000, Palmer invoked a 40% discount off chargemaster rates that Mercy allows for smaller insurance providers like the union. That cut the bill to about $50,000, for which the insurance company owed 80%, or about $40,000. That left Steve H. with a $10,000 bill.

Sean Recchi wasn't as fortunate. His bill—which included not only the aggressively marked-up charge of $13,702 for the Rituxan cancer drug but also the usual array of chargemaster fees for basics like generic Tylenol, blood tests and simple supplies—had one item not found on any other bill I examined: MD Anderson's charge of $7 each for "ALCOHOL PREP PAD." This is a little square of cotton used to apply alcohol to an injection. A box of 200 can be bought online for $1.91.

We have seen that to the extent that most hospital administrators defend such chargemaster rates at all, they maintain that they are just starting points for a negotiation. But patients don't typically know they are in a negotiation when they enter the hospital, nor do hospitals let them know that. And in any case, at MD Anderson, the Recchis were made to pay every penny of the chargemaster bill up front because their insurance was deemed inadequate. That left Penne, the hospital spokeswoman, with only this defense for the most blatantly abusive charges for items like the alcohol squares: "It is difficult to compare a retail store charge for a common product with a cancer center that provides the item as part of its highly specialized and personalized care," she wrote in an e-mail. Yet the hospital also charges for that "specialized and personalized" care through, among other items, its $1,791-a-day room charge.

Before MD Anderson marked up Recchi's Rituxan to $13,702, the profit taking was equally aggressive, and equally routine, at the beginning of the supply chain—at the drug company. Rituxan is a prime product of Biogen Idec, a company with $5.5 billion in annual sales. Its CEO, George Scangos, was paid $11,331,441 in 2011, a 20% boost over his 2010 income. Rituxan is made and sold by Biogen Idec in partnership with Genentech, a South San Francisco–based biotechnology pioneer.

Genentech brags about Rituxan on its website, as did Roche, Genentech's $45 billion parent, in its latest annual report. And in an Investor Day presentation last September, Roche CEO Severin Schwann stressed that his company is able to keep prices and margins high because of its focus on "medically differentiated therapies." Rituxan, a cancer wonder drug, certainly meets that test.

A spokesman at Genentech for the Biogen Idec–Genentech partnership would not say what the drug cost the companies to make, but according to its latest annual report, Biogen Idec's cost of sales—the incremental expense of producing and shipping each of its products compared with what it sells them for—was only 10%. That's lower than the incremental cost of sales for most software companies, and the software companies usually don't produce anything physical or have to pay to ship anything.

This would mean that Sean Recchi's dose of Rituxan cost the Biogen Idec–Genentech partnership as little as $300 to make, test, package and ship to MD Anderson for $3,000 to $3,500, whereupon the hospital sold it to Recchi for $13,702.

As 2013 began, Recchi was being treated back in Ohio because he could not pay MD Anderson for more than his initial treatment. As for the $13,702-a-dose Rituxan, it turns out that Biogen Idec's partner Genentech has a charity-access program that Recchi's Ohio doctor told him about that enabled him to get those treatments free. "MD Anderson never said a word to us about the Genentech program," says Stephanie Recchi. "They just took our money up front."

Genentech spokeswoman Charlotte Arnold would not disclose how much free Rituxan had been dispensed to patients like Recchi in the past year, saying only that Genentech has "donated $2.85 billion in free medicine to uninsured patients in the U.S." since 1985. That seems like a lot until the numbers are broken down. Arnold says the $2.85 billion is based on what the drugmaker sells the product for, not what it costs Genentech to make. On the basis of Genentech's historic costs and revenue since 1985, that would make the cost of these donations less than 1% of Genentech's sales—not something likely to take the sizzle out of CEO Severin's Investor Day.

Nonetheless, the company provided more financial support than MD Anderson did to Recchi, whose wife reports that he "is doing great. He's in remission."

Penne of MD Anderson stressed that the hospital provides its own financial aid to patients but that the state legislature restricts the assistance to Texas residents. She also said MD Anderson "makes every attempt" to inform patients of drug-company charity programs and that 50 of the hospital's 24,000 inpatients and outpatients, one of whom was from outside Texas, received charitable aid for Rituxan treatments in 2012.

3

Catastrophic Illness—And the Bills to Match

WHEN MEDICAL CARE BECOMES A MATTER OF LIFE AND death, the money demanded by the health care ecosystem reaches a wholly different order of magnitude, churning out reams of bills to people who can't focus on them, let alone pay them.

Soon after he was diagnosed with lung cancer in January 2011, a patient whom I will call Steven D. and his wife Alice knew that they were only buying time. The crushing question was, How much is time really worth? As Alice, who makes about $40,000 a year running a child-care center in her home, explained, "[Steven] kept saying he wanted every last minute he could get, no matter what. But I had to be thinking about the cost and how all this debt would leave me and my daughter."

By the time Steven D. died at his home in Northern California the following November, he had lived for an additional 11 months. And Alice had collected bills totaling $902,452.

The family's first bill—for $348,000—which arrived when Steven got home from the Seton Medical Center in Daly City, Calif., was full of all the usual chargemaster profit grabs: $18 each for 88 diabetes-test strips that Amazon sells in boxes of 50 for $27.85; $24 each for 19 niacin pills that are sold in drugstores for about a nickel apiece. There were also four boxes of sterile gauze pads for $77 each. None of that was considered part of what was provided in return for Seton's facility charge for the intensive-care unit for two days at $13,225 a day, 12 days in the critical unit at $7,315 a day and one day in a standard room (all of which totaled $120,116 over 15 days). There was also $20,886 for CT scans and $24,251 for lab work.

CT Scans PATIENT WAS CHARGED $6,538 FOR THREE CT SCANS. MEDICARE WOULD HAVE PAID A TOTAL OF ABOUT $825 FOR ALL THREE

Alice responded to my question about the obvious overcharges on the bill for items like the diabetes-test strips or the gauze pads much as Mrs. Lincoln, according to the famous joke, might have had she been asked what she thought of the play. "Are you kidding?" she said. "I'm dealing with a husband who had just been told he has Stage IV cancer. That's all I can focus on ... You think I looked at the items on the bills? I just looked at the total."

Steven and Alice didn't know that hospital billing people consider the chargemaster to be an opening bid. That's because no medical bill ever says, "Give us your best offer." The couple knew only that the bill said they had maxed out on the $50,000 payout limit on a UnitedHealthcare policy they had bought through a community college where Steven had briefly enrolled a year before. "We were in shock," Alice recalls. "We looked at the total and couldn't deal with it. So we just started putting all the bills in a box. We couldn't bear to look at them."

The $50,000 that UnitedHealthcare paid to Seton Medical Center was worth about $80,000 in credits because any charges covered by the insurer were subject to the discount it had negotiated with Seton. After that $80,000, Steven and Alice were on their own, not eligible for any more discounts.

Four months into her husband's illness, Alice by chance got the name of Patricia Stone, a billing advocate based in Menlo Park, Calif. Stone's typical clients are middle-class people having trouble with insurance claims. Stone felt so bad for Steven and Alice—she saw the blizzard of bills Alice was going to have to sort through—that, says Alice, she "gave us many of her hours," for which she usually charges $100, "for free."

Stone was soon able to persuade Seton to write off $297,000 of its $348,000 bill. Her argument was simple: There was no way the D.'s could pay it now or in the future, though they would scrape together $3,000 as a show of good faith. With the couple's $3,000 on top of the $50,000 paid by the UnitedHealthcare insurance, that $297,000 write-off amounted to an 85% discount.

According to its latest financial report, Seton applies so many discounts and write-offs to its chargemaster bills that it ends up with only about 18% of the revenue it bills for. That's an average 82% discount, compared with an average discount of about 65% that I saw at the

Date	Svc Code	Description	Units	Debits	Credits
	10000176	COULTER GROUP WITH DI	1	64.00	
	10000435	VENIPUNCTURE	1	26.00	
	10000715	URINE DIP W/MICROSCOP	1	42.00	
	10600206	BASIC METABOLIC PANEL	1	177.00	
	10600629	TROPONIN	1	239.00	
	15080100	C.T. HEAD W/O CONTRAS	1	1788.00	
	15080272	CT MAXILLOFACIAL W/O	1	2375.00	
	15080281	CT CERVICAL SPINE W/O	1	2375.00	
	20000129	PERCOCET-5 TAB	1	1.00	
	20001019	LORAZEPAM 2MG/ML 1ML	1	9.00	
	20003399	KETOROLAC 30MG INJ	1	5.00	
	31600770	IV PUSH INITIAL	1	199.00	
	31600773	IV HYD EACH ADDL HR<=	1	67.00	
	31600923	IV		.00	

other hospitals whose bills were examined—except for the MD Anderson and Sloan-Kettering cancer centers, which collect about 50% of their chargemaster charges.

Seton's discounting practices may explain why it is the only hospital whose bills I looked at that actually reported a small operating loss—$5 million—on its last financial report.

Of course, had the D.'s not come across Stone, the incomprehensible but terrifying bills would have piled up in a box, and the Seton Medical Center bill collectors would not have been kept at bay. Robert Issai, the CEO of the Daughters of Charity Health System, which owns and runs Seton, refused through an e-mail from a public relations assistant to respond to requests for a comment on any aspect of his hospital's billing or collections policies. Nor would he respond to repeated requests for a specific comment on the $24 charge for niacin pills, the $18 charge for the diabetes-test strips or the $77 charge for gauze pads. He also declined to respond when asked, via a follow-up e-mail, if the hospital thinks that sending patients who have just been told they are terminally ill bills that reflect chargemaster rates that the hospital doesn't actually expect to be paid might unduly upset them during a particularly sensitive time.

To begin to deal with all the other bills that kept coming after Steven's first stay at Seton, Stone was also able to get him into a special high-risk insurance pool set up by the state of California. It helped but not much. The insurance premium was $1,000 a month, quite a burden on a family whose income was maybe $3,500 a month. And it had an annual payout limit of $75,000. The D.'s blew through that in about two months.

The bills kept piling up. Sequoia Hospital—where Steven was an inpatient as well as an outpatient between the end of January and November following his initial stay at Seton—weighed in with 28 bills, all at chargemaster prices, including invoices for $99,000, $61,000 and $29,000. Doctor-run outpatient chemotherapy clinics wanted more than $85,000. One outside lab wanted $11,900.

Stone organized these and other bills into an elaborate spreadsheet—a ledger documenting how catastrophic illness in America unleashes its own mini-GDP.

In July, Stone figured out that Steven and Alice should qualify for Medicaid, which is called Medi-Cal in California. But there was a catch: Medicaid is the joint federal-state program directed at the poor that is often spoken of in the same breath as Medicare. Although most of the current national debate on entitlements is focused on Medicare, when Medicaid's subsidiary program called Children's Health Insurance, or CHIP, is counted, Medicaid actually covers more people: 56.2 million compared with 50.2 million.

As Steven and Alice found out, Medicaid is also more vulnerable to cuts and conditions that limit coverage, probably for the same reason that most politicians and the press don't pay the same attention to it that they do to Medicare: its constituents are the poor.

The major difference in the two programs is that while Medicare's rules are pretty much uniform across state lines, the states set the key rules for Medicaid because the state finances a big portion of the claims. According to Stone, Steven and Alice immediately ran into one of those rules. For people even with their modest income, the D.'s would have to pay $3,000 a month in medical bills before Medi-Cal would kick in. That amounted to most of Alice's monthly take-home pay.

53% of Americans surveyed said they plan to work longer than they would otherwise to continue to receive health insurance through their employer

Medi-Cal was even willing to go back five months, to February, to cover the couple's mountain of bills, but first they had to come up with $15,000. "We didn't have anything close to that," recalls Alice.

Stone then convinced Sequoia that if the hospital wanted to see any of the Medi-Cal money necessary to pay its bills (albeit at the big discount Medi-Cal would take), it should give Steven a "credit" for $15,000—in other words, write it off. Sequoia agreed to do that for most of the bills. This was clearly a maneuver that Steven and Alice never could have navigated on their own.

Covering most of the Sequoia debt was a huge relief, but there were still hundreds of thousands of dollars in bills left unpaid as Steven approached his end in the fall of 2011. Meantime, the bills kept coming.

"We started talking about the cost of the chemo," Alice recalls. "It was a source of tension between us ... Finally," she says, "the doctor told us that the next one scheduled might prolong his life a month, but it would be really painful. So he gave up."

By the one-year anniversary of Steven's death, late last year, Stone had made a slew of deals with his doctors, clinics and other providers whose services Medi-Cal did not cover. Some, like Seton, were generous. The home health care nurse ended up working for free in the final days of Steven's life, which were over the Thanksgiving weekend. "He was a saint," says Alice. "He said he was doing it to become accredited, so he didn't charge us."

Others, including some of the doctors, were more hard-nosed, insisting on full payment or offering minimal discounts. Still others had long since sold the bills to professional debt collectors, who, by definition, are bounty hunters. Alice and Stone were still hoping Medi-Cal would end up covering some or most of the debt.

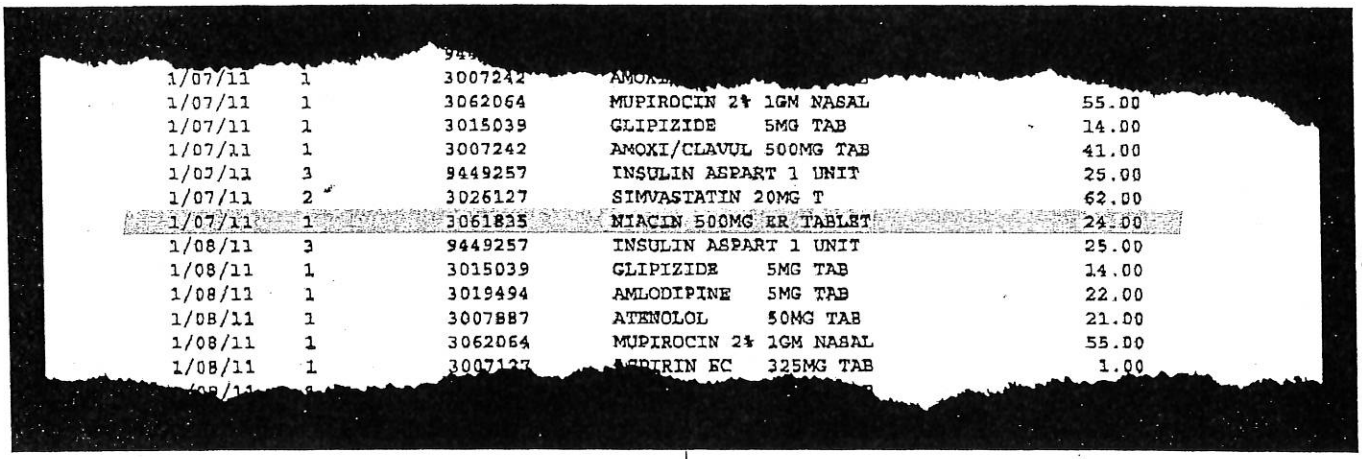
As 2012 closed, Alice had paid out about $30,000 of her own money (including the $3,000 to Seton) and still owed $142,000—her losses from the fixed poker game that she was forced to play in the worst of times with the worst of cards. She was still getting letters and calls from bill collectors. "I think about the $142,000 all the time. It just hangs over my head," she said in December.

One lesson she has learned, she adds: "I'm never going to remarry. I can't risk the liability."[2]

$132,303: The Lab-Test Cash Machine

AS 2012 BEGAN, A COUPLE I'LL CALL REBECCA AND SCOTT S., both in their 50s, seemed to have carved out a comfortable semiretirement in a suburb near Dallas. Scott had

2. In early February, Alice told TIME that she had recently eliminated "most of" the debt through proceeds from the sale of a small farm in Oklahoma her husband had inherited and after further payments from Medi-Cal and a small life-insurance policy



1/07/11	1	3007242	AMOXI/CLAVUL 500MG TAB	41.00
1/07/11	1	3062064	MUPIROCIN 2% 1GM NASAL	55.00
1/07/11	1	3015039	GLIPIZIDE 5MG TAB	14.00
1/07/11	1	3007242	AMOXI/CLAVUL 500MG TAB	41.00
1/07/11	3	9449257	INSULIN ASPART 1 UNIT	25.00
1/07/11	2	3026127	SIMVASTATIN 20MG T	62.00
1/07/11	1	3061835	NIACIN 500MG ER TABLET	24.00
1/08/11	3	9449257	INSULIN ASPART 1 UNIT	25.00
1/08/11	1	3015039	GLIPIZIDE 5MG TAB	14.00
1/08/11	1	3019494	AMLODIPINE 5MG TAB	22.00
1/08/11	1	3007887	ATENOLOL 50MG TAB	21.00
1/08/11	1	3062064	MUPIROCIN 2% 1GM NASAL	55.00
1/08/11	1	3007127	ASPIRIN EC 325MG TAB	1.00

successfully sold his small industrial business and was working part time advising other industrial companies. Rebecca was running a small marketing company.

On March 4, Scott started having trouble breathing. By dinnertime he was gasping violently as Rebecca raced him to the emergency room at the University of Texas Southwestern Medical Center. Both Rebecca and her husband thought he was about to die, Rebecca recalls. It was not the time to think about the bills that were going to change their lives if Scott survived, and certainly not the time to imagine, much less worry about, the piles of charges for daily routine lab tests that would be incurred by any patient in the middle of a long hospital stay.

Scott was in the hospital for 32 days before his pneumonia was brought under control.

Rebecca recalls that "on about the fourth or fifth day, I was sitting around the hospital and bored, so I went down to the business office just to check that they had all the insurance information." She remembered that there was, she says, "some kind of limit on it."

"Even by then, the bill was over $80,000," she recalls. "I couldn't believe it."

The woman in the business office matter-of-factly gave Rebecca more bad news: Her insurance policy, from a company called Assurant Health, had an annual payout limit of $100,000. Because of some prior claims Assurant had processed, the S.'s were well on their way to exceeding the limit.

Just the room-and-board charge at Southwestern was $2,293 a day. And that was before all the real charges were added. When Scott checked out, his 161-page bill was $474,064. Scott and Rebecca were told they owed $402,955 after the payment from their insurance policy was deducted.

The top billing categories were $73,376 for Scott's room; $94,799 for "RESP SERVICES," which mostly meant supplying Scott with oxygen and testing his breathing and included multiple charges per day of $134 for supervising oxygen inhalation, for which Medicare would have paid $17.94; and $108,663 for "SPECIAL DRUGS," which included mostly not-so-special drugs such as "SODIUM CHLORIDE .9%." That's a standard saline solution probably used intravenously in this case to maintain Scott's water and salt levels. (It is also used to wet contact lenses.) You can buy a liter of the hospital version (bagged for intravenous use) online for $5.16. Scott was charged $84 to $134 for dozens of these saline solutions.

Niacin Tablet PATIENT WAS CHARGED $24 PER 500-MG TABLET OF NIACIN. IN DRUGSTORES, THE PILLS GO FOR ABOUT A NICKEL EACH

Then there was the $132,303 charge for "LABORATORY," which included hundreds of blood and urine tests ranging from $30 to $333 each, for which Medicare either pays nothing because it is part of the room fee or pays $7 to $30. Hospital spokesman Russell Rian said that neither Daniel Podolsky, Texas Southwestern Medical Center's $1,244,000-a-year president, nor any other executive would be available to discuss billing practices. "The law does not allow us to talk about how we bill," he explained.

Through a friend of a friend, Rebecca found Patricia Palmer, the same billing advocate based in Salem, Va., who worked on Steve H.'s bill in Oklahoma City. Palmer—whose firm, Medical Recovery Services, now includes her two adult daughters—was a claims processor for Blue Cross Blue Shield. She got into her current business after she was stunned by the bill her local hospital sent after one of her daughters had to go to the emergency room after an accident. She says it included items like the shade attached to an examining lamp. She then began looking at bills for friends as kind of a hobby before deciding to make it a business.

The best Palmer could do was get Texas Southwestern Medical to provide a credit that still left Scott and Rebecca owing $313,000.

Palmer claimed in a detailed appeal that there were also overcharges totaling $113,000—not because the prices were too high but because the items she singled out should not have been charged for at all. These included $5,890 for all of that saline solution and $65,600 for the management of Scott's oxygen. These items are supposed to be part of the hospital's general room-and-services charge, she argued, so they should not be billed twice.

In fact, Palmer—echoing a constant and convincing refrain I heard from billing advocates across the country—alleged that the hospital triple-billed for some items used in Scott's care in the intensive-care unit. "First they charge more than $2,000 a day for the ICU, because it's an ICU and it has all this special equipment and personnel," she says. "Then they charge $1,000 for some kit used in the ICU to give someone a transfusion or oxygen ... And then they charge

$50 or $100 for each tool or bandage or whatever that there is in the kit. That's triple billing."

Palmer and Rebecca are still fighting, but the hospital insists that the S.'s owe the $313,000 balance. That doesn't include what Rebecca says were "thousands" in doctors' bills and $70,000 owed to a second hospital after Scott suffered a relapse.

The only offer the hospital has made so far is to cut the bill to $200,000 if it is paid immediately, or for the full $313,000 to be paid in 24 monthly payments. "How am I supposed to write a check right now for $200,000?" Rebecca asks. "I have boxes full of notices from bill collectors ... We can't apply for charity, because we're kind of well off in terms of assets," she adds. "We thought we were set, but now we're pretty much on the edge."

Insurance That Isn't

"PEOPLE, ESPECIALLY RELATIVELY WEALTHY PEOPLE, ALWAYS think they have good insurance until they see they don't," says Palmer. "Most of my clients are middle- or upper-middle-class people with insurance."

Scott and Rebecca bought their plan from Assurant, which sells health insurance to small businesses that will pay only for limited coverage for their employees or to individuals who cannot get insurance through employers and are not eligible for Medicare or Medicaid. Assurant also sold the Recchis their plan that paid only $2,000 a day for Sean Recchi's treatment at MD Anderson.

Although the tight limits on what their policies cover are clearly spelled out in Assurant's marketing materials and in the policy documents themselves, it seems that for its customers the appeal of having something called health insurance for a few hundred dollars a month is far more compelling than comprehending the details. "Yes, we knew there were some limits," says Rebecca. "But when you see the limits expressed in the thousands of dollars, it looks O.K., I guess. Until you have an event."

Millions of plans have annual payout limits, though the more typical plans purchased by employers usually set those limits at $500,000 or $750,000—which can also quickly be consumed by a catastrophic illness. For that reason, Obamacare prohibited lifetime limits on any policies sold after the law passed and phases out all annual dollar limits by 2014. That will protect people like Scott and Rebecca, but it will also make everyone's premiums dramatically higher, because insurance companies risk much more when there is no cap on their exposure.

BUT OBAMACARE DOES LITTLE TO ATTACK THE COSTS THAT overwhelmed Scott and Rebecca. There is nothing, for example, that addresses what may be the most surprising sinkhole—the seemingly routine blood, urine and other laboratory tests for which Scott was charged $132,000, or more than $4,000 a day.

By my estimates, about $70 billion will be spent in the U.S. on about 7 billion lab tests in 2013. That's about $223 a person for 16 tests per person. Cutting the overordering and overpricing could easily take $25 billion out of that bill.

Much of that overordering involves patients like Scott S. who require prolonged hospital stays. Their tests become a routine, daily cash generator. "When you're getting trained as a doctor," says a physician who was involved in framing health care policy early in the Obama Administration, "you're taught to order what's called 'morning labs.' Every day you have a variety of blood tests and other tests done, not because it's necessary but because it gives you something to talk about with the others when you go on rounds. It's like your version of a news hook ... I bet 60% of the labs are not necessary."

The country's largest lab tester is Quest Diagnostics, which reported revenues in 2012 of $7.4 billion. Quest's operating income in 2012 was $1.2 billion, about 16.2% of sales.

But that's hardly the spectacular profit margin we have seen in other sectors of the medical marketplace. The reason is that the outside companies like Quest, which mostly pick up specimens from doctors and clinics and deliver test results back to them, are not where the big profits are. The real money is in health care settings that cut out the middleman—the in-house venues, like the hospital testing lab run by Southwestern Medical that billed Scott and Rebecca $132,000. In-house labs account for about 60% of all testing revenue. Which means that for hospitals, they are vital profit centers.

Labs are also increasingly being maintained by doctors who, as they form group practices with other doctors in their field, finance their own testing and diagnostic clinics. These labs account for a rapidly growing share of the testing revenue, and their share is growing rapidly.

These in-house labs have no selling costs, and as pricing surveys repeatedly find, they can charge more because they have a captive consumer base in the hospitals or group practices.

They also have an incentive to order more tests because they're the ones profiting from the tests. The *Wall Street Journal* reported last April that a study in the medical journal *Health Affairs* had found that doctors' urology groups with their own labs "bill the federal Medicare program for analyzing 72% more prostate tissue samples per biopsy while detecting fewer cases of cancer than counterparts who send specimens to outside labs."

If anything, the move toward in-house testing, and with it the incentive to do more of it, is accelerating the move by doctors to consolidate into practice groups. As one Bronx urologist explains, "The economics of having your own lab are so alluring."

More important, hospitals are aligning with these practice groups, in many cases even getting them to sign noncompete clauses requiring that they steer all patients to the partner hospital.

Some hospitals are buying physicians' practices outright; 54% of physician practices were owned by hospitals in 2012, according to a McKinsey survey, up from 22% 10 years before. This is primarily a move to increase the hospitals' leverage in negotiating with insurers. An expensive by-product is that it brings testing into the hospitals' high-profit labs.

Photograph by Nick Veasey for TIME

Acetaminophen

$1.50 Charge for one 325-mg tablet, the first of 344 lines in an eight-page hospital bill. You can buy 100 tablets on Amazon for $1.49

4

When Taxpayers Pick Up the Tab

WHETHER IT WAS EMILIA GILBERT TRYING TO GET OUT FROM under $9,418 in bills after her slip and fall or Alice D. vowing never to marry again because of the $142,000 debt from her husband's losing battle with cancer, we've seen how the medical marketplace misfires when private parties get the bills.

When the taxpayers pick up the tab, most of the dynamics of the marketplace shift dramatically.

In July 2011, an 88-year-old man whom I'll call Alan A. collapsed from a massive heart attack at his home outside Philadelphia. He survived, after two weeks in the intensive-care unit of the Virtua Marlton hospital. Virtua Marlton is part of a four-hospital chain that, in its 2010 federal filing, reported paying its CEO $3,073,000 and two other executives $1.4 million and $1.7 million from gross revenue of $633.7 million and an operating profit of $91 million. Alan A. then spent three weeks at a nearby convalescent-care center.

Medicare made quick work of the $268,227 in bills from the two hospitals, paying just $43,320. Except for $100 in incidental expenses, Alan A. paid nothing because 100% of inpatient hospital care is covered by Medicare.

The ManorCare convalescent center, which Alan A. says gave him "good care" in an "O.K. but not luxurious room," got paid $11,982 by Medicare for his three-week stay. That is about $571 a day for all the physical therapy, tests and other services. As with all hospitals in nonemergency situations, ManorCare does not have to accept Medicare patients and their discounted rates. But it does accept them. In fact, it welcomes them and encourages doctors to refer them.

Health care providers may grouse about Medicare's fee schedules, but Medicare's payments must be producing profits for ManorCare. It is part of a for-profit chain owned by Carlyle Group, a blue-chip private-equity firm.

ABOUT A DECADE AGO, ALAN A. WAS DIAGNOSED WITH non-Hodgkin's lymphoma. He was 78, and his doctors in southern New Jersey told him there was little they could do. Through a family friend, he got an appointment with one of the lymphoma specialists at Sloan-Kettering. That doctor told Alan A. he was willing to try a new chemotherapy regimen on him. The doctor warned, however, that he hadn't ever tried the treatment on a man of Alan A.'s age.

The treatment worked. A decade later, Alan A. is still in remission. He now travels to Sloan-Kettering every six weeks to be examined by the doctor who saved his life and to get a transfusion of Flebogamma, a drug that bucks up his immune system.

With some minor variations each time, Sloan-Kettering's typical bill for each visit is the same as or similar to the $7,346 bill he received during the summer of 2011, which included $340 for a session with the doctor.

Assuming eight visits (but only four with the doctor), that makes the annual bill $57,408 a year to keep Alan A. alive. His actual out-of-pocket cost for each session is a fraction of that. For that $7,346 visit, it was about $50.

In some ways, the set of transactions around Alan A.'s Sloan-Kettering care represent the best the American medical marketplace has to offer. First, obviously, there's the fact that he is alive after other doctors gave him up for dead. And then there's the fact that Alan A., a retired chemist of average means, was able to get care that might otherwise be reserved for the rich but was available to him because he had the right insurance.

Medicare is the core of that insurance, although Alan A.—as do 90% of those on Medicare—has a supplemental-insurance policy that kicks in and generally pays 90% of the 20% of costs for doctors and outpatient care that Medicare does not cover.

Here's how it all computes for him using that summer 2011 bill as an example.

Not counting the doctor's separate $340 bill, Sloan-Kettering's bill for the transfusion is about $7,006.

In addition to a few hundred dollars in miscellaneous items, the two basic Sloan-Kettering charges are $414 per hour for five hours of nurse time for administering the Flebogamma and a $4,615 charge for the Flebogamma.

According to Alan A., the nurse generally handles three or four patients at a time. That would mean Sloan-Kettering is billing more than $1,200 an hour for that nurse. When I asked Paul Nelson, Sloan-Kettering's director of financial planning, about the $414-per-hour charge, he explained that 15% of these charges is meant to cover overhead and indirect expenses, 20% is meant to be profit that will cover discounts for Medicare or Medicaid patients, and 65% covers direct expenses. That would still leave the nurse's time being valued at about $800 an hour (65% of $1,200), again assuming that just three patients were billed for the same hour at $414 each. Pressed on that, Nelson conceded that the profit is higher and is meant to cover other hospital costs like research and capital equipment.

Whatever Sloan-Kettering's calculations may be, Medicare—whose patients, including Alan A., are about a third of all Sloan-Kettering patients—buys into none of that math. Its cost-based pricing formulas yield a price of $302 for everything other than the drug, including those hourly charges for the nurse and the miscellaneous charges. Medicare pays 80% of that, or $241, leaving Alan A. and his private insurance company together to pay about $60 more to Sloan-Kettering. Alan A. pays $6, and his supplemental insurer, Aetna, pays $54.

Bottom line: Sloan-Kettering gets paid $302 by Medicare for about $2,400 worth of its chargemaster charges, and Alan A. ends up paying $6.

The Cancer Drug Profit Chain

IT'S WITH THE BILL FOR THE TRANSFUSION THAT THE PECULIAR economics of American medicine take a different turn, even when Medicare is involved. We have seen that even

with big discounts for insurance companies and bigger discounts for Medicare, the chargemaster prices on everything from room and board to Tylenol to CT scans are high enough to make hospital costs a leading cause of the $750 billion Americans overspend each year on health care. We're now going to see how drug pricing is a major contributor to the way Americans overpay for medical care.

By law, Medicare has to pay hospitals 6% above what Congress calls the drug company's "average sales price," which is supposedly the average price at which the drugmaker sells the drug to hospitals and clinics. But Congress does not control what drugmakers charge. The drug companies are free to set their own prices. This seems fair in a free-market economy, but when the drug is a one-of-a-kind lifesaving serum, the result is anything but fair.

Applying that formula of average sales price plus the 6% premium, Medicare cuts Sloan-Kettering's $4,615 charge for Alan A.'s Flebogamma to $2,123. That's what the drugmaker tells Medicare the average sales price is plus 6%. Medicare again pays 80% of that, and Alan A. and his insurer split the other 20%, 10% for him and 90% for the insurer, which makes Alan A.'s cost $42.50.

In practice, the average sales price does not appear to be a real average. Two other hospitals I asked reported that after taking into account rebates given by the drug company, they paid an average of $1,650 for the same dose of Flebogamma, and neither hospital had nearly the leverage in the cancer-care marketplace that Sloan-Kettering does. One doctor at Sloan-Kettering guessed that it pays $1,400. "The drug companies give the rebates so that the hospitals will make more on the drug and therefore be encouraged to dispense it," the doctor explained. (A spokesperson for Medicare would say only that the average sales price is based "on manufacturers' data submitted to Medicare and is meant to include rebates.")

Nelson, the Sloan-Kettering head of financial planning, said the price his hospital pays for Alan A.'s dose of Flebogamma is "somewhat higher" than $1,400, but he wasn't specific, adding that "the difference between the cost and the charge represents the cost of running our pharmacy—which includes overhead cost—plus a markup." Even assuming Sloan-Kettering's real price for Flebogamma is "somewhat higher" than $1,400, the hospital would be making about 50% profit from Medicare's $2,123 payment. So even Medicare contributes mightily to hospital profit—and drug-company profit—when it buys drugs.

Flebogamma's Profit Margin

THE SPANISH BUSINESS AT THE BEGINNING OF THE FLEBOgamma supply chain does even better than Sloan-Kettering.

Made from human plasma, Flebogamma is a sterilized solution that is intended to boost the immune system. Sloan-Kettering buys it from either Baxter International in the U.S. or, as is more likely in Alan A.'s case, a Barcelona-based company called Grifols.

In its half-year 2012 shareholders report, Grifols featured a picture of the Flebogamma plasma serum and its packaging—"produced at the Clayton facility, North Carolina," according to the caption. Worldwide sales of all Grifols products were reported as up 15.2%, to $1.62 billion, in the first half of 2012. In the U.S. and Canada, sales were up 20.5%. "Growth in the sales ... of the main plasma derivatives" was highlighted in the report, as was the fact that "the cost per liter of plasma has fallen." (Grifols operates 150 donation centers across the U.S. where it pays plasma donors $25 apiece.)

Grifols spokesman Christopher Healey would not discuss what it cost Grifols to produce and ship Alan A.'s dose, but he did say that the company's average cost to produce its bioscience products, Flebogamma included, was approximately 55% of what it sells them for. However, a doctor familiar with the economics of cancer-care drugs said that plasma products typically have some of the industry's higher profit margins. He estimated that the Flebogamma dose for Alan A.—which Sloan-Kettering bought from Grifols for $1,400 or $1,500 and sold to Medicare for $2,135—"can't cost them more than $200 or $300 to collect, process, test and ship."

In Spain, as in the rest of the developed world, Grifols' profit margins on sales are much lower than they are in the U.S., where it can charge much higher prices. Aware of the leverage that drug companies—especially those with unique lifesaving products—have on the market, most developed countries regulate what drugmakers can charge, limiting them to certain profit margins. In fact, the drugmakers' securities filings repeatedly warn investors of tighter price controls that could threaten their high margins—though not in the U.S.

The difference between the regulatory environment in the U.S. and the environment abroad is so dramatic that McKinsey & Co. researchers reported that overall prescription-drug prices in the U.S. are "50% higher for comparable products" than in other developed countries. Yet those regulated profit margins outside the U.S. remain high enough that Grifols, Baxter and other drug companies still aggressively sell their products there. For example, 37% of Grifols' sales come from outside North America.

More than $280 billion will be spent this year on prescription drugs in the U.S. If we paid what other countries did for the same products, we would save about $94 billion a year. The pharmaceutical industry's common explanation for the price difference is that U.S. profits subsidize the research and development of trailblazing drugs that are developed in the U.S. and then marketed around the world. Apart from the question of whether a country with a health-care-spending crisis should subsidize the rest of the developed world—not to mention the question of who signed Americans up for that mission—there's the fact that the companies' math doesn't add up.

According to securities filings of major drug companies, their R&D expenses are generally 15% to 20% of gross revenue. In fact, Grifols spent only 5% on R&D for the first nine months of 2012. Neither 5% nor 20% is enough to have cut deeply into the pharmaceutical companies' stellar bottom-line *net* profits. This is not *gross* profit, which counts only the cost of producing the drug, but the profit *after* those R&D expenses are taken into account. Grifols made a 32.3% net operating profit after all its R&D expenses—as well as sales, management and other expenses—were tallied. In other words, even counting all the R&D across the entire company, including research for drugs that did not pan out,

Of New York City's 18 largest private employers, eight are hospitals and four are banks

Jonathan Blum

'When hospitals say they are losing money on Medicare, my reaction is that Central Florida is overflowing with Medicare patients and all those hospitals are expanding and advertising for Medicare patients,' says Blum, deputy administrator of the Centers for Medicare and Medicaid Services. 'Hospitals don't lose money when they serve Medicare patients.'

Grifols made healthy profits. All the numbers tell one consistent story: Regulating drug prices the way other countries do would save tens of billions of dollars while still offering profit margins that would keep encouraging the pharmaceutical companies' quest for the next great drug.

Handcuffs On Medicare

OUR LAWS DO MORE THAN PREVENT THE GOVERNMENT from restraining prices for drugs the way other countries do. Federal law also restricts the biggest single buyer—Medicare—from even trying to negotiate drug prices. As a perpetual gift to the pharmaceutical companies (and an acceptance of their argument that completely unrestrained prices and profit are necessary to fund the risk taking of research and development), Congress has continually prohibited the Centers for Medicare and Medicaid Services (CMS) of the Department of Health and Human Services from negotiating prices with drugmakers. Instead, Medicare simply has to determine that average sales price and add 6% to it.

Similarly, when Congress passed Part D of Medicare in 2003, giving seniors coverage for prescription drugs, Congress prohibited Medicare from negotiating.

Nor can Medicare get involved in deciding that a drug may be a waste of money. In medical circles, this is known as the comparative-effectiveness debate, which nearly derailed the entire Obamacare effort in 2009.

Doctors and other health care reformers behind the comparative-effectiveness movement make a simple argument: Suppose that after exhaustive research, cancer drug A, which costs $300 a dose, is found to be just as effective as or more effective than drug B, which costs $3,000. Shouldn't the person or entity paying the bill, e.g. Medicare, be able to decide that it will pay for drug A but not drug B? Not according to a law passed by Congress in 2003 that requires Medicare to reimburse patients (again, at average sales price plus 6%) for any cancer drug approved for use by the Food and Drug Administration. Most states require insurance companies to do the same thing.

Peter Bach, an epidemiologist at Sloan-Kettering who has also advised several health-policy organizations, reported in a 2009 *New England Journal of Medicine* article that Medicare's spending on the category dominated by cancer drugs ballooned from $3 billion in 1997 to $11 billion in 2004. Bach says costs have continued to increase rapidly and must now be more than $20 billion.

With that escalating bill in mind, Bach was among the policy experts pushing for provisions in Obamacare to establish a Patient-Centered Outcomes Research Institute to expand comparative-effectiveness research efforts. Through painstaking research, doctors would try to determine the comparative effectiveness not only of drugs but also of procedures like CT scans.

However, after all the provisions spelling out elaborate research and review processes were embedded in the draft law, Congress jumped in and added eight provisions that restrict how the research can be used. The prime restriction: Findings shall "not be construed as mandates for practice guidelines, coverage recommendations, payment, or policy recommendations."

With those 14 words, the work of Bach and his colleagues was undone. And costs remain unchecked.

"Medicare could see the research and say, Ah, this drug works better and costs the same or is even cheaper," says Gunn, Sloan-Kettering's chief operating officer. "But they are not allowed to do anything about it."

Along with another doomed provision that would have allowed Medicare to pay a fee for doctors' time spent counseling terminal patients on end-of-life care (but not on euthanasia), the Obama Administration's push for comparative effectiveness is what brought opponents' cries that the bill was creating "death panels." Washington bureaucrats would now be dictating which drugs were worth giving to which patients and even which patients deserved to live or die, the critics charged.

The loudest voice sounding the death-panel alarm belonged to Betsy McCaughey, former New York State lieutenant governor and a conservative health-policy advocate. McCaughey, who now runs a foundation called the Committee to Reduce Infection Deaths, is still fiercely opposed to Medicare's making comparative-effectiveness decisions. "There is comparative-effectiveness research being done in the medical journals all the time, which is fine," she says. "But it should be used by doctors to make decisions—not by the Obama bureaucrats at Medicare to make decisions for doctors."

Bach, the Sloan-Kettering doctor and policy wonk, has become so frustrated with the rising cost of the drugs he uses that he and some colleagues recently took matters into their own hands. They reported in an October op-ed in the New York *Times* that they had decided on their own that they were no longer going to dispense a colorectal-cancer drug called Zaltrap, which cost an average of $11,063 per month for treatment. All the research shows, they wrote, that a drug called Avastin, which cost $5,000 a month, is just as effective. They were taking this stand, they added, because "the typical new cancer drug coming on the market a decade ago cost about $4,500 per month (in 2012 dollars); since 2010, the median price has been around $10,000. Two of the new cancer drugs cost more than $35,000 each per month of treatment. The burden of this cost is borne, increasingly, by patients themselves—and the effects can be devastating."

The CEO of Sanofi, the company that makes Zaltrap, initially dismissed the article by Bach and his Sloan-Kettering colleagues, saying they had taken the price of the drug out of context because of variations in the required dosage. But four weeks later, Sanofi cut its price in half.

Bureaucrats You Can Admire

BY THE NUMBERS, MEDICARE LOOKS LIKE A GOVERNMENT program run amok. After President Lyndon B. Johnson signed Medicare into law in 1965, the House Ways and Means Committee predicted that the program would cost $12 billion in 1990. Its actual cost by then was $110 billion. It is likely to be nearly $600 billion this year. That's due to

Photograph by Stephen Voss for TIME

the U.S.'s aging population and the popular program's expansion to cover more services, as well as the skyrocketing costs of medical services generally. It's also because Medicare's hands are tied when it comes to negotiating the prices for drugs or durable medical equipment. But Medicare's growth is not a matter of those "bureaucrats" that Betsy McCaughey complains about having gone off the rails in how they operate it.

In fact, seeing the way Alan A.'s bills from Sloan-Kettering were vetted and processed is one of the more eye-opening and least discouraging aspects of a look inside the world of medical economics.

The process is fast, accurate, customer-friendly and impressively high-tech. And it's all done quietly by a team of nonpolitical civil servants in close partnership with the private sector. In fact, despite calls to privatize Medicare by creating a voucher system under which the Medicare population would get money from the government to buy insurance from private companies, the current Medicare system is staffed with more people employed by private contractors (8,500) than government workers (700).

$1.5 Billion A Day

SLOAN-KETTERING SENDS ALAN A.'S BILLS TO MEDICARE electronically, all elaborately coded according to Medicare's rules.

There are two basic kinds of codes for the services billed. The first is a number identifying which of the 7,000 procedures were performed by a doctor, such as examining a chest X-ray, performing a heart transplant or conducting an office consultation for a new patient (which costs more than a consultation with a continuing patient—coded differently—because it typically takes more time). If a patient presents more complicated challenges, then these basic procedures will be coded differently; for example, there are two varieties of emergency-room consultations. Adjustments are also made for variations in the cost of living where the doctor works and for other factors, like whether doctors used their own office (they'll get paid more for that) or the hospital. A panel of doctors set up by the American Medical Association reviews the codes annually and recommends updates to Medicare. The process can get messy as the doctors fight over which procedures in which specialties take more time and expertise or are worth relatively more. Medicare typically accepts most of the panel's recommendations.

The second kind of code is used to pay the hospital for its services. Again, there are thousands of codes based on whether the person checked in for brain surgery, an appendectomy or a fainting spell. To come up with these numbers, Medicare takes the cost reports—including allocations for everything from overhead to nursing staff to operating-room equipment—that hospitals across the country are required to file for each type of service and pays an amount equal to the composite average costs.

The hospital has little incentive to overstate its costs because it's against the law and because each hospital gets paid not on the basis of its own claimed costs but on the basis of the average of every hospital's costs, with adjustments made for regional cost differences and other local factors. Except for emergency services, no hospital has to accept Medicare patients and these prices, but they all do.

Similar codes are calculated for laboratory and diagnostic tests like CT scans, ambulance services and, as we saw with Alan A.'s bill, drugs dispensed.

"When I tell my friends what I do here, it sounds boring, but it's exciting," says Diane Kovach, who works at Medicare's Maryland campus and whose title is deputy director of the provider billing group. "We are implementing a program that helps millions and millions of people, and we're doing it in a way that makes every one of us proud," she adds.

Kovach, who has been at Medicare for 21 years, operates some of the gears of a machine that reviews the more than 3 million bills that come into Medicare every day, figures out the right payments for each and churns out more than $1.5 billion a day in wire transfers.

The part of that process that Kovach and three colleagues, with whom I spent a morning recently, are responsible for involves overseeing the writing and vetting of thousands of instructions for coders, who are also private contractors, employed by HP, General Dynamics and other major technology companies. The codes they write are supposed to ensure that Medicare pays what it is supposed to pay and catches anything in a bill that should not be paid.

For example, hundreds of instructions for code changes were needed to address Obamacare's requirement that certain preventive-care visits, such as those for colonoscopies or contraceptive services, no longer be subject to Medicare's usual outpatient co-pay of 20%. Adding to the complexity, the benefit is limited to one visit per year for some services, meaning instructions had to be written to track patient timelines for the codes assigned to those services.

When performing correctly, the codes produce "edits" whenever a bill is submitted with something awry on it—if a doctor submits two preventive-care colonoscopies for the same patient in the same year, for example. Depending on the code, an edit will result in the bill's being sent back with questions or being rejected with an explanation. It all typically happens without a human being reading it. "Our goal at the first stage is that no one has to touch the bill," says Leslie Trazzi, who focuses on instructions and edits for doctors' claims.

Alan A.'s bills from Sloan-Kettering are wired to a data center in Shelbyville, Ky., run by a private company (owned by WellPoint, the insurance company that operates under the Blue Cross and Blue Shield names in more than a dozen states) that has the contract to process claims originating from New York and Connecticut. Medicare is paying the company about $323 million over five years—which, as with the fees of other contractors serving other regions, works out to an average of 84¢ per claim.

In Shelbyville, Alan A.'s status as a beneficiary is verified, and then the bill is sent electronically to a data center in Columbia, S.C., operated by another contractor, also a subsidiary of an insurance company. There, the codes are checked for edits, after which Alan A.'s Sloan-Kettering bill goes electronically to a data center in Denver, where the payment instructions are prepared and entered into what Karen Jackson, who

The use of CT scans in American emergency rooms has more than quadrupled in recent decades

supervises Medicare's outside contractors, says is the largest accounting ledger in the world. The whole process takes three days—and that long only because the data is sent in batches.

There are multiple backups to make sure this ruthlessly efficient system isn't just ruthless. Medicare keeps track of and publicly reports the percentage of bills processed "clean"—i.e., with no rejected items—within 30 days. Even the speed with which the contractors answer the widely publicized consumer phone lines is monitored and reported. The average time to answer a call from a doctor or other provider is 57.6 seconds, according to Medicare's records, and the average time to answer one of the millions of calls from patients is 2 minutes 41 seconds, down from more than eight minutes in 2007. These times might come as a surprise to people who have tried to call a private insurer. That monitoring process is, in turn, backstopped by a separate ombudsman's office, which has regional and national layers.

Beyond that, the members of the House of Representatives and the Senate loom as an additional 535 ombudsmen. "We get calls every day from congressional offices about complaints that a beneficiary's claim has been denied," says Jonathan Blum, the deputy administrator of CMS. As a result, Blum's agency has an unusually large congressional liaison staff of 52, most of whom act as caseworkers trying to resolve these complaints.

All the customer-friendliness adds up to only about 10% of initial Medicare claims' being denied, according to Medicare's latest published *Composite Benchmark Metric Report*. Of those initial Medicare denials, only about 20% (2% of total claims) result in complaints or appeals, and the decisions in only about half of those (or 1% of the total) end up being reversed, with the claim being paid.

The astonishing efficiency, of course, raises the question of whether Medicare is simply funneling money out the door as fast as it can. Some fraud is inevitable—even a rate of 0.1% is enough to make headlines when $600 billion is being spent. It's also possible that people can game the system without committing outright fraud. But Medicare has multiple layers of protection against fraud that the insurance companies don't and perhaps can't match because they lack Medicare's scale.

According to Medicare's Jackson, the contractors are "vigorously monitored for all kinds of metrics" and required every quarter "to do a lot of data analysis and submit review plans and error-rate-reduction plans."

And then there are the RACs—a wholly separate group of private "recovery audit contractors." Established by Congress during the George W. Bush Administration, the RACs, says one hospital administrator, "drive the doctors and the hospitals and even the Medicare claims processors crazy." The RACs' only job is to review provider bills after they have been paid by Medicare claims processors and look for system errors, like faulty processing, or errors in the bills as reflected in doctor or hospital medical records that the RACs have the authority to audit.

The RACs have an incentive that any champion of the private sector would love. They get no up-front fees but instead are paid a percentage of the money they retrieve. They eat what they kill. According to Medicare spokeswoman Emma Sandoe, the RAC bounty hunters retrieved $797 million in the 2011 fiscal year, for which they were paid 9% to 12.5% of what they brought in, depending on the region where they were operating.

44% of low-wage workers at small firms were uninsured in 2010

This process can "get quite anal," says the doctor who recently treated me for an ear infection. Although my doctor is on Park Avenue, she, like 96% of all specialists, accepts Medicare patients despite the discounted rates it pays, because, she says, "they pay quickly." However, she recalls getting bills from Medicare for 21¢ or 85¢ for supposed overpayments.

The DHHS's inspector general is also on the prowl to protect the Medicare checkbook. It reported recovering $1.2 billion last year through Medicare and Medicaid audits and investigations (though the recovered funds had probably been doled out over several fiscal years). The inspector general's work is supplemented by a separate, multiagency federal health-care-fraud task force, which brings criminal charges against fraudsters and issues regular press releases claiming billions more in recoveries.

This does not mean the system is airtight. If anything, all that recovery activity suggests fallibility, even as it suggests more buttoned-up operations than those run by private insurers, whose payment systems are notoriously erratic.

Too Much Health Care?

IN A REVIEW OF OTHER BILLS OF THOSE ENROLLED IN Medicare, a pattern of deep, deep discounting of chargemaster charges emerged that mirrored how Alan A.'s bills were shrunk down to reality. A $121,414 Stanford Hospital bill for a 90-year-old California woman who fell and broke her wrist became $16,949. A $51,445 bill for the three days an ailing 91-year-old spent getting tests and being sedated in the hospital before dying of old age became $19,242. Before Medicare went to work, the bill was chock-full of creative chargemaster charges from the California Pacific Medical Center—part of Sutter Health, a dominant nonprofit Northern California chain whose CEO made $5,241,305 in 2011.

Another pattern emerged from a look at these bills: some seniors apparently visit doctors almost weekly or even daily, for all varieties of ailments. Sure, as patients age they are increasingly in need of medical care. But at least some of the time, the fact that they pay almost nothing to spend their days in doctors' offices must also be a factor, especially if they have the supplemental insurance that covers most of the 20% not covered by Medicare.

Alan A. is now 89, and the mound of bills and Medicare statements he showed me for 2011—when he had his heart attack and continued his treatments at Sloan-Kettering—seemed to add up to about $350,000, although I could not tell for sure because a few of the smaller ones may have been duplicates. What is certain—because his insurance company tallied it for him in a year-end statement—was that his total out-of-pocket expense was $1,139, or less than 0.2% of his overall medical bills. Those bills included what seemed to be 33 visits in one year to 11 doctors who had nothing to do with his recovery from the heart attack or his cancer. In all cases, he was routinely asked to pay almost

nothing: $2.20 for a check of a sinus problem, $1.70 for an eye exam, 33¢ to deal with a bunion. When he showed me those bills he chuckled.

A comfortable member of the middle class, Alan A. could easily afford the burden of higher co-pays that would encourage him to use doctors less casually or would at least stick taxpayers with less of the bill if he wants to get that bunion treated. AARP (formerly the American Association of Retired Persons) and other liberal entitlement lobbies oppose these types of changes and consistently distort the arithmetic around them. But it seems clear that Medicare could save billions of dollars if it required that no Medicare supplemental-insurance plan for people with certain income or asset levels could result in their paying less than, say, 10% of a doctor's bill until they had paid $2,000 or $3,000 out of their pockets in total bills in a year. (The AARP might oppose this idea for another reason: it gets royalties from UnitedHealthcare for endorsing United's supplemental-insurance product.)

Medicare spent more than $6.5 billion last year to pay doctors (even at the discounted Medicare rates) for the service codes that denote the most basic categories of office visits. By asking people like Alan A. to pay more than a negligible share, Medicare could recoup $1 billion to $2 billion of those costs yearly.

Too Much Doctoring?

ANOTHER DOCTOR'S BILL, FOR WHICH ALAN A.'S SHARE WAS 19¢, suggests a second apparent flaw in the system. This was one of 50 bills from 26 doctors who saw Alan A. at Virtua Marlton hospital or at the ManorCare convalescent center after his heart attack or read one of his diagnostic tests at the two facilities. "They paraded in once a day or once every other day, looked at me and poked around a bit and left," Alan A. recalls. Other than the doctor in charge of his heart-attack recovery, "I had no idea who they were until I got these bills. But for a dollar or two, so what?"

The "so what," of course, is that although Medicare deeply discounted the bills, it—meaning taxpayers—still paid from $7.48 (for a chest X-ray reading) to $164 for each encounter.

"One of the benefits attending physicians get from many hospitals is the opportunity to cruise the halls and go into a Medicare patient's room and rack up a few dollars," says a doctor who has worked at several hospitals across the country. "In some places it's a Monday-morning tradition. You go see the people who came in over the weekend. There's always an ostensible reason, but there's also a lot of abuse."

When health care wonks focus on this kind of

Sloan-Kettering

The Profit Of Prestigious Cancer Care

Like MD Anderson's aggressive pricing for Sean Recchi's stay, Sloan-Kettering's markup on drugs like the Flebogamma given to Alan A. is one reason cancer care is so profitable. In 2011, the hospital and research institution of Sloan-Kettering had an operating profit of $406 million even after everything it spent on research and the education of a small army of young cancer doctors.

The cash flow comes from more than just drug markups. It also comes from the high pricing enabled by a great brand and an enterprise that has learned how to expand the reach of its brand.

One of Sloan-Kettering's major revenue sources is the outpatient clinics it has been opening around New York City in recent years so that patients don't have to travel to the busy Upper East Side of Manhattan for the kind of treatments Alan A. gets every six weeks. There is a cancer-screening and treatment outpost (run in partnership with Ralph Lauren's foundation) in Harlem and a chemotherapy clinic in Brooklyn, and clinical-care facilities can also be found in five of the New York City metropolitan area's wealthier suburbs, such as Sleepy Hollow in Westchester County, New York, and Basking Ridge, N.J. A sixth is being constructed in Harrison, another wealthy Westchester town.

Building on the deserved allure of the Sloan-Kettering brand, these outposts eat into the profits of area hospitals, which would otherwise be providing the same high-margin outpatient cancer care either on the basis of what their own doctors prescribed or according to instructions from Sloan-Kettering's specialists. "Sloan-Kettering can open these clinics and treat people 9 to 5 at their [high] rates, and because they've got the brand name, they'll be very successful because they don't have to run a 24/7 operation," complains the president of one hospital in a wealthy suburb north of New York City. "But if those patients need help at midnight on Saturday, they'll end up in our emergency room." That may be true, but Sloan-Kettering's foray beyond the Upper East Side of Manhattan also represents a rare outbreak of competition in the current hospital marketplace.

Sloan-Kettering may be fishing for business in these wealthy suburbs, but it does have a financial-aid process that is both proactive and well publicized to patients seeking care. It provides discounts of varying amounts for those who are uninsured or underinsured and have incomes of less than 500% above the poverty line, which comes out to about $115,000 a year for a family of four. Counselors also help patients get other aid from the state or local government, from research programs or, as happened with Sean Recchi in Ohio, from drug companies.

That still leaves out many people, especially the uninsured or underinsured whose incomes are above $115,000 but well below what they would pay for treatment at Sloan-Kettering. And it undoubtedly leaves others struggling just to meet the co-pays required even with good insurance. Sloan-Kettering chief operating

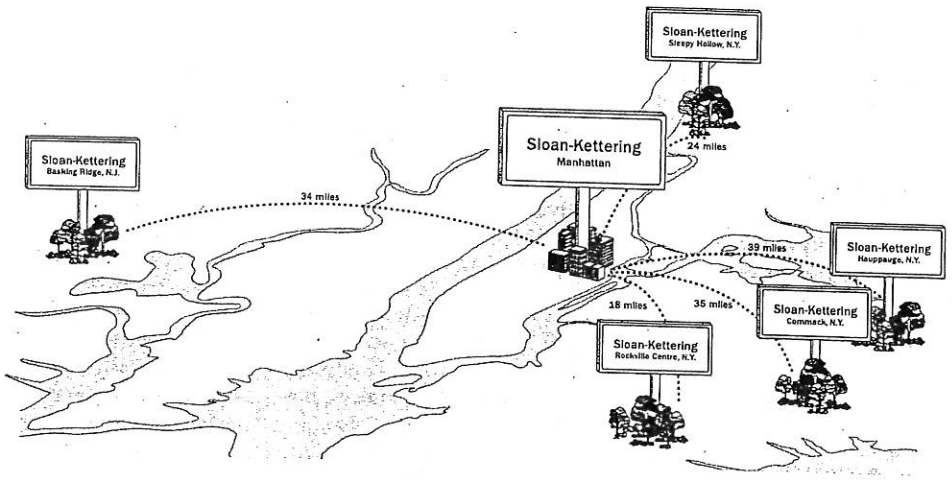
overdoctoring, they complain (and write endless essays) about what they call the fee-for-service mode, meaning that doctors mostly get paid for the time they spend treating patients or ordering and reading tests. Alan A. didn't care how much time his cancer or heart doctor spent with him or how many tests he got. He cared only that he got better.

Some private care organizations have made progress in avoiding this overdoctoring by paying salaries to their physicians and giving them incentives based on patient outcomes. Medicare and private insurers have yet to find a way to do that with doctors, nor are they likely to, given the current structure that involves hundreds of thousands of private providers billing them for their services.

In passing Obamacare, Congress enabled Medicare to drive efficiencies in hospital care based on the notion that good care should be rewarded and the opposite penalized. The primary lever is a system of penalties Obamacare imposes on hospitals for bad care—a term defined as unacceptable rates of adverse events, such as infections or injuries during a patient's hospital stay or readmissions within a month after discharge. Both kinds of adverse events are more common than you might think: 1 in 5 Medicare patients is readmitted within 30 days, for example. One Medicare report asserts that "Medicare spent an estimated $4.4 billion in 2009 to care for patients who had been harmed in the hospital, and readmissions cost Medicare another $26 billion." The anticipated savings that will be produced by the threat of these new penalties are what has allowed the Obama Administration to claim that Obamacare can cut hundreds of billions of dollars from Medicare over the next 10 years without shortchanging beneficiaries. "These payment penalties are sending a shock through the system that will drive costs down," says Blum, the deputy administrator of the Centers for Medicare and Medicaid Services.

There are lots of other shocks Blum and his colleagues would like to send. However, Congress won't allow him to. Chief among them, as we have seen, would be allowing Medicare, the world's largest buyer of prescription drugs, to negotiate the prices that it pays for them and to make purchasing decisions on the basis of comparative effectiveness. But there's also the cane that Alan A. got after his heart attack. Medicare paid $21.97 for it. Alan A. could have bought it on Amazon for about $12. Other than in a few pilot regions that Congress designated in 2011 after a push by the Obama Administration, Congress has not allowed Medicare to drive down the price of any so-called durable medical equipment through competitive bidding.

This is more than a matter of the 124,000 canes Medicare



officer John Gunn says patients not formally in the financial-assistance program might still be offered discounts of some kind and that only "2% or 3% of our patients pay our full list prices"—chargemaster prices that he acknowledges are high "because we have better outcomes."

Most of those asked to pay chargemaster rates, Gunn adds, are "wealthy foreigners, whom we screen and tell in advance what it's likely to cost them." Insurance companies negotiate discounts off of Sloan-Kettering's chargemaster prices, but Gunn acknowledges that his hospital can drive a hard bargain because insurers want "to make sure we are in" their network.

That kind of brand strength produces not only lavish cash flow but also lavish incomes for the nondoctors who work to generate it. Six Sloan-Kettering administrators made salaries of over $1 million in 2010, the most recent year for which the hospital filed its nonprofit tax return. (The 2011 return is "on extension," says Gunn, who was paid $1,531,991 in 2010.) Including those six, 14 made over $500,000.

Compared with their peers at equally venerable nonprofits, these executives are comfortably ensconced in a medical ecosystem that's in a world of its own. For example, Sloan-Kettering listed two development-office executives, or fundraisers, as making $1,483,000 and $844,000. Another venerable New York nonprofit that mines the same field for donors—the Metropolitan Museum of Art—pays its top development officer $345,000. Harvard pays its chief fundraiser $392,000. Asked why salaries at Sloan-Kettering are so much higher than those at nonprofits like the Met and Harvard, Gunn replies, "All of us hospitals have the same compensation consultants, so I guess it's a self-fulfilling prophecy."

Whatever the origins of the compensation rates, the prospectus that Sloan-Kettering's bankers and lawyers used to sell the bonds that helped finance those suburban clinics struck a tone that is at odds with the daily sight of men and women rushing through the halls of Sloan-Kettering doing God's work. The halls may be sprinkled with cheerful posters aimed at patients, but the prospectus is sprinkled with phrases like *market share, improved pricing* and *rate and volume increases.* Then again, the same prospectus describes the core of the business this way: "higher five-year survival rates for cancer patients as compared to other institutions."

ILLUSTRATION BY BROWN BIRD DESIGN FOR TIME

reports that it buys every year. It's about mail-order diabetic supplies, wheelchairs, home medical beds and personal oxygen supplies too. Medicare spends about $15 billion annually for these goods.

In the areas of the country where Medicare has been allowed by Congress to conduct a competitive-bidding pilot program, the process has produced savings of 40%. But so far, the pilot programs cover only about 3% of the medical goods seniors typically use. Taking the program nationwide and saving 40% of the entire $15 billion would mean saving $6 billion a year for taxpayers.

The Way Out Of the Sinkhole

"I WAS DRIVING THROUGH CENTRAL FLORIDA A YEAR OR TWO ago," says Medicare's Blum. "And it seemed like every billboard I saw advertised some hospital with these big shiny buildings or showed some new wing of a hospital being constructed ... So when you tell me that the hospitals say they are losing money on Medicare and shifting costs from Medicare patients to other patients, my reaction is that Central Florida is overflowing with Medicare patients and all those hospitals are expanding and advertising for Medicare patients. So you can't tell me they're losing money ... Hospitals don't lose money when they serve Medicare patients."

If that's the case, I asked, why not just extend the program to everyone and pay for it all by charging people under 65 the kinds of premiums they would pay to private insurance companies? "That's not for me to say," Blum replied.

In the debate over controlling Medicare costs, politicians from both parties continue to suggest that Congress raise the age of eligibility for Medicare from 65 to 67. Doing so, they argue, would save the government tens of billions of dollars a year. So it's worth noting another detail about the case of Janice S., which we examined earlier. Had she felt those chest pains and gone to the Stamford Hospital emergency room a month later, she would have been on Medicare, because she would have just celebrated her 65th birthday.

If covered by Medicare, Janice S.'s $21,000 bill would have been deeply discounted and, as is standard, Medicare would have picked up 80% of the reduced cost. The bottom line is that Janice S. would probably have ended up paying $500 to $600 for her 20% share of her heart-attack scare. And she would have paid only a fraction of that—maybe $100—if, like most Medicare beneficiaries, she had paid for supplemental insurance to cover most of that 20%.

In fact, those numbers would seem to argue for lowering the Medicare age, not raising it—and not just from Janice S.'s standpoint but also from the taxpayers' side of the equation. That's not a liberal argument for protecting entitlements while the deficit balloons. It's just a matter of hardheaded arithmetic.

As currently constituted, Obamacare is going to require people like Janice S. to get private insurance coverage and will subsidize those who can't afford it. But the cost of that private insurance—and therefore those subsidies—will be much higher than if the same people were enrolled in Medicare at an earlier age. That's because Medicare buys health care services at much lower rates than any insurance company. Thus the best way both to lower the deficit and to help save money for people like Janice S. would seem to be to bring her and other near seniors into the Medicare system before they reach 65. They could be required to pay premiums based on their incomes, with the poor paying low premiums and the better off paying what they might have paid a private insurer. Those who can afford it might also be required to pay a higher proportion of their bills—say, 25% or 30%—rather than the 20% they're now required to pay for outpatient bills.

Meanwhile, adding younger people like Janice S. would lower the overall cost per beneficiary to Medicare and help cut its deficit still more, because younger members are likelier to be healthier.

From Janice S.'s standpoint, whatever premium she would pay for this age-64 Medicare protection would still be less than what she had been paying under the COBRA plan that she wished she could have kept after the rules dictated that she be cut off after she lost her job.

The only way this would not work is if 64-year-olds started using health care services they didn't need. They might be tempted to, because, as we saw with Alan A., Medicare's protection is so broad and supplemental private insurance costs so little that it all but eliminates patients' obligation to pay the 20% of outpatient-care costs that Medicare doesn't cover. To deal with that, a provision could be added requiring that 64-year-olds taking advantage of Medicare could not buy insurance freeing them from more than, say, 5% or 10% of their responsibility for the bills, with the percentage set according to their wealth. It would be a similar, though more stringent, provision of the kind I've already suggested for current Medicare beneficiaries as a way to cut the cost of people overusing benefits.

If that logic applies to 64-year-olds, then it would seem to apply even more readily to healthier 40-year-olds or 18-year-olds. This is the single-payer approach favored by liberals and used by most developed countries.

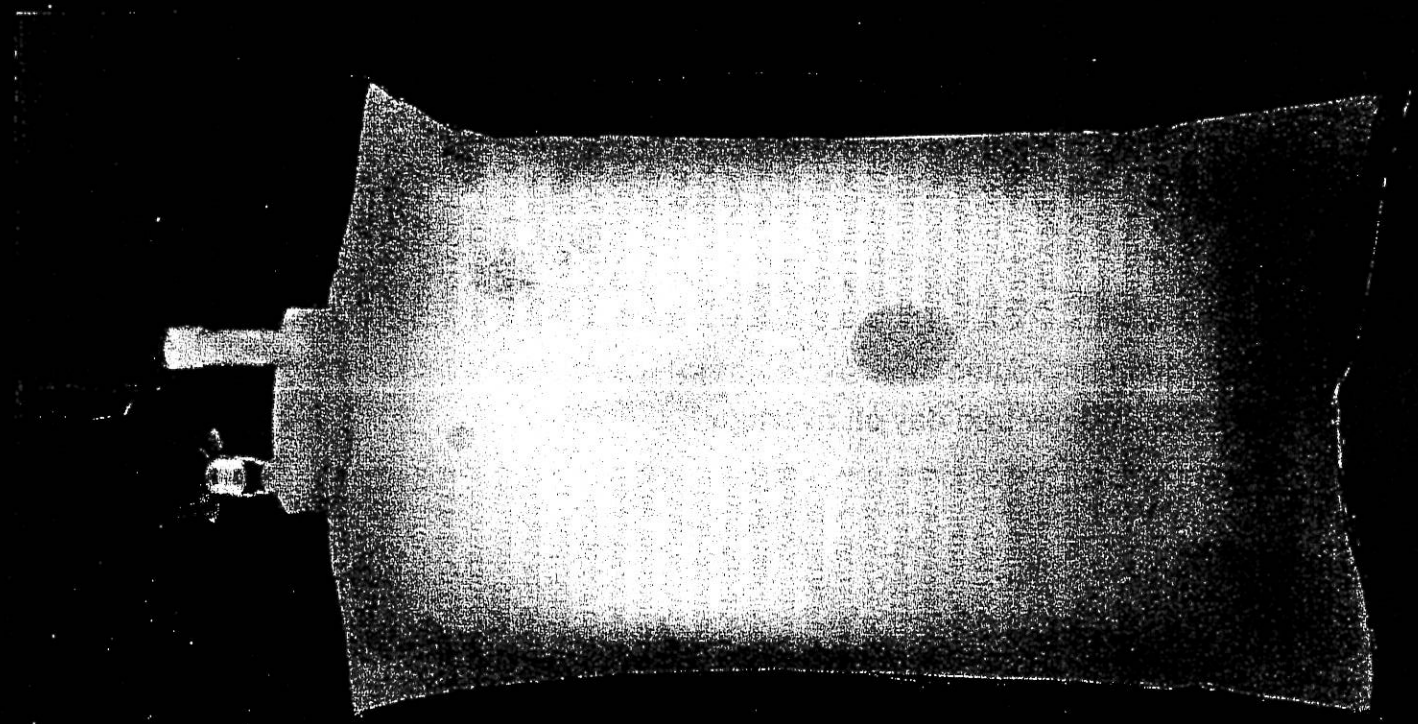
Then again, however much hospitals might survive or struggle under that scenario, no doctor could hope for anything approaching the income he or she deserves (and that will make future doctors want to practice) if 100% of their patients yielded anything close to the low rates Medicare pays.

"If you could figure out a way to pay doctors better and separately fund research ... adequately, I could see where a single-payer approach would be the most logical solution," says Gunn, Sloan-Kettering's chief operating officer. "It would certainly be a lot more efficient than hospitals like ours having hundreds of people sitting around filling out dozens of different kinds of bills for dozens of insurance companies." Maybe, but the prospect of overhauling our system this way, displacing all the private insurers and other infrastructure after all these decades, isn't likely. For there would be one group of losers—and these losers have lots of clout. They're the health care providers like hospitals and CT-scan-equipment makers whose profits—embedded in the bills we have examined—would be sacrificed. They would suffer because of the lower prices Medicare would pay them when the patient is 64, compared with what they are able to charge when that patient is either covered by private insurance or has no insurance at all.

That kind of systemic overhaul not only seems unrealistic but is also packed with all kinds of risk related to

Photograph by Nick Veasey for TIME

$84 Hospital charge for standard saline solution. Online, a liter bag costs $5.16



Sodium Chloride

the microproblems of execution and the macro issue of giving government all that power.

Yet while Medicare may not be a realistic systemwide model for reform, the way Medicare works does demonstrate, by comparison, how the overall health care market doesn't work.

Unless you are protected by Medicare, the health care market is not a market at all. It's a crapshoot. People fare differently according to circumstances they can neither control nor predict. They may have no insurance. They may have insurance, but their employer chooses their insurance plan and it may have a payout limit or not cover a drug or treatment they need. They may or may not be old enough to be on Medicare or, given the different standards of the 50 states, be poor enough to be on Medicaid. If they're not protected by Medicare or they're protected only partly by private insurance with high co-pays, they have little visibility into pricing, let alone control of it. They have little choice of hospitals or the services they are billed for, even if they somehow know the prices before they get billed for the services. They have no idea what their bills mean, and those who maintain the chargemasters couldn't explain them if they wanted to. How much of the bills they end up paying may depend on the generosity of the hospital or on whether they happen to get the help of a billing advocate. They have no choice of the drugs that they have to buy or the lab tests or CT scans that they have to get, and they would not know what to do if they did have a choice. They are powerless buyers in a seller's market where the only sure thing is the profit of the sellers.

Indeed, the only player in the system that seems to have to balance countervailing interests the way market players in a real market usually do is Medicare. It has to answer to Congress and the taxpayers for wasting money, and it has to answer to portions of the same groups for trying to hold on to money it shouldn't. Hospitals, drug companies and other suppliers, even the insurance companies, don't have those worries.

Moreover, the only players in the private sector who seem to operate efficiently are the private contractors working—dare I say it?—under the government's supervision. They're the Medicare claims processors that handle claims like Alan A.'s for 84¢ each. With these and all other Medicare costs added together, Medicare's total management, administrative and processing expenses are about $3.8 billion for processing more than a billion claims a year worth $550 billion. That's an overall administrative and management cost of about two-thirds of 1% of the amount of the claims, or less than $3.80 per claim. According to its latest SEC filing, Aetna spent $6.9 billion on operating expenses (including claims processing, accounting, sales and executive management) in 2012. That's about $30 for each of the 229 million claims Aetna processed, and it amounts to about 29% of the $23.7 billion Aetna pays out in claims.

The real issue isn't whether we have a single payer or multiple payers. It's whether whoever pays has a fair chance in a fair market. Congress has given Medicare that power when it comes to dealing with hospitals and doctors, and we have seen how that works to drive down the prices Medicare pays, just as we've seen what happens when Congress handcuffs Medicare when it comes to evaluating and buying drugs, medical devices and equipment. Stripping away what is now the sellers' overwhelming leverage in dealing with Medicare in those areas and with private payers in all aspects of the market would inject fairness into the market. We don't have to scrap our system and aren't likely to. But we can reduce the $750 billion that we overspend on health care in the U.S. in part by acknowledging what other countries have: because the health care market deals in a life-or-death product, it cannot be left to its own devices.

Put simply, the bills tell us that this is not about interfering in a free market. It's about facing the reality that our largest consumer product by far—one-fifth of our economy—does not operate in a free market.

So how can we fix it?

The U.S. has the highest annual per capita spending on hospitalization among developed countries: $2,300 per bed day on average

Changing Our Choices

WE SHOULD TIGHTEN ANTITRUST LAWS RELATED TO HOSPITALS to keep them from becoming so dominant in a region that insurance companies are helpless in negotiating prices with them. The hospitals' continuing consolidation of both lab work and doctors' practices is one reason that trying to cut the deficit by simply lowering the fees Medicare and Medicaid pay to hospitals will not work. It will only cause the hospitals to shift the costs to non-Medicare patients in order to maintain profits—which they will be able to do because of their increasing leverage in their markets over insurers. Insurance premiums will therefore go up—which in turn will drive the deficit back up, because the subsidies on insurance premiums that Obamacare will soon offer to those who cannot afford them will have to go up.

Similarly, we should tax hospital profits at 75% and have a tax surcharge on all nondoctor hospital salaries that exceed, say, $750,000. Why are high profits at hospitals regarded as a given that we have to work around? Why shouldn't those who are profiting the most from a market whose costs are victimizing everyone else chip in to help? If we recouped 75% of all hospital profits (from nonprofit as well as for-profit institutions), that would save over $80 billion a year before counting what we would save on tests that hospitals might not perform if their profit incentives were shaved.

To be sure, this too seems unlikely to happen. Hospitals may be the most politically powerful institution in any congressional district. They're usually admired as their community's most important charitable institution, and their influential stakeholders run the gamut from equipment makers to drug companies to doctors to thousands of rank-and-file employees. Then again, if every community paid more attention to those administrator salaries, to those nonprofits' profit margins and to charges like $77 for gauze pads, perhaps the political balance would shift.

We should outlaw the chargemaster. Everyone involved, except a patient who gets a bill based on one (or worse, gets sued on the basis of one), shrugs off chargemasters as a fiction. So why not require that they be rewritten to reflect a process that considers actual and thoroughly transparent costs? After all, hospitals are supposed to be government-sanctioned institutions accountable to the public. Hospitals love the chargemaster because it gives them a big number to put in front of rich uninsured patients (typically from outside the U.S.) or, as is more likely, to attach to lawsuits or give to bill collectors,

establishing a place from which they can negotiate settlements. It's also a great place from which to start negotiations with insurance companies, which also love the chargemaster because they can then make their customers feel good when they get an Explanation of Benefits that shows the terrific discounts their insurance company won for them.

But for patients, the chargemasters are both the real and the metaphoric essence of the broken market. They are anything but irrelevant. They're the source of the poison coursing through the health care ecosystem.

We should amend patent laws so that makers of wonder drugs would be limited in how they can exploit the monopoly our patent laws give them. Or we could simply set price limits or profit-margin caps on these drugs. Why are the drug profit margins treated as another given that we have to work around to get out of the $750 billion annual overspend, rather than a problem to be solved?

Just bringing these overall profits down to those of the software industry would save billions of dollars. Reducing drugmakers' prices to what they get in other developed countries would save over $90 billion a year. It could save Medicare—meaning the taxpayers—more than $25 billion a year, or $250 billion over 10 years. Depending on whether that $250 billion is compared with the Republican or Democratic deficit-cutting proposals, that's a third or a half of the Medicare cuts now being talked about.

Similarly, we should tighten what Medicare pays for CT or MRI tests a lot more and even cap what insurance companies can pay for them. This is a huge contributor to our massive overspending on outpatient costs. And we should cap profits on lab tests done in-house by hospitals or doctors.

Finally, we should embarrass Democrats into stopping their fight against medical-malpractice reform and instead provide safe-harbor defenses for doctors so they don't have to order a CT scan whenever, as one hospital administrator put it, someone in the emergency room says the word *head*. Trial lawyers who make their bread and butter from civil suits have been the Democrats' biggest financial backer for decades. Republicans are right when they argue that tort reform is overdue. Eliminating the rationale or excuse for all the extra doctor exams, lab tests and use of CT scans and MRIs could cut tens of billions of dollars a year while drastically cutting what hospitals and doctors spend on malpractice insurance and pass along to patients.

Other options are more tongue in cheek, though they illustrate the absurdity of the hole we have fallen into. We could limit administrator salaries at hospitals to five or six times what the lowest-paid licensed physician gets for caring for patients there. That might take care of the self-fulfilling peer dynamic that Gunn of Sloan-Kettering cited when he explained, "We all use the same compensation consultants." Then again, it might unleash a wave of salary increases for junior doctors.

Or we could require drug companies to include a prominent, plain-English notice of the gross profit margin on the packaging of each drug, as well as the salary of the parent company's CEO. The same would have to be posted on the company's website. If nothing else, it would be a good test of embarrassment thresholds.

None of these suggestions will come as a revelation to the policy experts who put together Obamacare or to those before them who pushed health care reform for decades. They know what the core problem is—lopsided pricing and outsize profits in a market that doesn't work. Yet there is little in Obamacare that addresses that core issue or jeopardizes the paydays of those thriving in that marketplace. In fact, by bringing so many new customers into that market by mandating that they get health insurance and then providing taxpayer support to pay their insurance premiums, Obamacare enriches them. That, of course, is why the bill was able to get through Congress.

In 2012 the average employer contributed $7,225 in health premiums for each employee who enrolled in the employer's group health plans

Obamacare does some good work around the edges of the core problem. It restricts abusive hospital-bill collecting. It forces insurers to provide explanations of their policies in plain English. It requires a more rigorous appeal process conducted by independent entities when insurance coverage is denied. These are all positive changes, as is putting the insurance umbrella over tens of millions more Americans—a historic breakthrough. But none of it is a path to bending the health care cost curve. Indeed, while Obamacare's promotion of statewide insurance exchanges may help distribute health-insurance policies to individuals now frozen out of the market, those exchanges could raise costs, not lower them. With hospitals consolidating by buying doctors' practices and competing hospitals, their leverage over insurance companies is increasing. That's a trend that will only be accelerated if there are more insurance companies with less market share competing in a new exchange market trying to negotiate with a dominant hospital and its doctors. Similarly, higher insurance premiums—much of them paid by taxpayers through Obamacare's subsidies for those who can't afford insurance but now must buy it—will certainly be the result of three of Obamacare's best provisions: the prohibitions on exclusions for pre-existing conditions, the restrictions on co-pays for preventive care and the end of annual or lifetime payout caps.

Put simply, with Obamacare we've changed the rules related to who pays for what, but we haven't done much to change the prices we pay.

WHEN YOU FOLLOW THE MONEY, YOU SEE THE CHOICES we've made, knowingly or unknowingly.

Over the past few decades, we've enriched the labs, drug companies, medical device makers, hospital administrators and purveyors of CT scans, MRIs, canes and wheelchairs. Meanwhile, we've squeezed the doctors who don't own their own clinics, don't work as drug or device consultants or don't otherwise game a system that is so gameable. And of course, we've squeezed everyone outside the system who gets stuck with the bills.

We've created a secure, prosperous island in an economy that is suffering under the weight of the riches those on the island extract.

And we've allowed those on the island and their lobbyists and allies to control the debate, diverting us from what Gerard Anderson, a health care economist at the Johns Hopkins Bloomberg School of Public Health, says is the obvious and only issue: "All the prices are too damn high." ■

Brill, the author of Class Warfare: Inside the Fight to Fix America's Schools, *is the founder of Court TV and the* American Lawyer

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SHORT TAKES ON NEWS & EVENTS

Expert: Hospitals' 'Humongous Monopoly' Drives Prices High

By Jay Hancock
MARCH 4TH, 2013, 5:54 AM

The American Enterprise Institute didn't plan its panel last week on hospital consolidation to coincide with Steve Brill's much-talked-about Time magazine article on hospital prices. But the Friday session could have taken the piece, Bitter Pill: Why Medical Bills Are Killing Us, as its text. Participants mentioned it several times.

The basic message, delivered at the pro-markets AEI by prominent economic and legal scholars, is that the hospital market is broken and may not be fixable by the health law or other attempts at reform. They blamed much of the high price of health care on mergers over the past 30 years that have given hospitals "oligopoly" power to charge prices far higher than what would exist with more competition.

"Finally the evidence is catching up with the reality that we have a humongous monopoly problem in health care," said Robert Murray, a consultant and former director of Maryland's unique hospital rate-setting commission. Quoting former Medicare administrator Bruce Vladeck, he described the current system as "a massive environment for the reallocation of income" from households and employers to health care providers.

Barak Richman, law professor at Duke University, was even harsher: "We are in a real disaster," he told the audience. "The house indeed is on fire. It's been on fire for a long time."

Judges got much of the blame. Thinking that monopolistic mergers of nonprofit hospitals would prove less harmful than combinations of for-profit companies in other industries, the courts approved deals that never would have been allowed in, say, the supermarket business. The judges were wrong, evidence shows. Health care's unique financing system — in which employers pay most expenses and demand rarely slackens no matter how high prices go — gives consolidated hospitals even more power than conventional oligopolists, said Richman.

What to do? The Federal Trade Commission, the antitrust watchdog, has been winning cases opposing hospital mergers. A big victory came last month when the Supreme Court upheld the FTC's power to challenge a Georgia hospital deal that the agency argued would create a monopoly. But the FTC's hot streak may have come too late.

"Once there's been a lot of consolidation it's very hard to undo," said Carnegie Mellon economist Martin Gaynor. "Unfortunately a lot of that has already occurred in the hospital sector."

Many hold hope for accountable care organizations, alliances of doctors and hospitals working together under incentives to deliver better care more efficiently. The AEI panel was skeptical. ACOs have the potential to be "an anti-competitive sham" dominated by hospitals, Gaynor said.

The use of high-quality, out-of-town hospitals by large employers, exemplified by Walmart's

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recent agreement with Mayo Clinic and other providers, might help, said Gaynor.

"That opens up local markets to competition from distant providers," he said.

But Murray was skeptical of distant competition as well as ACOs and hopes of getting consumers to compare prices and be better health-care shoppers.

"Do we really think we can be good consumers when we are in the back of an ambulance going to the emergency room?" he asked. "All of these things are peanuts. They won't make a difference overall."

He even questioned whether Maryland's system of hospital rate-setting, which he ran for years, could work elsewhere. His ideas: rationalize the system by giving primary care doctors more power and increasing their pay, and limit all payments to some multiple — "call it 150 percent, 125 percent" — of Medicare reimbursement. Princeton economist Uwe Reinhardt made a similar suggestion Friday on the New York Times' Economix blog.

Regulators aren't out of ammo, Richman argued. They can challenge contractual terms between hospitals and insurers that limit competition, for example. He took comfort in the FTC's ability to oversee ACOs, which, after all, he said, involve more provider combinations. But he suggested they'll need to pay attention.

"ACOs do involve consolidation, and with consolidation we might see the exacerbation of all the problems we've seen," Richman said. "What we have in the industry, in the provider market, is a hard-wired market strategy to seek and exploit market power."

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As They Consolidate, Hospitals Get Pricier

THIS ENTRY WAS POSTED ON MONDAY, MARCH 4TH, 2013 AT 5:54 AM.

3 Responses to "Expert: Hospitals' 'Humongous Monopoly' Drives Prices High"

KELLY SAYS:
MARCH 4, 2013 AT 7:09 AM

This article is the best evidence yet to promote more reasons that support single-payer universal healthcare.

"Do we really think we can be good consumers when we are in the back of an ambulance going to the emergency room?"

The above statement alone says it all.

It's time to crack down on these outrageous monopolies and put control of our corrupt healthcare market back into the hands on consumers. Only government can do that. Big government!

EDMUND L. VALENTINE SAYS:
MARCH 4, 2013 AT 9:47 AM

Marketplace change takes time. When a monopoly is formed in a market, it can maintain its monopolistic position as long as it continues to drive prices down. Competitors are always willing to jump into a market where a price umbrella is formed and where they see an opportunity to make money while being able to capture share, generally by offering better service/products at a lower price. Hospitals are a big business….and markets are local. It takes time to create the price umbrella and yet more time for others to position themselves to move into the market. The free marketplace system made this country great. The profit potential has driven innovation and marketplace competition. Marketplace forces are efficient over time. Let's stop having knee jerk reactions drive policy…instead, let' trust in what made this country great, free market competition.

PAMELA SAYS:
MARCH 4, 2013 AT 10:34 AM

These are not marketplace forces at work and there is no good end result that can be achieved from our current status. The bogus fees and outrageous profits commandered by a US Healthcare system run amok are so out of control that the only way to bend the cost curve in the future is via government intervention. Medicare, a government program, is the best example

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of successful health care cost control in this country. Not perfect, but it works. Systemwide health reform can happen but the money hungry hospital CEOs, Pharma execs, etc need to start things off by giving up their million dollar-plus salaries since it's clear that nothing they've been doing has come close to being worth that level of compensation.

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ENSURING THE HEALTH CARE NEEDS OF WOMEN:

A Checklist for Health Exchanges

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The Connors Center for Women's Health and Gender Biology at Brigham's and Women's Hospital was established in 2002 to improve the health of women and transform their care through the discovery, dissemination and integration of knowledge of women's health and sex and gender-based differences and the application of this knowledge to the delivery of care. Our goals are to:

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- Build awareness of issues related to women's health and gender biology among clinicians, patients and the general public, and advocate for changes in public policy to improve the health of women;
- Develop leaders with the experience and skills to have a major impact on improving the health of women.

The Jacobs Institute of Women's Health (JIWH) is a nonprofit academic organization working to improve health care for women through research, dialogue, and information dissemination. Our mission is to:

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Ensuring the Health Care Needs of Women: A Checklist for Health Exchanges

Introduction:

Women's health is a major determinant of our nation's health and the health of future generations and should be a key consideration in the planning and design of new systems of coverage under national health care reform. As consumers, providers and coordinators of health care, women are disproportionately affected by changes in health care coverage and delivery of care. Women utilize more medical services than men due in part to longer life expectancies, the need for reproductive care, and a greater likelihood of chronic disease and disability. Furthermore, women take major responsibility for coordinating care for family members, shoulder higher annual health care expenses, face more affordability challenges, and are more likely to experience inconsistent insurance coverage compared to men.

A major feature of the Patient Protection and Affordable Care Act of 2010 (ACA), is the establishment of health insurance exchanges ("Exchanges") in every state, operated in whole by the state, as a partnership between the state and federal government, or as a fully federally-facilitated exchange (FFE) effective 2014. As Exchanges are established, attention to the major issues that affect women's coverage, affordability and access to quality health care, as well as the distinct challenges facing women from different racial/ethnic and socioeconomic backgrounds are key. In all aspects of planning, it is important for states to consider these differential impacts and make sure their strategies will meet the needs of women.

The following checklist presents crucial questions to consider as states work to design, establish, and implement Exchanges, drawing from national policy research and lessons learned from Massachusetts. Some states will work in partnership with the federal government to operate their Exchanges and some will choose a fully federally facilitated exchange, but they will not have the flexibility or autonomy that states operating their own exchanges will experience. In all cases, it will be important for policymakers at all levels to understand the issues impacting women's health to best meet the needs of women and their families.

Despite the large body of evidence that demonstrates women's different utilization of services and experiences with the health care system, relatively few analyses and reports on ACA implementation have focused on the broad range of services that are important to women throughout their lives. To fill this gap, this checklist also includes resources that address the impact of policy issues on women's health and access, as well as more general resources on areas of importance to women. Major issues for states to consider include:

- **Essential Health Benefits:** Designing benefits packages offered by Exchange plans that include the range and scope of health services needed by women;
- **Preventive Services:** With structure and guidance provided by federal regulations, monitoring the implementation of the new benefits for no-cost preventive services for women;
- **Network Adequacy Requirements:** Defining the range of provider and facility types, including Essential Community Providers (ECP), that will be included in plan networks so that they are appropriate to meet women's health needs;
- **Outreach and Enrollment:** Educating women about enrollment, scope of benefits, out-of-pocket charges, and exemptions;
- **Affordability and Transparency:** Ensuring continuous, affordable coverage, particularly through transparency of out-of-pocket costs, and allowing women to assess plan choices and;
- **Data Collection and Reporting Standards:** Measuring and reporting the impact and outcomes of health reform on women's health and access, including disproportionate impact on subgroups of racial/ethnic minority women and enforcing the nondiscrimination provisions of the ACA.

Essential Health Benefits

Women rely on a broad range of services over the course of a lifetime, including chronic illness management, mental health, preventive care, reproductive care, and long-term care. Under the ACA, insurance plans offered through the Exchange (as well as non-grandfathered plans in the individual and small group markets) must cover "essential health benefits" (EHB) that broadly include: ambulatory patient services; emergency services; hospitalizations; maternity care and newborn care; mental health and substance abuse disorder services, including behavioral health treatments; prescription drugs; rehabilitative and habilitative services and devices; lab services; preventive and wellness services; chronic disease management; and pediatric services. Within those categories, the details regarding the type and level of coverage that insurance policies provide are of great importance. States will choose a benchmark plan that will guide the minimum level of benefits provided by Qualified Health Plans sold in the Exchange.

- ✓ How is your state implementing the Essential Health Benefit (EHB) provisions? Will your exchange work with the state's insurance department to monitor and enforce this provision?
- ✓ Will the benefits be broader than the categories of federal requirements? For example, will it include mandatory state benefits?
- ✓ Does your state Exchange offer insurance products that cover the comprehensive range of health services important to women across the lifespan (e.g., prevention, reproductive care, mental health, chronic illnesses, and other care)?
- ✓ How is your state evaluating the adequacy of EHB benchmark plan in meeting the needs of women?
- ✓ Will there be a process for assessing whether the benefits offered by QHPs meet the EHB standards?

Lessons Learned:

- › Blue Cross Blue Shield of Massachusetts Foundation, Massachusetts Connector and Robert Wood Johnson Foundation, Determining Health Benefit Designs.
- › National Association for State Health Policy and Robert Wood Johnson Foundation, State Refor(u)m, State Progress on Essential Health Benefits.

Further Reading:

- › Centers for Medicare and Medicaid Services, Frequently Asked Questions on Essential Health Benefits Bulletin.
- › Families USA, Designing the Essential Health Benefits for Your State: An Advocates Guide.
- › Health Affairs and Robert Wood Johnson Foundation, Essential Health Benefits. States Will Determine the Minimum Set of Benefits to be Included in individual and Small Group Insurance Plans. What Lies Ahead?
- › Institute of Medicine, Essential Health Benefits: Balancing Coverage and Cost.
- › Kaiser Family Foundation, Essential Health Benefit (EHB) Benchmark Plans.
- › Kaiser Family Foundation, Impact of Health Reform on Women's Access to Coverage and Care.

Maternity Care

Maternity care is one of the EHB categories and encompasses a wide range of services that span the pre-conception, pregnancy, labor and delivery, postpartum, and inter-conception periods. In addition, a wide range of maternity-related services such as prenatal care, several screening tests, alcohol and tobacco counseling, and breast feeding supports are covered in Exchange plans without cost-sharing as preventive services. Experience from the individual market, where coverage for maternity care has been limited, has shown that women and their families have shouldered significant out-of-pocket expenses to pay for maternity care.[1] Due to the importance of maternity care for

Lessons Learned:

- › Childbirth Connection, Blueprint for Action: Steps Toward A High Quality , High Value Maternity Care System.
- › National Partnership for Women and Families, Guidelines for States on Maternity Care In the Essential Health Benefits Package.

Further Reading:

- › Guttmacher Institute, The Potential of Health Care Reform to Improve Pregnancy-Related Services and Outcomes.

Maternity Care (continued)

maternal and infant health outcomes, the range of services and provider types that are covered in the maternity care benefit are of considerable importance. Stakeholder groups, clinicians and other experts in the field can work with plan officials to develop a comprehensive set of maternity benefits and to assess the scope and quality of services provided to women.

- ✓ Will maternity care be defined to include services ranging from pre-and interconception to prenatal, delivery, and postpartum care?
- ✓ Will there be limits on the types of services and providers that can be covered under the plans? For example, will provider networks include free standing birth centers, birth attendants and nurse midwives?

Preventive Services

The ACA authorizes coverage without cost-sharing for preventive services recommended by the U.S. Preventive Services Task Force, such as Pap Smears and mammograms, vaccines recommended by the Advisory Committee on Immunization Practices, such as the HPV vaccine, and a new set of evidence-based services for women that were identified by a panel of experts of the Institute of Medicine (IOM), including contraceptives, intimate partner screening and counseling, and well women visits. These services will be available to women in new private plans as well as those in plans available in Exchanges. In order to receive these services without cost-sharing, women must use providers who are within their health plan's network. In addition, reasonable medical management rules and formularies will apply, so some, but not all, of the specific types of services and brands of contraceptives may be available.

- ✓ How will women be informed about preventive services benefits and how they work?
- ✓ How will the implementation of the new coverage benefit of preventive services for women without cost-sharing be enforced? Will your exchange work with the state's insurance department to monitor and enforce this provision? Which state entities will monitor enforcement of this benefit in private plans?
- ✓ How will the state monitor the impact of reasonable medical management limits on women's access to preventive services, including contraception?

Lessons Learned:

- › Centers for Medicare and Medicaid Services, Affordable Care Act Implementation FAQs – Set 12.
- › Congressional Research Service, Enforcement of the Preventive Health Care Services Requirements of the Patient Protection and Affordable Care Act.
- › Health Reform GPS, Contraception Coverage within Required Preventive Services.
- › Institute of Medicine, Clinical Preventive Services for Women: Closing the Gaps.
- › National Business Group on Health and the Centers for Disease Control and Prevention, A Purchaser's Guide to Clinical Preventive Services: Moving Science into Coverage.
- › National Health Law Program, NHeLP Breaks Down Preventive Health Services Standards & Contraceptive Coverage under the ACA.

Further Reading:

- › Center for American Progress, Young Women and Reproductive Health Care.
- › Guttmacher Institute, Family Planning and Health Care Reform: The Benefits and Challenges of Prioritizing Prevention.
- › National Women's Law Center, Women's Preventive Services in the Affordable Care Act: What's New as of August 1, 2012?
- › Raising Women's Voices, Affordable Preventive Health Care for Women: Improving Women's Health and Families' Economic Well-Being.

Chronic Health Conditions

Over one-third (35%), of women have at least one chronic health condition, such as cardiovascular disease, hypertension or obesity, that requires ongoing treatment.[2] Furthermore, women are at greater risk than men for several mental illnesses such as clinical depression, anxiety, and eating disorders. Early identification and treatments are often quite effective in managing chronic health problems and preventing other associated conditions down the road. Ensuring that plans cover a range of these treatments and services can directly affect health outcomes and reduce future costs.[3]

- ✓ Will plans be evaluated to assure that they cover a sufficiently wide range of services to address and effectively manage chronic health conditions that disproportionately or distinctly affect women?
- ✓ How will plans cover treatment for mental illnesses that disproportionately affect women, including clinical depression, anxiety, and eating disorders, and meet the requirements of federal parity laws?

Lessons Learned:

- › Centers for Disease Control and Prevention, Chronic Disease Prevention and Health Promotion.
- › Centers for Disease Control and Prevention, Preventing and Managing Chronic Disease to Improve the Health of Women and Infants.

Further Reading:

- › Congressional Research Service, Health Insurance Exchanges Under the Patient Protection and Affordable Care Act (ACA).
- › Jacobs Institute for Women's Health, Women's Health and Health Care Reform: The Economic Burden of Disease in Women.
- › Kaiser Family Foundation, A Profile of Health Insurance Exchange Enrollees.
- › Urban Institute, Protecting High-Risk, High-Cost Patients: "Essential Health Benefits," "Actuarial Value," and Other Tools in the Affordable Care Act.

Abortion

Abortion is one of the most common medical procedures for women, with approximately one-fifth of the 6.4 million pregnancies occurring every year ending in induced abortion.[4] Although the ACA allows for coverage of abortion, states can ban private insurance coverage of abortion in an Exchange set up in their state. Furthermore, there are restrictions on how federal funds for abortion may be allocated and accounted for by states with Exchanges that do offer abortion coverage. The ACA outlines a methodology for states to follow to ensure that federal funds are not used to pay for coverage of abortions beyond the rules of the Hyde Amendment, such as in cases of rape, incest, or a threat to the life of the woman.

- ✓ Will the state Exchange be designed to both meet the statutory requirements of the Hyde Amendment, which restricts the use of federal monies for abortions, as well as allow plans to cover abortion?
- ✓ Will the system be designed so that consumers can obtain abortion coverage in their plans if they want it?
- ✓ Will the state establish systems to assure that women are given adequate notification about their abortion coverage choices, and to monitor if the accounting rules will affect women's access to abortion services?

Lessons Learned:

- › Guttmacher Institute, Insurance Coverage of Abortion: The Battle to Date and the Battle to Come.
- › National Partnership for Women and Families, Why the ACA Matters for Women: Restrictions on Abortion Coverage.

Further Reading:

- › Kaiser Family Foundation, Access to Abortion Coverage and Health Reform.
- › Planned Parenthood, Abortion Care Coverage and Health Care Reform: Getting the Facts Straight.

Network Adequacy

Provider networks play a major role in women's access to the range of services they need. Many analysts predict provider shortages, particularly in primary care, as coverage is expanded to many more currently uninsured people.[5,6,7] Women have greater need for primary care across the lifespan and are more likely to use certain clinical services, such as reproductive care and mental health services. The ACA outlines minimum standards regarding provider networks that plans must meet in order to participate in an Exchange. Criteria include: ensuring sufficient choice and type of providers, providing information about the availability of in-network and out-of-network providers, and including essential community providers (ECPs), where available, that serve predominately low-income, medically underserved individuals. For low-income women, the inclusion of public clinics such as community health centers, family planning providers and safety-net hospitals as ECPs in the plan networks, will be key to maintaining established provider relationships and ensuring that women have access to available care near their homes.

- ✓ How will your state address the ACA's network adequacy requirement in terms of provider type and supply?
- ✓ What certification standards will be required for QHPs and do these ensure that the range of providers, including ECPs, is broad enough to meet the health needs of women across the lifespan (e.g., Ob/Gyn, Mental Health)?

Lessons Learned:

- Blue Cross Blue Shield Foundation of Massachusetts, Network Adequacy in the Commonwealth Care Program.
- Families USA, Consumer-Friendly Standards for Qualified Health Plans in Exchanges: Examples from the States.
- Guttmacher Institute, Working Successfully with Health Plans: An Imperative for Family Planning Centers.

Further Reading:

- Guttmacher Institute, Specialized Family Planning Clinics in the United States: Why Women Choose Them and Their Role in Meeting Women's Health Care Needs.
- Health Reform GPS, Essential Community Providers.
- National Association of Insurance Commissioners, Plan Management Function: Network Adequacy White Paper.
- National Association for State Health Policy, Potential Roles for Safety Net Providers in Supporting Continuity Across Medicaid and Health Insurance Exchanges.
- RAND Corporation, Nurse Practitioners and Sexual and Reproductive Health Services: An Analysis of Supply and Demand.

Outreach and Enrollment

Women play a central role in managing their families' health care and making choices about health insurance coverage and providers. In addition, women are more likely than men to move in and out of the workforce, resulting in insurance coverage volatility and gaps in coverage, known as "churn."[8] Although the ACA makes provisions to expand and stabilize coverage for millions of women, a sizable number are unaware of many of the law's benefits. Given women's key role as family health care decision makers, successful implementation will require a comprehensive, ongoing communications strategy that draws on both public and private-sector resources and is targeted to reach women. Implementation efforts should also include parallel targeted outreach and enrollment effort to reach vulnerable populations of women, including those with limited access to online resources or with language barriers.[9]

Lessons Learned:

- Blue Cross Blue Shield of Massachusetts Foundation, Massachusetts Connector and Robert Wood Johnson Foundation, Implementing a Successful Public Outreach and Marketing Campaign to Promote State Health Insurance Exchanges; Effective Education, Outreach and Enrollment for Populations Newly Eligible for Health Coverage.
- Enroll America and Families USA, The Ideal Application Process for Health Coverage.
- Kaiser Family Foundation, Explaining Health Reform: Uses of Express Lane Strategies to Promote Participation in Coverage.
- National Academy for State Health Policy, Hard Work Streamlining Enrollment Systems Pays Dividends to the Sooner State.

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Outreach and Enrollment (continued)

By designing Exchanges with a streamlined application process and educating women about their private insurance options, as well as their eligibility and their family's eligibility for government and subsidized programs (e.g., Medicaid or tax credits), states can help ensure continuous coverage and reduce coverage gaps associated with complex application processes.[10]

- ✓ How will your state ensure outreach efforts and enrollment systems are tailored to meet the needs of women and their families to ensure maximum enrollment and utilization of health benefits?
- ✓ How will states inform women about the scope of benefits and any exemptions in a manner that is simple and transparent?
- ✓ How will your state design systems that minimize gaps in coverage and maximize continuous, comprehensive care for women and their families?
- ✓ How is your state approaching issues of culturally-appropriate strategies to reach individuals across communities?
- ✓ How will navigators and/or in-person assisters be selected? Will they be trained in cultural competency? Will they reflect the communities they serve?

- › National Academy for State Health Policy, State Experiences with Express Lane Eligibility: Policy Considerations and Possibilities for the Future.
- › State Health Access Data Assistance Center, Best Practices in SHAP Outreach, Eligibility, and Enrollment Activities.
- › U. Mass Medical School, National Academy of Social Insurance, Robert Wood Johnson Foundation, Establishing the Technology Infrastructure for Health Insurance Exchanges Under the Affordable Care Act: Initial Observations from the "Early Innovator" and Advanced Implementation States.

Further Reading:

- › Commonwealth Fund, Realizing Health Reform's Potential: Maintaining Coverage, Affordability, and Shared Responsibility When Income and Employment Change.
- › Connors Center for Women's Health and Gender Biology, Women and National Health Care Reform; Massachusetts Health Reform: Impact on Women's Health Issue Brief
- › Families USA, Brokers and Agents and Health Insurance Exchanges.
- › Georgetown University Health Policy Institute, Designing Navigator Programs to Meet the Needs of Consumers: Duties and Competencies.
- › Health Reform GPS, State Health Insurance Exchange Navigators.
- › National Academy for State Health Policy and Robert Wood Johnson Foundation, New Denial and Disenrollment Coding Strategies to Drive State Enrollment Performance.
- › National Academy for State Health Policy and Robert Wood Johnson Foundation, Using Data to Drive State Improvement in Enrollment and Retention Performance.
- › National Association of Insurance Commissioners, Navigators, Agents and Brokers, Marketing and Summary of Benefits and Coverage.
- › Robert Wood Johnson Foundation and National Academy of Social Insurance, Building a Relationship Between Medicaid, the Exchange, and the Individual Insurance Market.

Affordability and Transparency

Compared to men, women have lower lifetime earnings, higher medical expenditures across the lifespan, and higher out-of-pocket health care expenses.[11] Financial barriers to care such as premiums, cost-sharing charges, and benefit limitations can negatively affect both insured and uninsured women. In addition to selecting different plans, women will also have to select a Qualified Health Plan (QHP) coverage tiers - bronze, silver, gold, or platinum - that will affect both premium costs and out-of-pocket spending. There is a large body of research that finds cost-sharing can affect the amount and type of services people use, sometimes resulting in even higher downstream costs due to lower use of preventive or treatment services.[12]

- ✓ Will women be able to find affordable health care coverage, taking into account premiums, cost-sharing and benefit limits?
- ✓ Is the state considering options to make coverage more affordable for exchange enrollees, such as adopting a Basic Health Plan (BHP) or negotiating premium rates with QHPs?
- ✓ How will your state ensure costs, including out-of-pocket costs, are transparent and services are affordable for women under the Exchange?
- ✓ Will your state develop systems to assist women and their families make informed choices about their plan and tier selection?

Lessons Learned:

- › California Health Care Foundation, Ten Years of California's Independent Medical Review Process: A Look Back and Prospects for Change.
- › Connors Center for Women's Health and Gender Biology, Massachusetts Health Reform: Impact on Women's Health.
- › Georgetown University Health Policy Institute and Robert Wood Johnson Foundation, The Massachusetts and Utah Health Insurance Exchanges: Lessons Learned.
- › Kaiser Family Foundation, Patient Cost-Sharing Under the Affordable Care Act.
- › National Partnership for Women and Families, Why the Affordable Care Act Matters for Women: Expanding Affordability and Choice in the Marketplace.
- › National Women's Law Center, Still Nowhere to Turn: Insurance Companies Treat Women Like a Pre-Existing Condition.

Further Reading:

- › Centers for Medicare & Medicaid Services, Actuarial Value and Cost Sharing Reductions Bulletin.
- › Commonwealth Fund, Oceans Apart: The Higher Health Costs of Women in the U.S. Compared to Other Nations, and How Reform Is Helping.
- › Kaiser Family Foundation, Policy Insights: Transparency and Complexity.

Data Collection and Reporting Standards

Because the ACA is bound to have differential impacts on health, access, and coverage for various populations, it will be critically important to both collect and report data for women and men separately as well as for women of color, women with different health needs, ages, sexual orientations, and incomes. This will be essential in understanding the impact of the ACA on specific populations of women at the national, state, and plan levels as well as for informing policies and health care delivery in the future. With this in mind, states should consider that Exchanges have an opportunity to enforce the provisions of the ACA which prohibit discrimination in federal health programs and those receiving federal dollars.

Lessons Learned:

- › Connors Center for Women's Health and Gender Biology, Women and National Health Care Reform.
- › Institute of Medicine, Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement.
- › Institute of Medicine, Women's Health Research: Progress, Pitfalls, and Promise.
- › Kaiser Family Foundation, Performance Measurement Under Health Reform: Proposed Measures for Eligibility and Enrollment Systems and Key Issues and Trade-offs to Consider.

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Data Collection and Reporting Standards (continued)

- ✓ How will your state monitor and ensure compliance with the new coverage, services and protections afforded to women under the ACA?
- ✓ What metrics is your state using to evaluate the impact of the Exchange on coverage, affordability and access to health care for women and other subpopulations? Within that context, what data will be collected and what process will there be for analysis that will include appropriate stakeholder input?
- ✓ How will your state enforce nondiscrimination provisions of the ACA which prohibit discrimination against women and other subpopulations?

Further Reading:

- › Dorsey R and Graham G, "New HHS Data Standards for Race, Ethnicity, Sex, Primary Language, and Disability Status."
- › National Academy for State Health Policy, State Policymakers' Guide for Advancing Health Equity through Health Reform Implementation.
- › Robert Wood Johnson Foundation, Can Collecting Data on Patients' Race, Ethnicity and Language Help Reduce Disparities in Care?

[1] Pollitz, K., Kofman, M., Salganicoff, A. & Ranji, U. (2007). *Maternity care and consumer-driven health plans*. Kaiser Family Foundation.

[2] Ranji, U. & Salganicoff, A. (2011). *Women's health care chartbook*. Kaiser Family Foundation.

[3] Masiosek, MV. (2010). *Greater use of preventive services in U.S. health care could save lives at little or no cost. Health Affairs*, 29(9), 1656-1660.

[4] Kaiser Family Foundation. (2008). *Abortion in the U.S.: utilization, financing, and access*.

[5] Hoffman, C., Damico, A., & Garfield, R. (2011). *Insurance coverage and access to care in primary care shortage*. Kaiser Family Foundation.

[6] Dill, MJ & Salsberg, ES. (2008). *The complexities of physician supply and demand: Projections through 2025*. Association of American Medical Colleges.

[7] Council on Graduate Medical Education. (2010). *Advancing primary care*.

[8] Sered, S. & Proulx, MD. (2011). *Lessons for women's health from the Massachusetts reform: affordability, transitions, and choice. Women's Health Issues*, 21(1), 1-5.

[9] Raymond, AG. (2011). *Lessons from the implementation of Massachusetts health reform*. Blue Cross Blue Shield of Massachusetts Foundation.

[10] Rodman, M. (2012). Enroll America: *The ideal application process for health coverage*. Families USA.

[11] Patchias, EM. & Waxman, J. (2007). *Women and health coverage: The affordability gap*. The Commonwealth Fund.

[12] Swartz, K. (2010). *Cost-sharing: Effects on spending and outcomes*. Robert Wood Johnson Foundation.

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Study of
Health-e-App
Public Access

Health-E-App Public Access: A New Online Path to Children's Health Care Coverage in California

RESEARCH BRIEF 2 FEBRUARY 2013

Background:

Health-e-App is a web-based application that was originally designed for enrolling low-income children and pregnant women in the Healthy Families Program or screening them for Medi-Cal.[1] The California HealthCare Foundation (CHCF) and The California Endowment supported its development, in partnership with the Managed Risk Medical Insurance Board (MRMIB), the California Department of Health Care Services, MAXIMUS, and Social Interest Solutions. Health-e-App was pilot-tested in San Diego County. Since 2000, certified application assistants and other professionals have used Health-e-App when they help residents apply for health coverage. A self-service version of the tool, Health-e-App Public Access (HeA PA), was launched in December 2010 to enable applicants to use it independently via the internet. In January 2013, California closed new enrollment in the Healthy Families Program. The state continues to process HeA PA applications for Medi-Cal for Families.

MATHEMATICA
Policy Research

Applicant Characteristics and Experiences

by Adam Dunn and Leslie Foster

This is the second brief in a series about the first year of California's Health-e-App Public Access (HeA PA) enrollment system, following its introduction in December 2010. In 2011, California received about 4,000 HeA PA applications per month, or about 20 percent of all applications submitted to the state processing center that year. Across counties, the share of applications submitted through HeA PA ranged from 5 to 48 percent. HeA PA is available in English and Spanish.

This brief describes HeA PA applicants and their experience with the self-service tool. It draws on data from applications submitted in 2011, including responses to optional survey questions received from 14,690 applicants. Information is not available about people who began HeA PA applications but did not submit them and who may have different characteristics, experiences, and levels of satisfaction.[2]

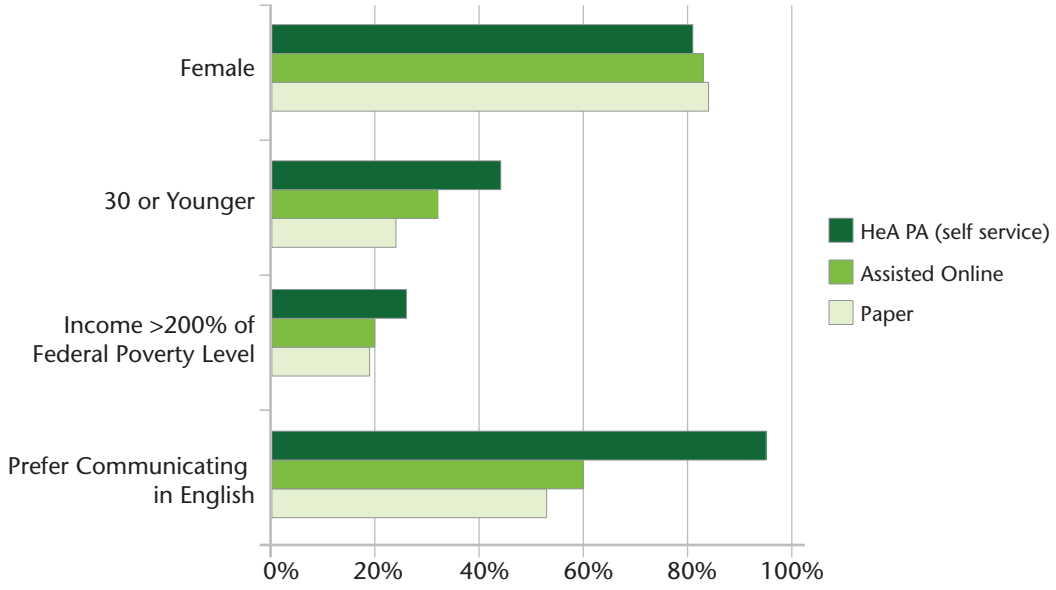
What types of applicants used HeA PA?

In 2011, applicants (usually a parent or guardian on behalf of their minor child) who used HeA PA were somewhat younger and had slightly higher incomes than applicants who used paper applications or applied online with professional assistance (Figure 1). Women submitted about 81 percent of HeA PA applications, a percentage similar to other application types. Almost all HeA PA applicants used the tool in English (98 percent) and indicated that they preferred for Healthy Families or Medi-Cal to communicate with them in English (95 percent). Further, HeA PA applicants were far more likely to prefer to communicate in English than those who submitted paper applications (53 percent) or assisted-online applications (60 percent).

A sizable minority of people who applied for Healthy Families indicated that they preferred for Healthy Families or Medi-Cal to communicate with them in Spanish, but few of these applicants used HeA PA in its first year. Only 4 percent of HeA PA applications were from applicants who preferred to communicate in Spanish (not shown). By contrast, 42 percent of paper applications and 37 percent of assisted-online applications were from applicants who preferred Spanish. Among the small number of HeA PA applicants who preferred to communicate in Spanish, half used HeA PA in Spanish and half in English.

Figure 1.

HeA PA Applicants Differ from Other Applicants on Some Characteristics

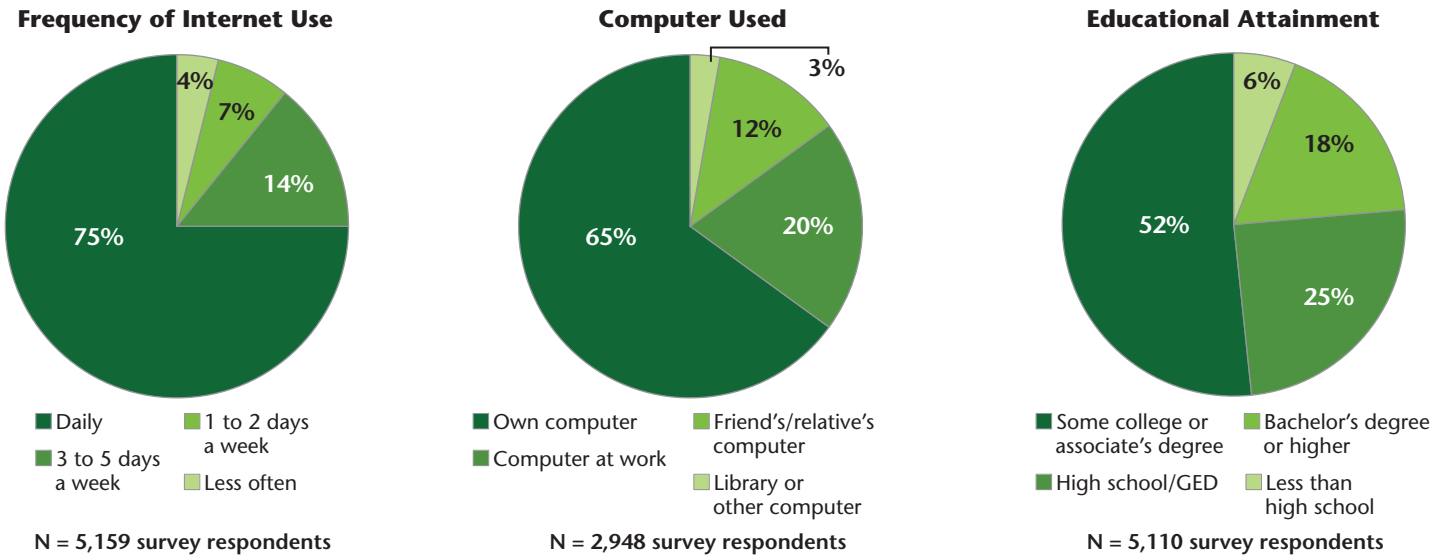


Source: MRMIB's Healthy Families Data Warehouse. Applications from December 20, 2010 to December 31, 2011.

Most HeA PA applicants said they use the internet regularly and have some college education. Roughly 90 percent said they use the internet at least three times a week (Figure 2). Two-thirds (65 percent) of HeA PA applicants submitted their applications from their own computer, and nearly all (97 percent) used a high-speed internet connection (not shown). Seventy percent of HeA PA applicants had attended at least some college (Figure 2). (Data on education and internet use are not available for those who submitted paper or assisted-online applications.)

Figure 2.

Most HeA PA Applicants Use the Internet Daily, on a Home or Work Computer, and Have Some College Education

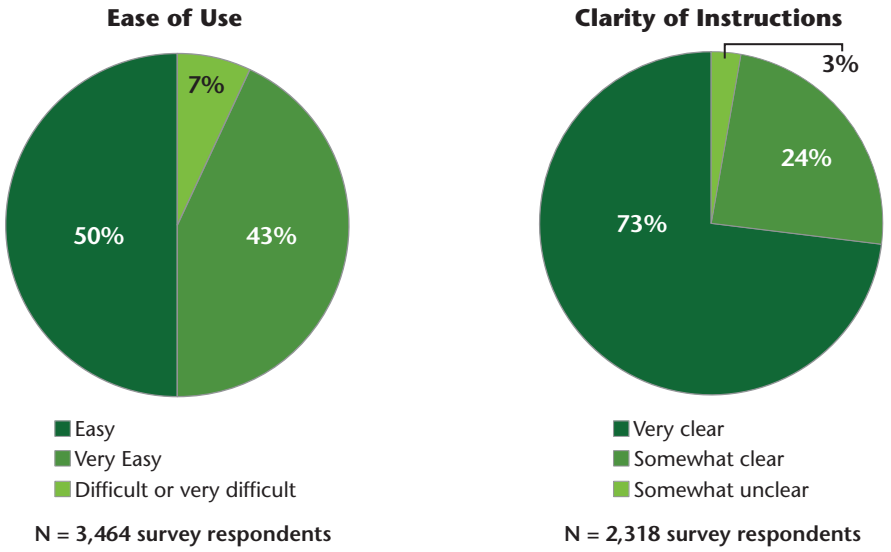


Source: MRMIB's Healthy Families Data Warehouse. HeA PA applications and integrated survey items, July 15 to December 31, 2011.

What did applicants say about using HeA PA?

Nearly everyone who submitted an application through HeA PA said it was easy to use (93 percent) and that the instructions were clear (97 percent; Figure 3). However, the small number of applicants who used the internet less than once a week were less likely than other applicants to say HeA PA was easy to use (78 versus 95 percent; not shown). Also, the small share of applicants who preferred to communicate in Spanish were more likely than those who preferred English to say HeA PA was difficult to use (12 versus 6 percent; not shown), regardless of whether they applied in Spanish or English.

Figure 3.
Most Applicants Said HeA PA Was Easy to Use

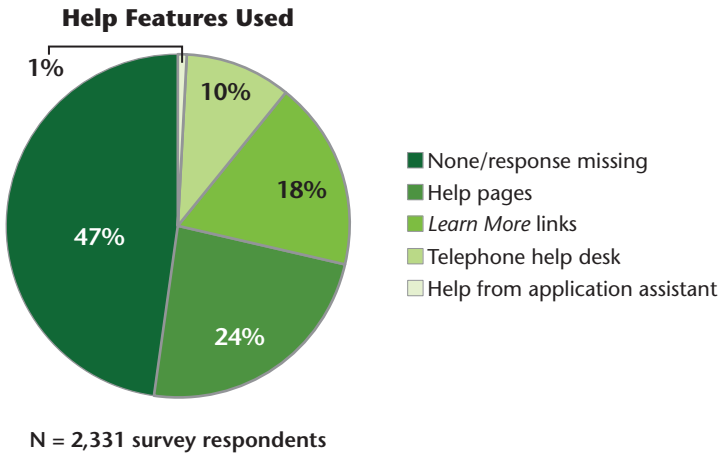


Source: MRMIB's Healthy Families Data Warehouse. HeA PA applications and integrated survey items, July 15 to December 31, 2011.

Slightly more than half of applicants (53 percent) said they used a HeA PA help feature, including *Learn More* links (18 percent), help pages (24 percent), and the toll-free telephone help desk (10 percent; Figure 4). More applicants used one of the built-in help features than turned to live help by telephone, which suggests that applicants may have preferred built-in features and found them adequate.

In addition to help features, HeA PA includes a preliminary eligibility calculator to help applicants decide whether to complete an application, as well as a feature for tracking application status after submission. Almost all applicants said these features were very important to them (not shown).

Figure 4.
Half of Applicants Used Help Features

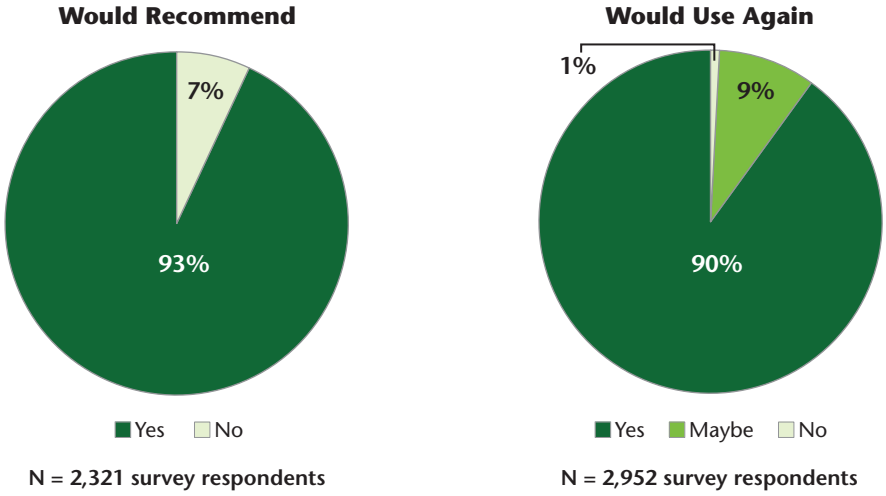


Source: MRMIB's Healthy Families Data Warehouse. HeA PA applications and integrated survey items, July 15 to December 31, 2011.

Were applicants satisfied with HeA PA overall?

Most applicants said they would recommend HeA PA to family or friends (93 percent), and most said they would use HeA PA for annual renewal or to apply for coverage for another child (90 percent; Figure 5). This was true regardless of applicants' language preference. Infrequent internet users were somewhat less likely than frequent users to say they would use HeA PA again (79 versus 91 percent), but they were about as likely as frequent users to say they would recommend it (not shown).

Figure 5.
Nearly All Applicants Would Recommend HeA PA and Would Use It Again



Source: MRMIB's Healthy Families Data Warehouse. HeA PA applications and integrated survey items, July 15 to December 31, 2011.

Is it realistic to think more people could use HeA PA?

Given levels of use and user satisfaction in 2011, HeA PA seems to be an attractive option for many families. Several factors could lead to greater use of HeA PA in the future, including increased access to high-speed internet in key populations. For example, in the United States today, Latino households are less likely than non-Latino households to have high-speed internet access. This fact could partially explain why relatively few applicants who indicated a preference to hear from the Healthy Families Program in Spanish used HeA PA during the year we studied. However, from 2008 to 2012, high-speed internet access rose 24 points (to 58 percent) for Latino adults in California. As more Latino households gain high-speed internet access, the number of HeA PA applicants with Spanish-language preference could increase. High-speed internet access also increased 27 points (to 60 percent) for California adults with annual household incomes less than $40,000.[3] If this trend continues, eligible lower-income families in general may be more likely to apply online for public health insurance.

Other factors that will influence HeA PA use include awareness of the tool, and attitudes about its legitimacy and about sharing personal information online. In late 2011, California conducted an outreach campaign to increase awareness of and trust in HeA PA. A future brief will explore the effects of the campaign. Another brief will present anecdotal information about factors that affect HeA PA use from the perspective of certified application assistants, who interact daily with applicants.

What experience do other states have with self-service online applications for public health insurance?

Like California, at least 34 other states have online applications for professional enrollment staff and/or the public to use.[4]

Self-service usage rates vary among states, according to published data. For example, most applications for Oklahoma's Medicaid program, and most new applications for Utah's Medicaid program, were submitted online by self-service applicants in a recent period (Table 1). In Arizona, more than one-quarter of new Medicaid and Children's Health Insurance Program (CHIP) applications were submitted online by self-service applicants. In Delaware, only about 10 percent of new applications were submitted online by self-service applicants.

The cross-state variation in use of online applications likely results from a number of factors, including how long the application has been available, outreach and advertising efforts, the user-friendliness of the application interface, the ability to apply for other public programs at the same time, and whether there are other ways to apply for the same benefits.

Self-service online applications will become more available in coming months and years, at least partly because the federal Centers for Medicare & Medicaid Services has established this expectation under the Patient Protection and Affordable Care Act (ACA). The agency has directed states to provide a high quality, convenient online application experience, similar to what consumers expect in private-sector online transactions.[5]

Table 1.
Use of Self-Service Online Applications Varies Across States

Online Application	Public Programs Included	Percentage of All Applications Submitted[a]		Year Self-Service Option Became Available
		Online[b]	Online by Self-Service Applicants	
California HeA	HFP, Medi-Cal	43	22	2010
Delaware ASSIST	Medicaid, TANF, SNAP	10[c]	10[c]	2005
Health-e-Arizona	Medicaid, CHIP, TANF, SNAP	34–39[c]	27–31[c]	2008
Oklahoma mySoonerCare	Medicaid	94	54	2010
Utah Helps	Medicaid, SNAP, TANF	75[c]	75[c]	2007

Sources: MRMIB's Healthy Families Data Warehouse, January to December 2011. Kauff et al., "Promoting Public Benefits Access Through Web-Based Tools and Outreach," Washington, DC: Mathematica Policy Research, December 2011. Weiss, Alice. "Hard Work Streamlining Enrollment Systems Pays Dividends to the Sooner State." Health Affairs, vol. 32, no. 1, 2013, pp. 7–10.
[a] Percentages are based on data from periods of 1 to 13 months.
[b] Applications submitted online include those from self-service applicants and from people who received application assistance from approved agencies.
[c] Percentage of new applications.

What might California's experience with HeA PA imply for the use of online applications under ACA?

Findings from this brief suggest that tools like HeA PA are a good option for people who have convenient access to high-speed internet service and do not need extensive in-person help when applying for coverage. Additional outreach efforts may be necessary to increase awareness of HeA PA and similar tools among this target population. Spanish-speaking Latino households may be less likely to use self-service online applications during the early stages of ACA implementation, but this may change as more of these households acquire high-speed internet service. More broadly, the use of tools like HeA PA seems likely to grow as both awareness of their availability and access to high-speed internet improve among individuals and families seeking coverage.

Endnotes

[1] Healthy Families is California's Children's Health Insurance Program; Medi-Cal is its Medicaid program.

[2] In 2011, about two-thirds of people (69 percent) who created a self-service HeA PA account submitted an application. No information is available about whether those that did not submit an application did so because they discovered they were ineligible after using the eligibility calculator, or for other reasons. Thus, it is difficult to speculate as to how those who created an account and submitted an application may differ from those who created an account but did not submit an application.

[3] Baldassare, Mark, Dean Bonner, Sonja Petek, and Jui Shrestha. "California's Digital Divide." San Francisco, CA: Public Policy Institute of California, August 2012. Available at [www.ppic.org/content/pubs/jtf/JTF_DigitalDivideJTF.pdf]. Accessed November 7, 2012.

[4] For more information on states that use online enrollment for public health insurance, see www.statehealthfacts.org/comparemaptable.jsp?ind=897&cat=4&sub=59&yr=257&typ=5&rgnhl=49.

[5] Centers for Medicare & Medicaid Services. Guidance for Exchange and Medicaid Information Technology (IT) Systems. Version 2. May 2011.

ABOUT THIS BRIEF

This brief is one in a series that Mathematica Policy Research is producing with support from the David and Lucile Packard Foundation and CHCF, and in partnership with MRMIB. The brief draws on application and survey data from MRMIB's Healthy Families Program (HFP) Data Warehouse.

From July 15 to December 31, 2011, HFP added optional survey questions to HeA PA applications to ask applicants about their internet use, education, satisfaction with HeA PA, use of HeA PA features, and how they learned about HeA PA. A total of 22,856 applicants submitted HeA PA applications during that time. Of those, 14,690 (64 percent) responded to survey questions. The questions were grouped into six waves of two to three questions each. The first five waves were intermittently fielded for about one week at a time. The sixth wave was fielded continuously from October to December. Sample sizes ranged from 2,305 to 5,214 in each wave.

The survey coincided with an online outreach campaign to promote awareness of HeA PA among low-income families. Thus, people who used HeA PA during the online outreach campaign may have been more likely to be frequent internet users than people who applied at other times. On observable characteristics—such as age, gender, income level relative to poverty, language preference, and prior enrollment in HFP—applicants were similar regardless of whether they used HeA PA before the outreach campaign (the first half of 2011) or during the campaign.

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California HealthCare Foundation

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Health Policy Brief

February 2013

Limited English Proficient HMO Enrollees Remain Vulnerable to Communication Barriers Despite Language Assistance Regulations

Max W. Hadler, Xiao Chen, Erik Gonzalez and Dylan H. Roby

"HMO enrollees in poorer health experience the biggest language barriers."

SUMMARY: HMO enrollees with limited English proficiency, and particularly those in poorer health, face communication barriers despite language assistance regulations. More than 1.3 million California HMO enrollees ages 18 to 64 do not speak English well enough to communicate with medical providers and may experience reduced access to high-quality health care if they do not receive appropriate language assistance services. Based on analysis of the 2007 and 2009 California Health Interview Surveys (CHIS), commercial HMO enrollees with limited English proficiency (LEP) in poorer health are more likely to have difficulty understanding their doctors, placing this already vulnerable population at even greater risk. The analysis also uses CHIS to examine the potential impact of health plan monitoring starting in 2009 (due to a 2003 amendment to the Knox-Keene Health Care Services Act) requiring health plans to provide free qualified interpretation and translation services to HMO enrollees. The authors recommend that California's health plans continue to incorporate trained interpreters into their contracted networks and delivery systems, paying special attention to enrollees in poorer health. The results may serve as a planning tool for health plans, providing a detailed snapshot of enrollee characteristics that will help design effective programs now and prepare for a likely increase in insured LEP populations in the future, as full implementation of the Affordable Care Act takes place over the next decade.

Almost two-thirds of limited English proficient commercial HMO enrollees who reported communication barriers were in fair or poor health. The recent implementation of regulations to improve commercial HMO provision of language assistance services may eventually help increase understanding, but in the first year of implementation, it does not appear that HMO policies ensuring access to language-appropriate services have led to immediate improvements in communication for the sickest enrollees.

Requirements for HMOs to Provide Language Access Services

In response to the passage of the Knox-Keene amendment in 2003, language access regulations were established in 2007 for all health plans covered by California's Department of Managed Health Care (DMHC) and select plans covered by the California Department of Insurance (CDI). The new regulations require insurers to assess their members' languages of preference and provide verbal interpretation in all languages, and written translation in threshold languages. Threshold languages generally include Spanish and Chinese and, for some health plans,

THE PATIENT ADVOCATE

Funded by the California Office of the Patient Advocate

"LEP Californians will make up a significant portion of the newly insured under health care reform."

Definitions

Threshold languages
Determined by the demographic makeup of a health plan's membership, these are languages for which plans must provide translated vital documents, including applications, consent forms, letters about eligibility or participation criteria, and notices advising changes in benefits and availability of free language assistance.[1]

Knox-Keene Health Care Services Act
California law established in 1975 that regulates managed care plans. The law has been amended multiple times since its inception, including in 2003 to address language access issues as a result of Senate Bill 853.

Limited English Proficiency (LEP)
Individuals who reported speaking English not well or not at all.

Fee-for-Service (FFS)
A method of payment in which health care providers are paid per service rendered. In California, most fee-for-service care is delivered to Medicare beneficiaries and Medicaid enrollees living in rural areas.

Preferred Provider Organization (PPO)
A health insurance plan that encourages members to seek care through contracted providers by requiring patients to pay a larger share for services delivered outside of its contracted network of providers. For example, a patient can see an in-network provider and pay 20% of the provider's fee, or see an out-of-network provider and pay 40% of that provider's fee.

Health Maintenance Organization (HMO)
A health plan that requires members to seek care in a contracted network. HMOs typically use primary care physicians and other protocols to authorize specialty care and medical procedures. Care delivered out-of-network is not covered except in emergency situations.

CHIS california health interview survey

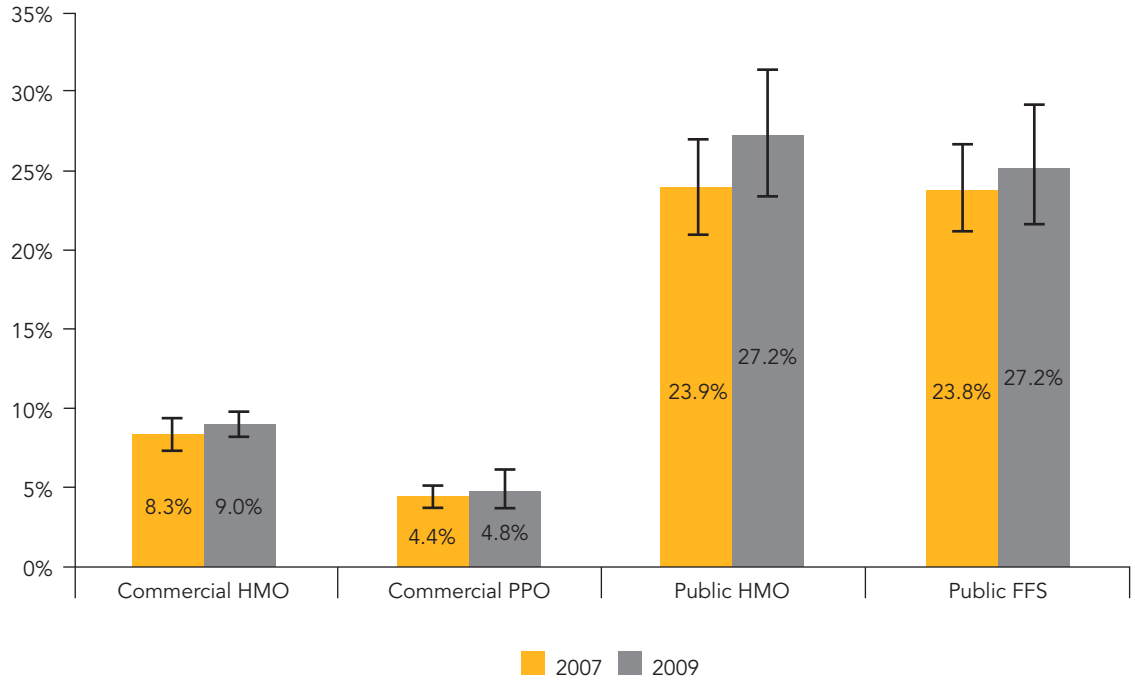
This publication contains data from the California Health Interview Survey (CHIS), the nation's largest state health survey. Conducted by the UCLA Center for Health Policy Research, CHIS data give a detailed picture of the health and health care needs of California's large and diverse population. Learn more at: ***www.chis.ucla.edu***

Vietnamese, Russian, Korean, Tagalog, Khmer, Armenian, Arabic, and/or Hmong.[2] DMHC began monitoring health plan compliance in January 2009, when all HMOs were required to have fully implemented language access policies and procedures.

The law is particularly important in the current health policy environment as LEP populations will make up a significant portion of the newly insured after implementation of the Affordable Care Act, including via the state's health benefits exchange, Covered California. A recent UC Berkeley and UCLA analysis estimated that 29% to 36% of non-elderly adults who take-up subsidized coverage in Covered California will be LEP.[3]

In this study, we examine the LEP HMO enrollee population and attempt to measure communication barriers and early progress since the Knox-Keene amendment went into effect. A limiting factor is that data from 2009 may refer to language barriers that existed as early as September 2007 and as late as April 2010 since respondents are

Percent of Enrollees Who Are Limited English Proficient by Type of Insurance, Ages 18-64, California, 2007-2009 **Exhibit 1**



Note: Based on chi-square test of proportions for each insurance category between 2007 and 2009. See Appendix 1 for further details.

Sources: 2007 and 2009 California Health Interview Surveys

asked about experiences up to two years prior to being surveyed. Although the regulations were published in early 2007, some of the results reported here preceded the implementation deadline in 2009. These data are an intermediate measure of progress toward improved language access after 2009.

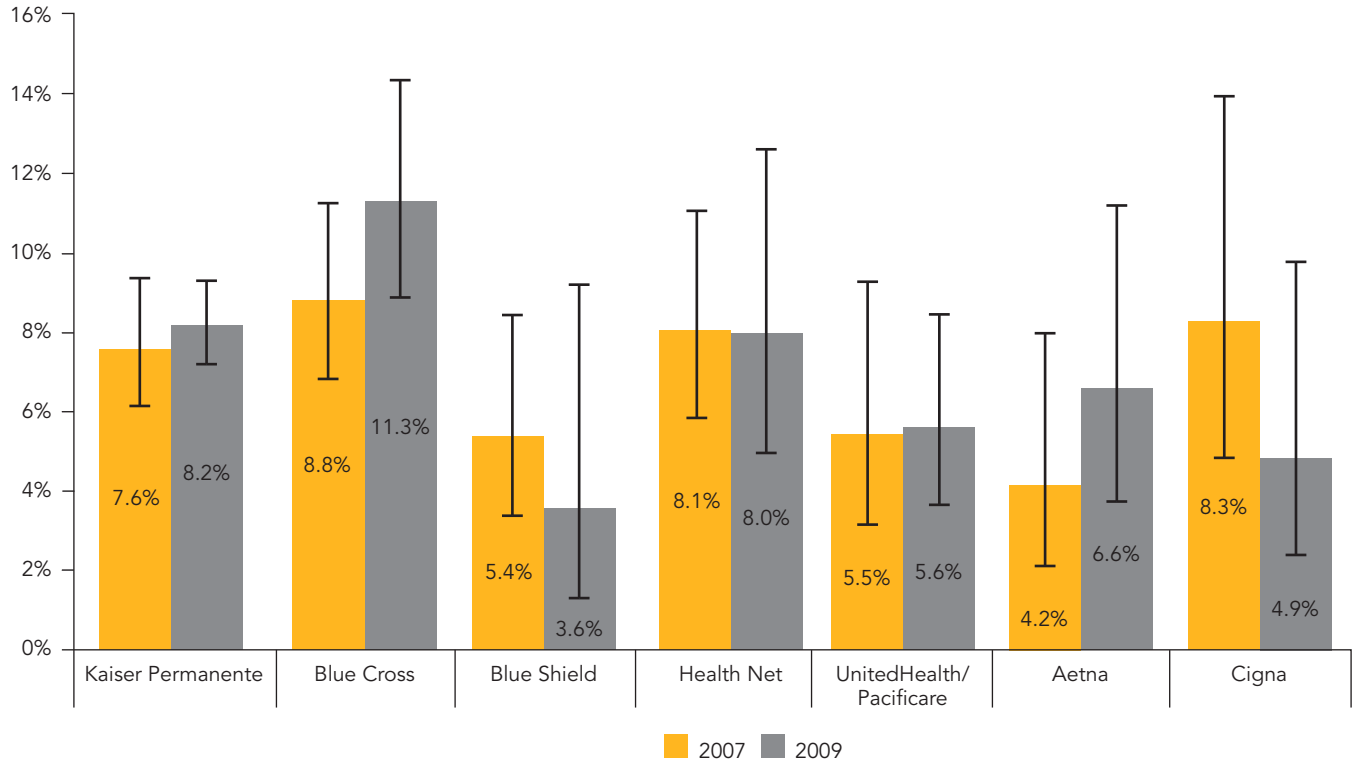
Limited English Proficient a Substantial Proportion of HMO Membership

In 2009, nearly one in eight HMO enrollees in California was LEP. A much larger proportion of enrollees in public programs such as Medicare and Medicaid (27.2%) were LEP when compared to those in commercial plans (9.5%), but the total number of LEP enrollees in commercial HMOs (842,000) was substantially larger than in public HMOs (460,000) given the greater number of people with commercial coverage (Exhibit 1 and Appendix 1). Examining large commercial insurers individually, LEP enrollees represented a substantial proportion of membership in many HMO plans (Exhibit 2 and Appendix 2).

The change in LEP as a percentage of all enrollees did not change significantly from 2007 to 2009 for commercial or public HMOs. This suggests that the plans have a relatively consistent membership profile to gauge demand and plan for language assistance services or language concordance with health care providers.

"LEP enrollees represent a substantial portion of membership in many HMO plans."

Exhibit 2 **Percent of Enrollees Who Are Limited English Proficient by Commercial HMO Plan, Ages 18-64, California, 2007-2009**



Note: See Appendix 2 for further details.
Sources: 2007 and 2009 California Health Interview Surveys

"Nearly half of LEP commercial HMO enrollees needing assistance did not receive professional interpretation."

Minimal Change in Patient-Doctor Communication

The proportion of LEP commercial HMO enrollees who had seen a doctor at least once in the past two years and reported having trouble understanding their physician remained stable from 2007 (12.1%) to 2009 (9.5%; Exhibit 3). For public HMO enrollees, difficulty understanding their physician was also stable from 2007 (9.1%) to 2009 (12%). The small changes in both variables were not statistically significant. However, change was not expected in public HMOs as the programs were already subject to more stringent regulations prior to DMHC monitoring of commercial plans.

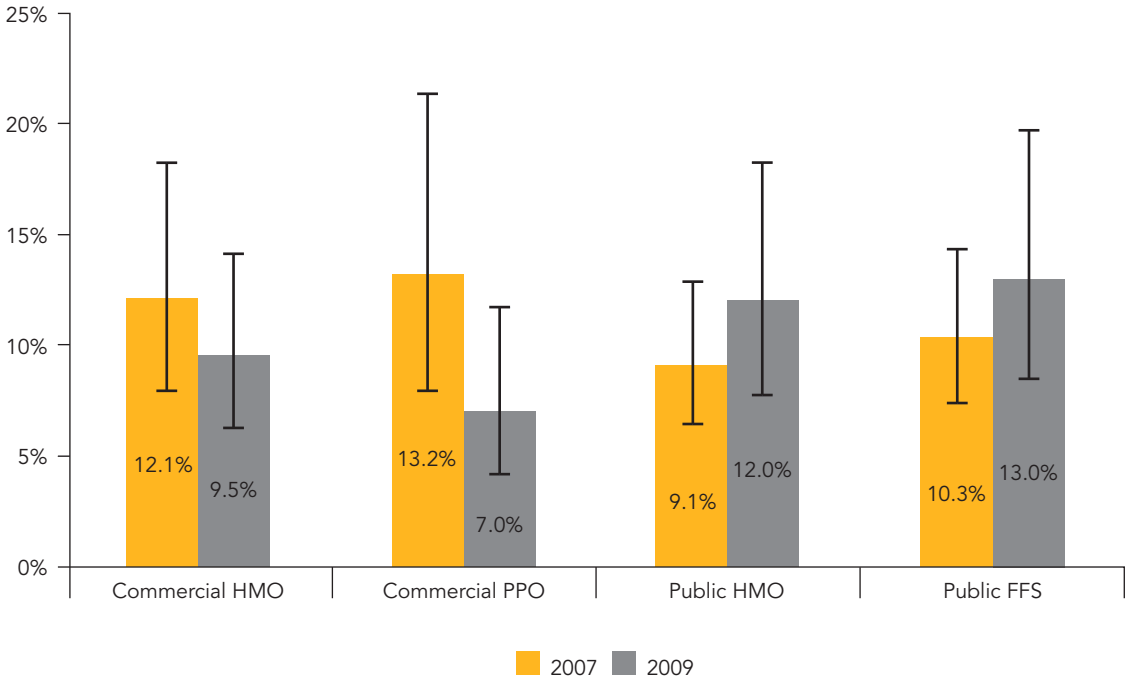
The limited change exhibited in CHIS 2009 data may be a reflection of the short time period since the implementation of the language access regulations. The data nonetheless offer a valuable planning tool to understand the LEP population and the subset of LEP individuals who report difficulty understanding their physician (Exhibit 4).

Sicker Limited English Proficient Enrollees Have Greater Communication Problems

In commercial HMOs and public fee-for-service plans, members in fair or poor health were more likely than their counterparts in better health to report difficulty understanding their physician. In commercial HMOs, the sickest enrollees made up over one-third of all LEP members (36.4%) but represented nearly two-thirds of those reporting communication troubles (63.5%). These results make clear that health plans must be particularly vigilant about ensuring access to language services to LEP enrollees in poorer health.

Percent of Limited English Proficient Enrollees Who Had Hard Time Understanding Doctor at Last Visit by Type of Insurance, Ages 18-64, California, 2007-2009

Exhibit 3



Note: Logistic regression model adjusted for income, gender, race/ethnicity, level of education, and percent of life spent in the U.S.

Sources: 2007 and 2009 California Health Interview Surveys

Nearly Half of Limited English Proficient Commercial HMO Enrollees Needing Assistance Did Not Receive Professional Interpretation

The regulations that resulted from the Knox-Keene amendment (codified in section 1300.67.04 of title 28 of the California Code of Regulations) require health plans to provide all enrollees with free "qualified interpretation services." The services were defined as in-person, telephonic or video assistance by someone who is trained in interpreting ethics, conduct and confidentiality, and has demonstrated proficiency in source and target language as pertains to standard communication, health care terminology and health care delivery systems.[4] Despite the efforts of health plans to train bilingual staff and contract with outside interpreting agencies, more than 40% of LEP commercial HMO enrollees who needed help to understand their doctor reported receiving assistance from a non-professional (Exhibit 4). The continued use of non-professionals as interpreters (including family members) suggests inconsistent quality of interpretation.

The solution to this variation can be found in a more detailed and consistent process for assuring language access, including the requirement that health care providers utilize trained staff or contracted professionals regardless of the availability of untrained patient companions. DMHC's 2011 Biennial Report to the Legislature on Language Assistance cites health plan deficiencies in ensuring adequate language access services at all points of contact, proficiency of bilingual staff, and offering interpreters when bilingual family members are present.[5] If bilingual staff members are an important asset to health plans in complying with regulations, these staff members must be able to perform tasks that require different skills from those for which

"Health care providers should use trained staff or interpreters even if bilingual family members are available."

"There is a disconnect between health plan perceptions of interpreter service provision and the actual experiences of enrollees."

they were hired, and their (or an interpreter's) availability must be ensured at all points of contact with the health care system.

Conclusions and Policy Implications

The implementation of language assistance programs with regulatory oversight by DMHC and CDI was an attempt to ensure equitable health care access for California's limited English proficient HMO enrollees. Based on DMHC's findings to date, most health plans have established language access mechanisms according to their specific enrollee populations.[5] However, the lack of progress in enrollees' ability to understand their physician and the disparities within LEP populations by health status suggest that there is a disconnect between health plan perceptions of interpreter service provision and the actual experiences of enrollees. Delegated HMO models and shifts in network participation could compromise the ability of health plans to proactively plan and implement language assistance strategies with their contracted providers throughout the state. DMHC should encourage more consistent contact between health plans and their providers to ensure that regulations for health plans are translated into clearer communication processes at the individual provider level for LEP enrollees, particularly for those in poor health, at all points of contact.

Given that respondents in CHIS 2009 were asked to recall past events and could be reporting on doctor visits prior to the implementation of the law, the future availability of CHIS 2011/2012 data will be important in understanding the impact of the policy change. Language access may continue to improve as DMHC monitoring becomes more established over time, but regulations alone will not be sufficient. Insurers and providers must continually contract with

Exhibit 4

Characteristics of the Limited English Proficient Population and Those Reporting Hard Time Understanding Doctor, Ages 18-64, California, 2009

	Commercial				Public			
	HMO		PPO		HMO		FFS	
	LEP	Hard Time	LEP	Hard Time	LEP	Hard Time	LEP	Hard Time
Total number	792,000	71,000	290,000	18,000	460,000	47,000	486,000	54,000
Gender (%)								
Female	50.9	63.8	41.9	65.7	56.6	57.8	69.7	53.2
Male	49.1	36.2	58.1	34.3	43.4	42.2	30.3	46.8
Age (mean years)	44.6	43.1	42.8	43.1	41.0	44.2	38.1	42.3
Race/Ethnicity (%)								
Latino	64.9	64.4	53.4	46.5	69.9	56.5	76.1	71.1
Asian/Pacific Islander	18.6	19.6	35.2	40.4	14.9	26.0	9.8	8.4
Other	16.5	16.0	11.4	13.1	15.2	17.5	14.1	20.5
Language (%)								
Spanish	79.6	80.1	62.7	59.6	82.5	70.2	89.8	91.2
Chinese	7.4	2.9	12.3	8.7	5.1	3.0	5.6	4.0
Vietnamese	3.1	9.6	2.0	6.9	4.6	4.2	2.2	3.3
Korean	1.2	<0.1	6.3	6.5	<0.1	0.1	0.2	<0.1
Other	8.7	7.4	16.7	18.3	7.8	22.5	2.2	1.5
Health Status (%)								
Excellent/Very Good/Good	63.6	36.5*	68.9	65.5	57.5	47.1	60.4	29.9*
Fair/Poor	36.4	63.5*	31.1	34.5	42.5	52.9	39.6	70.1*
Income (%)								
<200% FPL	55.7	50.7	64.6	64.8	91.6	93.9	95.1	98.9
≥200% FPL	44.3	49.3	35.4	35.2	8.4	6.1	4.9	1.1
Type of Help (%)**								
Professional		56.0		71.4		72.2		79.0

* Statistically significant at a level of $p<0.05$. In the marked insurance categories, the distribution of respondents reporting hard time understanding their doctor by health status is significantly different from the distribution of the overall LEP population by health status.

** Type of Help refers to the person aiding respondents who reported needing help to understand their doctor. Professional help is considered to be bilingual staff and professional interpreters. All other respondents either received help from informal, untrained sources or did not receive help at all.

Sources: 2007 and 2009 California Health Interview Surveys

outside professional interpreters, screen and train bilingual staff to be better equipped to handle the rigors and responsibilities of medical interpretation, and pay special attention to the communication needs of LEP enrollees in poorer health. Equal access to high-quality care is more important than ever given the expected increase in health care coverage and use by the LEP population through the Affordable Care Act and creation of Covered California.

Percent Limited English Proficient and Hard Time Understanding Doctor at Last Visit, by Type of Insurance, Ages 18-64, California, 2007-2009 **Appendix 1**

	2007		2009			
	%	N	%	N	Δ % '07→'09	p-value
Commercial HMOs						
Limited English Proficient (LEP)	8.3 [7.4-9.2]	9,182,000	9.0 [8.3-9.8]	8,804,000	0.7	0.24
Hard Time Understanding Doctor at Last Visit (Among LEP with Visit in Past Two Years)	12.1 [7.8-18.2]	690,000	9.5 [6.3-14.1]	742,000	-2.5	0.42
Public HMOs						
LEP	23.9 [21.0-27.1]	1,452,000	27.2 [23.4-31.3]	1,694,000	3.2	0.20
Hard Time Understanding Doctor at Last Visit (Among LEP with Visit in Past Two Years)	9.1 [6.4-12.8]	325,000	12.0 [7.7-18.3]	395,000	2.9	0.32
Commercial Preferred Provider Organization (PPO)/Fee For Service (FFS)						
LEP	4.4 [3.7-5.2]	6,402,000	4.8 [3.7-6.1]	6,102,000	0.4	0.60
Hard Time Understanding Doctor at Last Visit (Among LEP with Visit in Past Two Years)	13.2 [7.9-21.3]	231,000	7.0 [4.1-11.7]	251,000	-6.2	0.08
Public PPO/FFS						
LEP	23.8 [21.2-26.7]	1,681,000	25.2 [21.6-29.2]	1,926,000	1.4	0.54
Hard Time Understanding Doctor at Last Visit (Among LEP with Visit in Past Two Years)	10.3 [7.3-14.2]	361,000	13.0 [8.4-19.6]	419,000	2.7	0.38

Sources: 2007 and 2009 California Health Interview Surveys

Percent Limited English Proficient by Commercial HMO Plan, Ages 18-64, California, 2007-2009 **Appendix 2**

	2007		2009		
	% LEP	N	% LEP	N	Δ % '07→'09
Main Commercial HMOs					
Kaiser Permanente	7.6 [6.1-9.4]	3,743,000	8.2 [7.2-9.3]	3,653,000	0.6
Blue Cross	8.8 [6.9-11.3]	1,348,000	11.3 [8.8-14.2]	1,278,000	2.5
UnitedHealth/Pacificare	5.5 [3.2-9.3]	707,000	5.6 [3.6-8.4]	492,000	0.1
Blue Shield	5.4 [3.4-8.4]	837,000	3.6 [1.4-9.3]	780,000	-1.8
Health Net	8.1 [5.9-11.1]	794,000	8.0 [5.0-12.6]	814,000	-0.1
Aetna	4.2 [2.2-8.0]	366,000	6.6 [3.8-11.2]	454,000	2.4
Cigna	8.3 [4.8-13.9]	227,000	4.9 [2.4-9.8]	235,000	3.4

Sources: 2007 and 2009 California Health Interview Surveys

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Data Source and Methods

The 2007 and 2009 versions of the California Health Interview Survey (CHIS) were used for this study. Respondents ages 18-64 were included. The variables for HMO enrollment and health plan name were self-reported and manually cleaned using a consistent protocol to logically check for concordance of responses and account for inconsistencies as a result of missing values or incorrect responses. Some insurance type or HMO plan name responses were excluded from this analysis, assigned, or otherwise imputed, due to missing or incorrect values. To obtain additional information on CHIS data collection, methodology, and to download public use files, please visit *www.chis.ucla.edu*.

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Endnotes

1 California Health and Safety Code, Section 1367.04. Accessed on 10/15/2012 at: *http://www.leginfo.ca.gov/cgi-bin/displaycode?section=hsc&group=01001-02000&file=1367-1374.195*

2 California Department of Managed Health Care. *Threshold Languages by Health Plan*. Accessed on 10/12/2012 at: *http://www.dmhc.ca.gov/library/reports/news/thresholdlanguages.pdf*

3 Kominski GF, Jacobs K, Roby DH, Graham-Squire D, Kinane CM, Watson G, Gans D, Needleman J. *Health Insurance Coverage in California under the Affordable Care Act, Revision of the March 22, 2012 Presentation to the California Health Benefit Exchange Board*, UC Berkeley Center for Labor Research and Education and the UCLA Center for Health Policy Research, June 2012. Accessed on 11/30/2012 at: *http://laborcenter.berkeley.edu/healthcare/aca_chartpack.pdf*

4 California Department of Managed Health Care. *Title 28, California Code of Regulations*. Accessed on 10/12/2012 at: *http://www.dmhc.ca.gov/library/reports/news/lart.pdf*

5 California Department of Managed Health Care. Second Biennial Report to the Legislature on Language Assistance. Accessed on 10/12/2012 at: *http://www.dmhc.ca.gov/library/reports/news/11rpt2legisla.pdf*

Pinpoint: Accountable Care Organizations in California LINK TO PAGE

Accountable care organizations are growing in number and importance on the national stage. In the ACO model doctors, hospitals, and others coordinate care to improve quality and cost-effectiveness.

February 2013

This map shows the evolving distribution of accountable care organizations (ACOs) in California by these four types:

- **Medicare Shared Savings Program (MSSP) ACOs** are designated to coordinate care for Medicare fee-for-service beneficiaries.
- **Medicare Advanced Payment Model*** is a special version of the MSSP ACO model to support infrastructure development.
- **Medicare Pioneer ACOs*** were among the first Medicare-designated ACOs and take on more risk than the MSSP model.
- **Look-Alike ACOs** contract with commercial health plans to coordinate care in a similar model to those above.

Medicare Shared Savings Program

- Accountable Care Clinical Services (Orange)
- Accountable Care Clinical Services/Preferred ACO
- Affiliated Physicians Medical Group ACO
- Akira Health

Medicare Advanced Payment Model

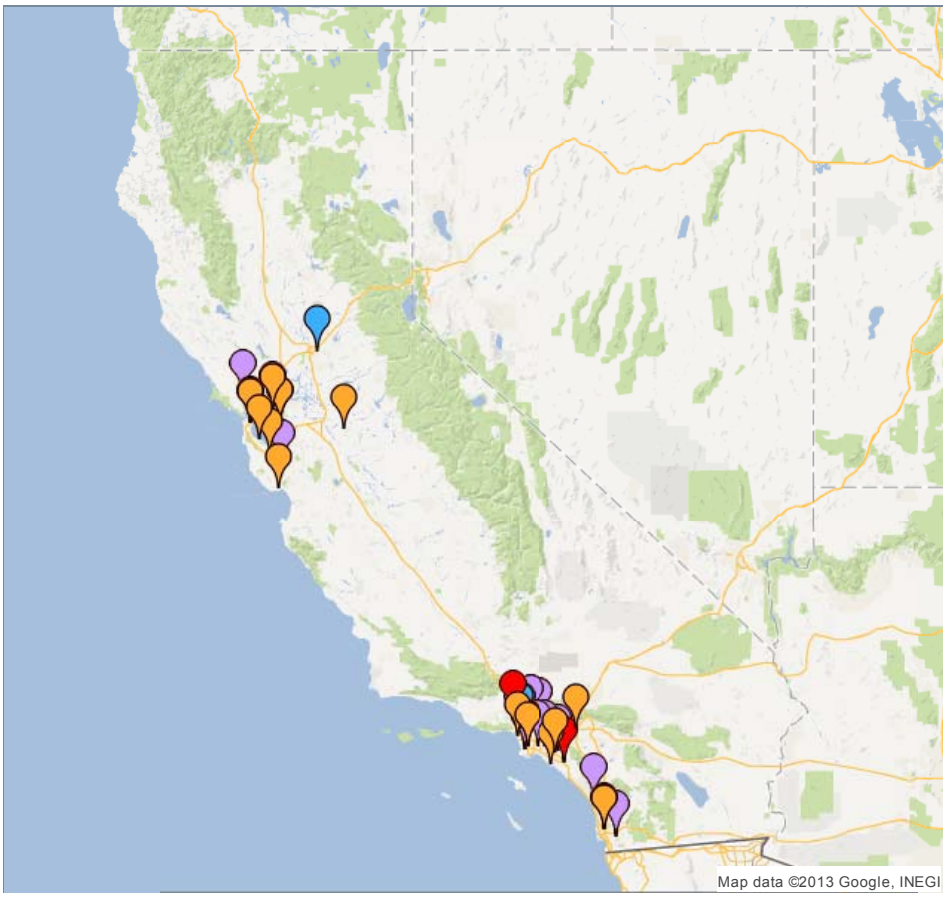
- Golden Life Healthcare
- National ACO

Medicare Pioneer

- Brown & Toland Physicians
- HealthCare Partners ACO
- Heritage California ACO
- Monarch HealthCare
- Sharp HealthCare

Look-Alike ACOs

- Access Medical Group/St. John's Health Center/NantWorks
- AllCare IPA/Doctors Medical Center
- Brown & Toland Physicians
- Brown & Toland Physicians/California Pacific



Click each entity in the panel at left to see details or pan the map and click on the pushpins. The gray-shaded counties show where the ACOs operate (pan the map to make sure the detail boxes do not obscure the service areas).

The map will be updated when new Medicare contracts are announced (last updated February 2013).

* Initiative of the Center for Medicare & Medicaid Innovation (the Innovation Center); see a map of other Innovation Center grantees.

RELATED CHCF PAGES

Pinpoint: Innovation Center Grantees in California LINK

This map of grantees shows the breadth of Innovation Center investments in California working to test innovative payment and care delivery models to reduce costs and maintain or improve quality of care for recipients of Medicare, Medicaid, and CHIP.

February 2013

The Center for Medicare & Medicaid Innovation (the Innovation Center) was established at the Centers for Medicare & Medicaid Services (CMS) through the Affordable Care Act (ACA) to test innovative payment and care delivery models to reduce costs and maintain or improve quality of care for recipients of Medicare, Medicaid, and the Children's Health Insurance Program. The map below shows the breadth and distribution of Innovation Center investments in California. It complements related CHCF-funded work tracking ACA implementation.

This map shows Innovation Center grantees in California by type:

- Bundled Payments for Care Improvement Initiative aims to align provider incentives to better coordinate patient care in the hospital and after discharge.
- Community-Based Care Transitions Program helps reduce hospital readmissions among high-risk Medicare beneficiaries.
- FQHC Advanced Primary Care Practice Demonstration tests the efficiency of patient-centered medical homes among Federally Qualified Health Centers.
- Health Care Innovation Awards fund compelling ideas aimed at delivering better health care at lower costs.
- Strong Start for Mothers and Newborns aims to reduce preterm births and improve outcomes for newborns and pregnant women.

California's participants in the Advance Payment ACO Model and Pioneer ACO Model can be seen on a map of Accountable Care Organization initiatives.

Bundled Payments for Care Improvement

- California Hospital Medical Center
- Community Hospital of San Bernardino
- Community Hospital of the Monterey Peninsula

Community-Based Care Transitions

- Advance Care Transitions
- AltaMed Health Services Corporation
- Glendale Memorial Hospital and Health Center

FQHC Advanced Primary Care Practice

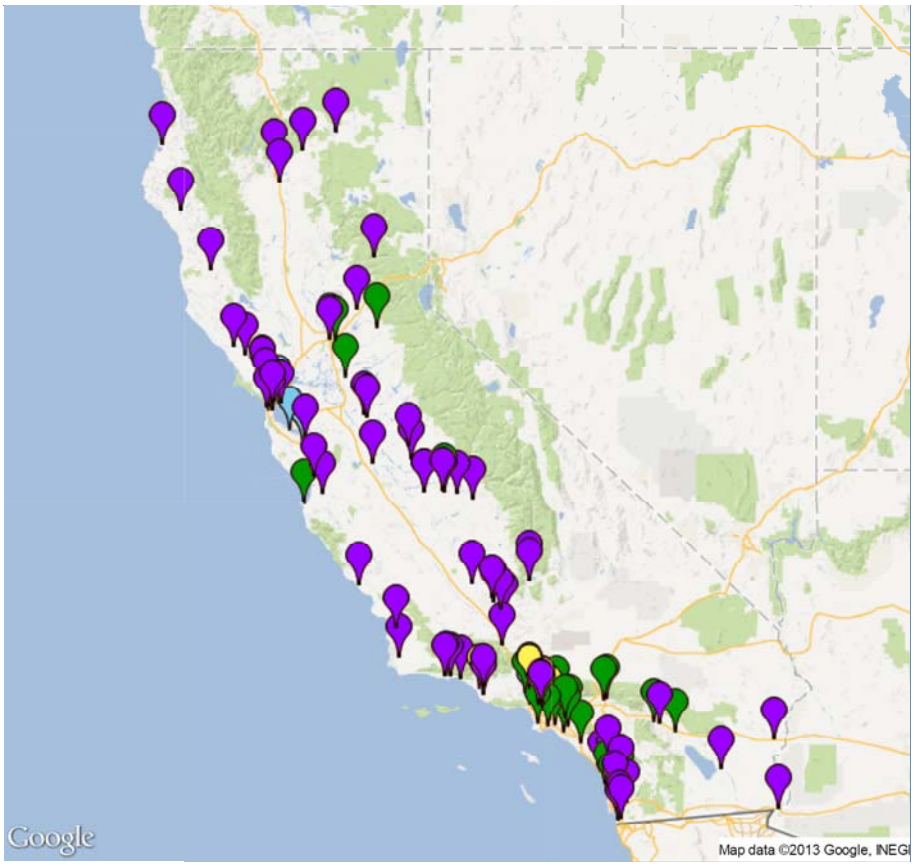
- 34th Street Community Health Center
- American Indian Health & Services
- Anderson Family Health & Dental Center

Health Care Innovation Awards

- Asian Americans for Community Involvement
- California Long-Term Care Education Center
- City College of San Francisco

Strong Start for Mothers and Newborns

- Los Angeles County Department of Health Services



This map will be updated as new initiatives or grantees are announced. CMS has maps of all Innovation Center grantees across the country.

This map excludes initiatives and grantees that are networks or individuals rather than organizations, in which the State of California participates, or that are not located in California:

- Health Care Innovation Awards. Six grantees based in other states list California in their geographic reach: Institute for Clinical Systems Improvement; National Health Care for the Homeless Council; Rutgers Center for State Health Policy, State University of New Jersey; Trustees of Dartmouth College; University of Arkansas for Medical Sciences; and University of North Texas Health Science Center.
- Innovation Advisors Program. Five individuals in California were selected: Parag Agnihotri, MD (Medical Clinic of Sacramento); Zahra Esmail, DO (White Memorial Medical Center); Paula Suter, MA, RN (Sutter Health); Sharon Tapper, MD (Palo Alto Medical Foundation); and Alen Voskanian, MD (VITAS Innovative Hospice Care).
- Medicaid Emergency Psychiatric Demonstration. The State of California is a participant.
- Medicaid Incentives Program for the Prevention of Chronic Diseases. The State of California is a participant.
- Partnership for Patients. This effort to reduce hospital errors and readmissions uses 26 Hospital Engagement Networks, including hospital associations and health systems, through which hundreds of California hospitals are offered tools and processes to improve patient safety.
- State Innovation Models Initiative. The State of California is a participant.

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Early Experience With A New Consumer Benefit: The Summary of Benefits and Coverage

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Acknowledgements

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About the Author

Lynn Quincy is a Senior Health Policy Analyst at Consumers Union. Ms. Quincy works on a wide variety of health policy issues, with a particular focus on consumer protections, consumers' health insurance literacy and health insurance reform at the federal and state levels. Her recent work includes studies testing consumer reactions to new health insurance disclosure forms; launching an initiative to measure consumers' health insurance literacy, a study that explores consumer friendly approaches to actuarial value estimation and a study that examines the use of "choice architecture" in health plan chooser tools. Work in progress includes consumer testing explanations of the new premium tax credit. Ms. Quincy also serves as a consumer expert in several venues: as a consumer representative with the National Association of Insurance Commissioners, a member of the Covered California Plan Management Advisory Workgroup and on the technical expert panel advising the development of new exchange enrollee satisfaction surveys.

Prior to joining Consumers Union, Ms. Quincy held senior positions with Mathematica Policy Research, Inc., the Institute for Health Policy Solutions and Watson Wyatt Worldwide (now Towers Watson). She holds a master's degree in economics from the University of Maryland.

Executive Summary

The Affordable Care Act calls for a new, standardized method of communicating health coverage information to consumers. This new document is called the "Summary of Benefits and Coverage" (SBC or Summary). This is far reaching policy is intended to benefit all consumers shopping for or enrolling in private health insurance coverage – approximately 170 million consumers.

This study examines how consumers fared during the first open enrollment period when the Summary was available–the Fall of 2012. Using a nationally representative survey and anecdotal stories provided by consumers, we learned:

- Awareness of the new benefit is low. Just 50 percent of consumers who shopped for or renewed private health insurance coverage recalled seeing the Summary. Rates were even lower for those who shopped for coverage on their own in the non-group market.
- Among shoppers that did see the Summary, their impressions were very favorable. Over 50% were very or completely satisfied with the specific features of the SBC, with very few expressing any dissatisfaction. When asked to rate the helpfulness of the SBC against other common sources of health plan information, the SBC was rated as helpful most often, followed by employer provided health plan comparisons (for those shopping for employer coverage) and by lists of participating doctors and Health insurer's brochure (for those shopping in the non-group market).
- When asked specifically about problems with the Summary, respondents were evenly divided over whether there was too much or too little information in the form, suggesting a wide variety of consumer preferences for the amount of content.
- Few consumers reported seeing the new feature called "Coverage Examples." These "examples" show how much the plan would pay for a hypothetical medical scenario, like having a baby. While these examples tested very well with consumers, they are near the back of the multi-page Summary which may explain why few consumers recalled seeing them.

These findings show that consumers value a uniform, consumer-friendly method of conveying health plan information – a finding reinforced by other research. We find it significant that, when consumers are aware of the SBC, they routinely find it more helpful than other types of health plan information also available to them.

Low rates of awareness among plan shoppers show that much more needs to be done to publicize consumers' rights to the SBC. A limited amount of anecdotal evidence suggests that insurers may need to improve dissemination to shoppers and current enrollees, particularly in the non-group market.

When consumers are aware of the SBC, they routinely find it more helpful than other types of health plan information available to them.

HHS may want to test moving the coverage examples closer to the front of the form to see if this increases consumers' awareness and use of this new feature. HHS may also want to be guided by consumers' suggestions for additional medical scenarios to be added to the coverage examples in the SBC, such as an example illustrating out-of-network coverage or a trip to the emergency room.

When these recent findings are viewed in conjunction with earlier evidence from pre-testing the Summary form, it suggests there is tremendous upside to continue to refine and promote the new SBC form. Ensuring that accurately completed forms are routinely provided to consumers is likely to improve consumer confidence when shopping for coverage and make our health insurance markets more competitive.

Introduction

The Affordable Care Act calls for a uniform health insurance "Summary of Benefits and Coverage" (SBC or Summary) to be provided to all consumers shopping for or enrolling in private health coverage – over 170 million consumers.[1] For the first time, this new disclosure standardizes the display of health insurance information regardless of who offers it. For example, spouses with an offer of coverage from both their employers can use this form to compare the two offers on an apples-to-apples basis.

There is wide-spread evidence – including Consumers Union's own testing – that shows traditional health plan summaries are often impossible for consumers to decipher, especially with respect to cost-sharing and the overall amount of coverage being offered.[2] The evidence also shows that consumers dread shopping for coverage. Together, these barriers undermine consumers' ability to find the health plan that is right for them.

Early consumer testing of the SBC indicated that the new form could be very useful to consumers. Consumers liked the uniform format because they could line up Summaries from different carriers and more easily compare them.[3] Further, the summaries contain a new feature called the Coverage Examples. These examples show, for the first time, how much health care costs and how much the plan would pay for selected medical scenarios (Exhibit 1). Testing showed that this information greatly increased consumers' willingness to make a health plan selection and increased their confidence in the selection.[4] Furthermore, polling indicates that a standardized health insurance summary is highly valued by consumers.[5]

This initial research suggests that the new Summaries could be transformative – if consumers know about their new benefit and can easily access their Summary.

This study explores how policy translated into reality by examining how consumers fared during the first season of SBC use – health plan open

Exhibit 1:
Coverage Example

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,490
- **Patient pays** $2,050

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$700
Copays	$30
Coinsurance	$1320
Limits or exclusions	$0
Total	**$2,050**

[1] *Decoding Your Health Insurance: The New Summary of Benefits and Coverage*, Families USA, May 2012.

[2] L. Quincy, *What's Behind the Door: Consumers' Difficulties Selecting Health Insurance*, Consumers Union, January 2012.

[3] Consumers Union and People Talk Research, *Early Consumer Testing of New Health Insurance Disclosure Forms*, December 2010 and *America's Health Insurance Plans Focus Group Summary*, JKM Research, October 2010.

[4] Consumers Union and Kleimann Communication Group, *Early Consumer Testing* of the *Coverage Facts Label: A New Way of Comparing Health Plans,* August 2011 and *America's Health Insurance Plans [and] Blue Cross Blue Shield Association Focus Group Summary*, JKM Research, May 2011.

[5] Kaiser Health Tracking Poll, November 2011.

enrollment during the Fall of 2012. Specifically, we sought to understand consumer awareness of, and reactions to, the SBC.

Research Approach

The majority of our findings are informed by a nationally representative survey commissioned by Consumers Union and conducted in December 2012. This information was augmented with consumer stories and other anecdotal data from selected stakeholders.

Target Audience

Household insurance decision makers between the ages of 18-64 who shopped for private coverage on their own or went through open enrollment with their employer in the Fall of 2012. This population includes federal[6] and state employees but excludes those shopping for PCIP, Medicaid, CHIP, Medicare, Medigap, Medicare Advantage, Medicare Part D drug plans or military coverage such as TRICARE or Veteran's benefits.

Below, we refer to this group as "people who shopped for coverage" in the Fall of 2012. We intend the phrase to include those who enrolled in coverage with their employer, even if they just renewed coverage they already had. We include in this group people who shopped for private coverage, even if they didn't end up enrolling in the coverage.

Nationally Representative Survey

We used GfK's (formerly Knowledge Networks) online panel for the survey. This KnowledgePanel® is a nationally representative probability sample of the U.S. adult population. Initially, participants are chosen scientifically by a random-selection of telephone numbers and residential addresses. Persons in selected households are then invited by telephone or by mail to participate in the web-enabled KnowledgePanel®. Panel respondents who do not have Internet access are provided with Internet service and free laptop computers by Knowledge Networks, to ensure that panel respondents are representative of the national population and are not limited only to those who already use the Internet.

A complete description of this survey, including the questionnaire, is available by contacting Consumers Union.

[6] While the Affordable Care Act doesn't require the form for Federal workers, the U.S. Office of Personnel Management enacted a rule requiring the SBC be provided by carriers offering coverage to federal employees. https://www.opm.gov/healthcare-insurance/healthcare/carriers/2012/2012-22.pdf

Respondents

Just over one thousand respondents met our screening tests to identify those who shopped for private health coverage in Fall of 2012. The vast majority of respondents enrolled in employer coverage during the Fall of 2012, although 6 percent enrolled in non-group coverage and four percent were "shoppers" who did not end up enrolling in any coverage (Exhibit 2).

EXHIBIT 2 — RESPONDENTS BY TYPE OF SHOPPING, FALL 2012

Type of Shopping	Distribution of Respondents
Covered by a health plan through my employer, family member's employer or former employer	90%
Covered by a health plan that was purchased privately	6%
Shopped for but did not enroll in health insurance	4%
All Respondents	100%

Source: Consumers Union Survey

For the full sample, sampling error was 3.9% at the 95% confidence level. For the subset of respondents who recalled viewing the SBC Form sampling error was 5.5% at the 95% confidence level. Sampling error is a term used to describe the range of possible results when survey findings are generalized to the entire population of the county. In this case, the sampling error estimates the most accurate percentage for the result and the range within which we would expect the true value to fall 95 times out of 100.

Respondents were shown an image of page 1 of the SBC to ensure that their responses did not apply to a different summary they may have received. Many of the respondents were renewing coverage they already had and many of them did not have a choice of plans. Our analysis explores these factors.

Survey Findings

Low Rates of Awareness

Only 50 percent of respondents recalled seeing the SBC when they renewed, enrolled in or shopped for coverage in the Fall of 2012 (Exhibit 3). Rates were significantly lower (approximately 35%) among those who shopped in the non-group market, had COBRA coverage or didn't end up enrolling in a plan.

EXHIBIT 3 — HALF RECALLED SEEING THE SBC WHEN THEY SHOPPED

(After being shown an image of page 1 of the SBC) *Do you recall viewing a similar form when you last shopped for, enrolled in, or renewed a health plan?*	**All Respondents**	**By Type of Coverage**			
		Current Employer (incl spouse's)	COBRA or Other Employer-Based Health Plan	Private Plan	No Health Plan
Yes, saw the form	50%	53%	36%	35%	36%
No, did not see the form	30%	29%	37%	37%	31%
Not sure	20%	19%	26%	28%	33%
All Respondents	1,076	906	61	61	49

Source: Consumers Union Survey. Subsamples of less than 100 respondents should be regarded with caution.

While type of coverage seems to impact whether or not consumers saw the SBC, among those that saw the form, their opinions about the form did not differ by type of coverage.

Only 50 percent of respondents recalled seeing the SBC when they shopped for coverage.

Among those who didn't recall seeing the form, about one quarter recall seeing a reference to the SBC but did not follow up on it (Exhibit 4).

EXHIBIT 4 — RESPONDENTS WHO DIDN'T SEE THE SUMMARY, FALL 2012

Although you do not recall viewing the new Summary of Benefits and Coverage form, do you remember seeing a postcard, or an Internet link, that described how to obtain one?	**Percentage**
I recall the Internet link to the form but I did not click it	17%
I recall a postcard, but I didn't mail it to request the form	7%
I recall some other method of obtaining the form, but didn't pursue it.	5%
None of the above	73%
All Respondents	540

Source: Consumers Union Survey

High Rates of Satisfaction Among Those Who Viewed the Summary

Among respondents who viewed the form (n=534), most were very satisfied with the specific features (Exhibit 5). Very few reported any dissatisfaction.

EXHIBIT 5 — HIGH LEVELS OF SATISFACTION WITH THE SBC

Please indicate how satisfied you were with the following aspects of the Summary of Benefits and Coverage form.	**Percent responding completely or very satisfied**	**Fairly Well Satisfied**	**Somewhat to Completely Dissatisfied**
It provided me with useful information to help me select the best health plan available	61%	31%	9%
The format allowed easy comparison of health plan options	57%	33%	9%
Clear presentation of the benefits and costs of the health plan	56%	35%	9%
Completeness of information presented about health plan	53%	41%	6%
Enough information was presented about getting care out-of-network	52%	36%	13%
Understandable presentation of the "fine print" (e.g., terms, conditions, and limitations of coverage in health plan)	43%	43%	14%
All Respondents	526-533 (not every respondent answered every question)		

Source: Consumers Union Survey

Little Consensus on Problems with the Summary

Shoppers who saw the SBC were asked specifically if they felt there were any problems with the form. When a problem was identified, there was little consensus around the nature of the problem (Exhibit 6). Indeed, respondents were almost evenly divided over whether the form had too little or too much information.

EXHIBIT 6 — LITTLE CONSENSUS ON PROBLEMS WITH THE FORM

Which, if any, of the following would you identify as problems with the Summary of Benefits Coverage form?	**Percentage**
There was too much information to absorb - the form was too long	21%
There was too little information about each plan	17%
The language used in the form was too technical, legal, or full of jargon	16%
It was not clear how consumers were supposed to use this information	16%
The format of the form did not allow an easy comparison of the health plan options	13%
Other :_____	3%
Base	537

Notes: Respondents could select more than one problem and 14% of respondents did so. 46 respondents replied "no problem" or similar in the "other" category and these were removed from the distribution so that only "other problems" are included in this table. The order of the fixed responses was randomized.

The "other" responses noted general confusion or that something wasn't clear (5 responses), needed more/better information on out-of-network costs (2 responses), wellness disclaimer wasn't clear (1 responses) or would like "prices next to benefits."

Coverage Examples Rarely Viewed

As noted above, the SBC includes a feature called Coverage Examples. This feature is new to consumers – traditional health plan summaries rarely show how much the plan would pay for a specific medical scenario.

When the prototype was pre-tested with consumers, these examples proved very helpful to consumers.[7] In this survey, half of respondents did not recall seeing these examples (located near the end of the multi-page form) and twenty percent reported they did not find the examples helpful (Exhibit 7).

EXHIBIT 7 — COVERAGE EXAMPLES RARELY VIEWED

Were the two "Coverage Examples" showing plan benefits and bottom line costs for "having a baby" and "diabetes" helpful to you?	**Percentage**
Yes	26%
No	22%
Don't recall seeing this part	52%
All Respondents	532

Source: Consumers Union Survey

The U.S. Department of Health and Human Services (HHS) has committed to providing up to six examples, although only two were required in the Fall of 2012 – "having a baby" and "treating diabetes." All respondents who saw the SBC were asked which additional example they would like to see. Responses which were fairly evenly divided over a number of scenarios, with a significant percentage being unsure of which they would prefer (Exhibit 8).

[7] Consumers Union and Kleimann Communication Group, *Early Consumer Testing* of the *Coverage Facts Label: A New Way of Comparing Health Plans*, August 2011 and *America's Health Insurance Plans [and] Blue Cross Blue Shield Association Focus Group Summary*, JKM Research, May 2011.

EXHIBIT 8 — COVERAGE EXAMPLES RARELY VIEWED

If you could add an additional scenario illustrating plan benefits, what would your first choice be?	**Percentage**
Getting care out-of-network	21%
Trip to Emergency Room for broken leg	20%
Care received by a typical family with children	17%
Heart attack	6%
Treatment of breast cancer	5%
Other	3%
Not sure	28%
All Respondents	531

Note: The presentation of these items was randomized. Source: Consumers Union Survey

When completing the "other" response, consumers answered:

- Inpatient hospital for surgery (3 responses)
- Illustrate preventive care vs. non-preventive care (2)
- Mental health coverage (1)
- Multiple Sclerosis (1)
- Coverage not available while traveling (1)
- Care for a family with health problems (1)
- "Total care" (this may be all care for a year) (1)

During development of the form, a breast cancer scenario was tested but not included in the initial requirements for the SBC. Because of the high charges associated with this scenario (roughly $100,000), this example generated the biggest consumer response among the three that were tested. Seeing that medical care can result in unexpected, very high charges reminded consumers that having health insurance protects families.[8] Hence, a high cost scenario like breast cancer or heart attack may help consumers, even if they don't report it on a survey such as this one.

[8] Ibid.

The SBC Ranked Highly Among All Sources of Health Plan Information

Among shoppers that saw the SBC, this source of information ranked above other sources of information in terms of helpfulness (Exhibit 9).

For those with employer-based coverage, employer provided plan summaries also ranked highly, followed by lists of participating doctors provided by health plans. Advice from co-workers, friends and family, the HR department or the insurer provided documents were also found helpful by just over half of respondents with employer coverage who saw the SBC.

The SBC was ranked as very or somewhat helpful more often than other documents.

EXHIBIT 9 — HELPFULNESS OF SBC, COMPARED TO OTHER SOURCES OF INFORMATION

Source of Information	Percent finding this source of information very or somewhat helpful	
	Shopped for Employer Coverage	Shopped for private, non-group coverage
The Summary of Benefits and Coverage Form	89%	90%
Employer-prepared health plans comparison	78%	N/A
Lists of participating doctors provided by health plans	76%	81%
Health insurer's brochure	66%	78%
Advice from employers' Human Resources Department	61%	N/A
Advice from friends and family	57%	71%
Advice from co-workers	55%	39%
Health plan ratings viewed on the Internet	49%	67%
Broker or agent's advice	N/A	58%
Health insurer's renewal letter	N/A	45%
All Respondents	477-493	35-38

Note: Subsamples of less than 100 respondents should be regarded with caution. Source: Consumers Union Survey.

Among those who shopped for coverage in the non-group market, the SBC was ranked as very or somewhat helpful more often than other documents. Other sources that also ranked highly include lists of participating doctors and brochures from health insurers. Unlike those shopping for employer coverage, advice from co-workers was cited as helpful for shoppers in this market only 39 percent of the time.

We asked a similar question of those who shopped for coverage in the Fall of 2012 but did *not* recall viewing the SBC. In terms of the relative importance of each source of information, their responses were very similar to those who *did* view the SBC, once the SBC is removed as an option (Exhibit 10). For example, among the choices, employer provided health plan comparison were ranked as very or somewhat helpful more often than other sources.

Interestingly, almost all information sources were ranked as helpful less often compared to the group that viewed the SBC. For example, those viewing the SBC found "Employer-prepared health plans comparisons" very or somewhat helpful 78 percent of the time compared to 61 percent for the group that didn't view the SBC.

EXHIBIT 10 — HELPFULNESS OF SOURCES OF INFORMATION, AMONG THOSE WHO DIDN'T VIEW THE SBC

Source of Information	Percent finding this source of information very or somewhat helpful	
	Shopped for Employer Coverage	Shopped for private, non-group coverage
The Summary of Benefits and Coverage Form	N/A	N/A
Employer-prepared health plans comparison	61%	N/A
Lists of participating doctors provided by health plans	56%	70%
Health insurer's brochure	48%	71%
Advice from employers' Human Resources Department	56%	N/A
Advice from friends and family	49%	56%
Advice from co-workers	57%	29%
Health plan ratings viewed on the Internet	28%	33%
Broker or agent's advice	N/A	27%
Health insurer's renewal letter	N/A	49%
All Respondents	454-465	60-62

Note: Subsamples of less than 100 respondents should be regarded with caution. Source: Consumers Union Survey.

Impressions Were Even More Favorable When Shoppers Were Careful Reviewers of The Form

Among all consumers who shopped for private coverage in the Fall of 2012, a significant portion did not have a choice of plans (Exhibit 11). Even among those with a choice of plans, many did not seriously weigh alternatives.

Only 36 percent of employer-based respondents seriously weighed other health insurance options, compared to over 50 percent of those shopping in the non-group market. Twenty-eight percent of employer-based shoppers reported only one choice of plan.

Surprisingly, 21 percent of non-group shoppers reported they had no choice of plans. These may be shoppers who were locked into their plan due to their pre-existing medical conditions, or perhaps they felt they lacked meaningful choices due to the high cost of coverage in this market.

EXHIBIT 11 — CHOICE OF PLANS AMONG ALL SHOPPERS (WHETHER OR NOT SBC VIEWED)

Which of the following best describes your choice of health plans in recent months?	**Shopped for Employer Coverage**	**Shopped for Individual Coverage**
I had only one choice of plans	28%	21%
I had more than one choice, but I really didn't weigh other options	37%	26%
I had more than one choice, and I seriously weighed other options	36%	54%
All Respondents	968	99

Source: Consumers Union Survey

Not surprisingly, among those that recalled seeing the SBC, those who seriously weighed more than one health coverage option reported they were more likely to read the SBC "very carefully."

Those who read the SBC "very carefully" were more likely to report that they found the SBC features "very helpful." When asked about perceived problems, they were more likely to report that the jargon was too technical than to report being dissatisfied with the amount of information in the document.

Relatively few respondents reported not reading the form carefully. When asked why, the dominant reason was "I knew I would renew my old plan and did not feel the need to review [the SBC] more carefully."

Shoppers who seriously weighed more than one health coverage option more likely to read the SBC very carefully .

Anecdotal Reports from Fall Enrollment

Survey data provides a comprehensive, nationally representative overview of SBC awareness around the country and it can suggest areas for further investigation but it isn't always nuanced enough to tell us what policy changes, if any, might be indicated.

Therefore, we also solicited consumer experiences via an online feedback tool and other methods. Further, we spoke with experts at *Consumers Checkbook*. *Consumers Checkbook* is a popular tool that provides comparative health plan data to federal employees, encompassing 248 different health plans. As such, we were interested in their experience trying to gather SBCs in order to populate their comparison tool.

Anecdotal Evidence Suggests Difficulty Obtaining SBC

Significantly, *Checkbook* experts reported difficulty obtaining the SBC for about 50 percent of plans and, as they put it, "we knew what we were looking for."

EXHIBIT 12 — EASE/DIFFICULTY OF OBTAINING SBCS FOR FEHB PLANS

Ease or Difficulty	**Percentage**
SBC relatively easy to find on plan website	50%
SBC difficult to find on plan website or had to call and request	35%
Never found SBC and plan rep did not return call	15%
Total Number FEHB Plans	248

Source: Staff at Consumers Checkbook

Checkbook staff suggested that the name of the document – "Summary of Benefits and Coverage" – was too similar to other insurance documents and insurer staff may not yet be trained in what term refers to.

This is similar to the experience of a Pennsylvania consumer who had tremendous difficulty obtaining a correct SBC. The health plan sent him the wrong document when he directly requested the SBC (see Side Bar: Even When You Know What to Ask For...).

These anecdotal reports – reinforced by our survey data – suggest that insurers need to do more to ensure that consumers can easily access their SBC.

EVEN WHEN YOU KNOW WHAT TO ASK FOR…

A consumer in Pennsylvania had a very poor experience obtaining an accurate SBC, including:

- Customer called his carrier to request an SBC, but customer was sent a different document, identified as the "Personal Choice Welcome Kit," that didn't include the SBC. Customer was not directed to the SBC online.
- On his own, customer looked for the SBC online. The SBC was not prominent or easy to locate. Customer was able to locate it but only after entering his login information. Hence, the SBC description was not available to shoppers who don't yet have login information as they aren't yet enrollees (a violation of federal rules).
- Once obtained, the SBC was found to have several errors including: (a) maternity is not covered by this plan but the carrier failed to list it on page 7 "Services your plan does NOT cover;" and (b) the coverage example "Managing Type 2 Diabetes" shows that plan pays all but $80 of these services. This is incorrect given the $5,000 deductible associated with these services.
- When the customer brought the *Managing Type 2 Diabetes* error to the attention of the carrier, he was told that it "didn't matter because the document clearly says that it is not a cost-estimator."
- Bringing these problems to the attention of the PA Department of Insurance provided no remedy, as the department noted it was not authorized to enforce the rules.

Some SBC Contained Errors

Several SBC documents that we received from consumers contained errors, particularly with the coverage examples (see Side Bar). There is no way to tell how wide-spread this problem is, but it bears closer monitoring by state insurance departments and HHS.

SBCs Aren't As Uniform as Intended

In the first year of use, it is not surprising that the rules intended to standardize the language facing consumers were not always followed, or in some cases, that the rules didn't address areas where standardization was needed.

An example from *Consumers Checkbook*: one of the common medical events for which coverage is described is "preventive services." As required by the ACA, these services are required to be covered without cost-sharing – something that should be fairly simple to convey to consumers. Yet in the "limitations and exceptions" column of the SBC, plans reported a wide variety of "exceptions" for this service, undermining the main idea of uniform treatment across plans:

- "under unique circumstances" plan may pay out-of-network
- "age and frequency schedules may apply"
- "none"
- "preventive services required by ACA covered in full"
- "limited to one per year for each covered service"
- "benefit includes 8 age or periodicity limits that vary…"
- "one routine exam per person every calendar year."

While all of these statements may be technically accurate, any differences are extremely rare and probably should not be mentioned in this Summary document.

Conclusion and Recommendations

These findings confirm earlier evidence that consumers will benefit from the new Summary of Benefits and Coverage. In this nationally representative survey, they report finding the SBC one of the most helpful sources of plan information available to them. But low rates of awareness and problems with insurer provision of the form suggest that much more needs to be done to publicize consumers' rights to the SBC and to improve standardization and accuracy of the document.

The survey data and anecdotal evidence suggests that insurers may need to make it easier for shoppers and current enrollees to access their SBC, particularly in the non-group market. In some cases, additional training of staff answering consumer help lines and reviews of SBC for accuracy may be needed.
HHS may want to test moving the coverage examples closer to the front of the form to see if this increases consumers' awareness of this new feature. HHS may also want to be guided by consumers' suggestions for additional scenarios to be added to the coverage examples in the SBC.

We believe this study demonstrates the value of monitoring early experience with new consumer disclosures to see if policy goals are being achieved, and so adjustments can be made accordingly. We would like to see a mixed-methods approach to monitoring become a regular practice of federal and state agencies that provide new disclosures to consumers.

ConsumersUnion
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Consumers Union is the policy and advocacy division of *Consumer Reports*. We have a long history of advocating for improvements in the consumer marketplace. Since our creation in 1936, we have worked for safer, more affordable, and better quality products and services at both the state and federal levels. We are a non-profit, non-partisan organization with an overarching mission to test, inform and protect.

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Kentucky Health Benefit Exchange

Branding Campaign Research

Final Report
January 2013

BACKGROUND

BACKGROUND

Objectives

To explore the meanings and emotions communicated by several creative concepts related to branding efforts for the Kentucky Healthcare Exchange.

Specific objectives included…

- Understanding what, if anything, respondents know about Healthcare Reform in general and the Kentucky Health Benefit Exchange in particular.
- Exploring the meanings and emotions communicated by alternative names, logo designs and taglines for the Kentucky HBE.
- Understanding which creative elements are most meaningful and relevant to respondents.

BACKGROUND

Methods

A total of twelve focus groups were conducted in Louisville, London and Paducah, KY December 3-7, 2012.

A total of 106 respondents were recruited for 72 to show.

- 4 focus groups consisted of Economically Disenfranchised respondents, who do not have health insurance.
  - Approximately 50% of these respondents were recruited to be 18-49 years old, with children in the household and at or below the poverty line.
  - Approximately 50% were recruited to be 36-60 years old and lower to middle income (above poverty line) but can be newly retired but not eligible for Medicare.

BACKGROUND

Methods

- 3 focus groups consisted of 25-64 year olds with at least some college, self-employed but cannot afford an individual plan or do not see the value of having one.

- 3 focus groups consisted of Small Business Owners with 49 or fewer employees who because of high costs have not been able to offer an insurance plan to all of their employees

- 2 focus groups consisted of Primary Care Physicians who have had or anticipate having discussions with their patients about how health care reform will affect them.

GENERAL INSIGHTS

GENERAL INSIGHTS

A lack of knowledge

Most respondents – even physicians and business owners – expressed little knowledge of the Affordable Care Act and its implications.

A vague understanding at best… Most healthcare consumer respondents expressed only a vague understanding of Healthcare Reform. Many said they are aware that the law will require them to have insurance but they know little of what this actually means, how they will access health insurance options in the future, or what, if any, subsidies they might qualify for.

Little knowledge of the HBE… Respondents also expressed little knowledge of the Health Benefit Exchange and how it might work in Kentucky.

- This lack of knowledge was consistent across Disenfranchised, Self-Employed and Small Business Employer groups. Knowledge of the Healthcare Reform law varied widely among physicians, with some claiming to have read a great deal and others saying they knew little about it. However, almost all physicians expressed little knowledge of the HBE and its implications for them and their patients.

GENERAL INSIGHTS

Feelings of uncertainty

Because of their lack of knowledge, many respondents expressed feelings of *uncertainty* and *suspicion* about Healthcare Reform.

Complicated and confusing… These feelings are fueled by existing perceptions that healthcare in general and health insurance in particular are, and always have been, complicated and confusing.

Less choice, more control… In addition, many assume they are going to experience less choice and more government control in a post-Healthcare Reform world.

- These feelings tended to be consistent across segments with the Disenfranchised, Self-Employed, Small Business owners and several physicians assuming more control and less freedom as a result of the Affordable Care Act.

- However, it should be noted that a few respondents in each market – particularly among the Disenfranchised – had positive perceptions of Healthcare Reform.

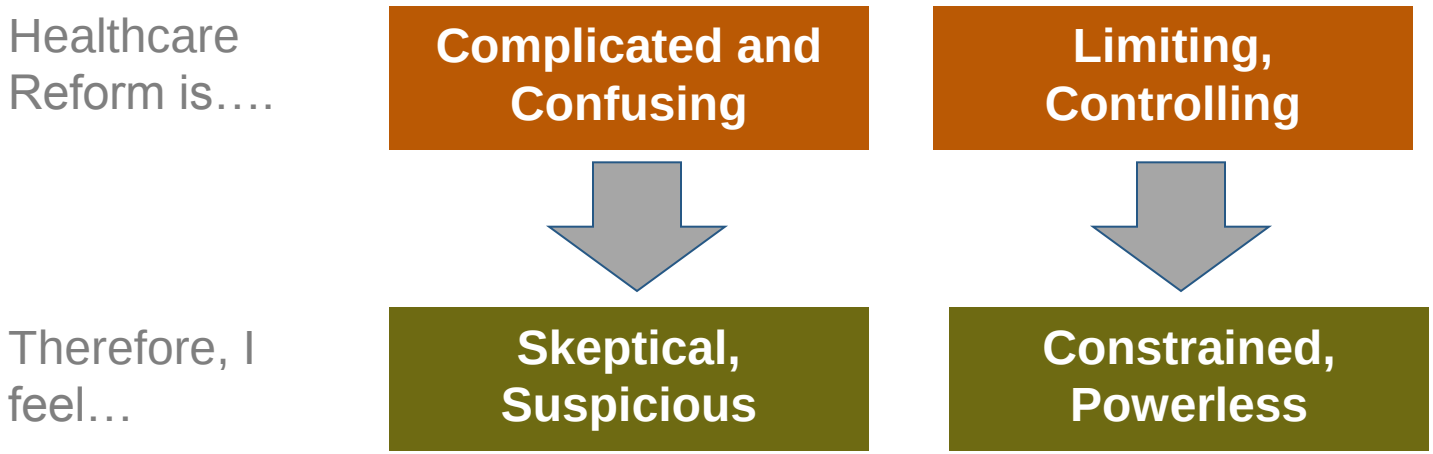
GENERAL INSIGHTS

Feelings of uncertainty

The fact that many are confused about Healthcare Reform and assume it will result in less choice creates feelings of skepticism, on the one hand, and constraint and powerlessness on the other.

Indeed, many respondents are deeply suspicious about what Healthcare Reform will bring and pessimistic about whether it will make a meaningful, positive difference in their lives.

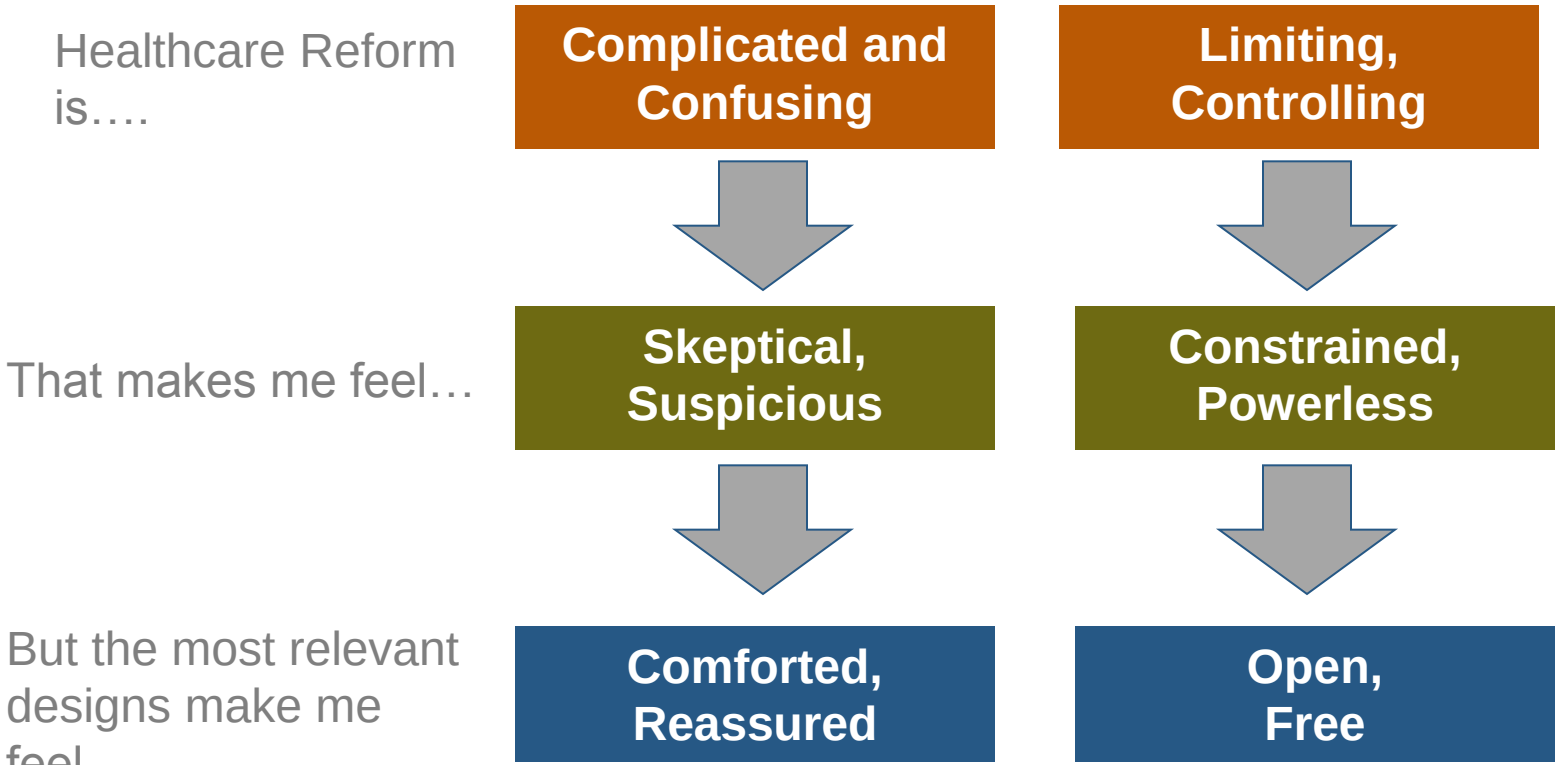
Current beliefs and emotions



GENERAL INSIGHTS

Most relevant designs

The Kentucky HBE brand names, logo designs and taglines that respondents found the most relevant were those that helped overcome these feelings and reassure them.



MOST RELEVANT DESIGNS

MOST RELEVANT DESIGNS

Most relevant designs

In particular, these two designs projected feelings of approachability, optimism and openness that respondents found “comforting,” “hopeful” and “reassuring.”

These feelings helped to counteract the skepticism and doubt many associate with Healthcare Reform.

kynect
Kentucky’s Health Connection

KENTUCKY
HEALTHCARE MARKETPLACE

MOST RELEVANT DESIGNS

"A new day in Kentucky"

The logo design of a sunrise over the state of Kentucky conveyed feelings of warmth, optimism and hope across segments of respondents.

Some respondents described its message as "A new day in Kentucky." In general, it visually positioned Healthcare Reform as a reason for hope, not fear.

This version of the design possessed an old-timey familiarity and, when coupled with the word "marketplace," triggered thoughts of an idyllic farmer's market, where merchants care about their customers.

The different colors of this version – which was exposed to respondents in Louisville only – possessed a "brighter," "more upbeat" feel, which contributed to the design's overall sense of optimism and hope. Many also commented on the familiarity of the "Kentucky" blue.

MOST RELEVANT DESIGNS

"A new day in Kentucky"

The optimistic, approachable feel of the design helped soften the name "Kentucky Healthcare Marketplace."

Healthcare marketplace… On its own, the name received mixed interpretations. While some interpreted a "healthcare marketplace" as a place offering "options" and "choices," others – primarily Disenfranchised respondents – found it somewhat threatening. For them, it evoked thoughts of large, impersonal marketplaces filled with risk, like "the stock market."

Thoughts of a farmers' market… But in the context of this design, the concept of a healthcare marketplace was much more universally accepted among respondents. The design triggered thoughts of "a farmers' market," where people "care about their customers" and "know you by name."

MOST RELEVANT DESIGNS

“A new day in Kentucky”

However, some respondents pointed out that the visual of this logo alone did not trigger thoughts of health, healthcare or health insurance the way that some other logo designs did.

Needing the name for clarity… These respondents mentioned that without the “Kentucky Healthcare Marketplace” tagline, the visual story of this design would be much less clear.

- They contrasted this design with others – specifically, one featuring an outline of Kentucky with a medical cross integrated into it – that visually communicated the idea of health or healthcare.

MOST RELEVANT DESIGNS

Friendly innovation

The “kynect” logo treatment featuring lowercase letters and a double-pointed arrow also conveyed a friendly, welcoming feel that helped overcome the negative emotions associated with Healthcare Reform.

Low stress, unintimidating… The logo’s inviting typeface, playful lowercase letters and soft blue color tones worked together to suggest an online environment that would not be stressful or intimidating.

Suggesting technology… In addition, this design was strongly associated with technology and the internet, and – among those who responded positively to it – a sense of progress and innovation. The lowercase lettering and font, and associations with internet “connection” contributed to this meaning.

kynect
Kentucky’s Health Connection

MOST RELEVANT DESIGNS

Friendly innovation

But a few respondents found this design to be too “playful,” describing it as “juvenile” and “childish.” Some were reminded of the Kinect toy brand. For them, the design’s playfulness tended to diminish its credibility.

Few pronunciation problems… Only a few respondents struggled to pronounce they word “kynect” in the context of this design. The arrow “connecting” the ends of the word and the name “Kentucky’s Health Connection” helped clarify the word’s proper pronunciation.

- Indeed, the pairing of this design with the tagline “Kentucky Healthcare Marketplace” did not seem to lead respondents to the correct pronunciation as quickly.

OTHER DESIGNS

OTHER DESIGNS

“Corporate” and “impersonal”

The “sunrise” and “kynect” designs contrasted with the designs below, which struck respondents as overly professional, stiff and corporate.

Reinforcing fears of Healthcare Reform… These designs tended to reinforce negative perceptions of a controlling and impersonal government bureaucracy. They evoked thoughts of large institutions and cold, impersonal environments.

Intimidating and unwelcoming… Instead of deriving a sense of solidity, trust and confidence from these designs, respondents felt intimidated and unwelcomed by them.

OTHER DESIGNS

“Corporate” and “impersonal”

And, as mentioned above, more respondents struggled with the pronunciation of KYNECT in this logo design, due to the different colors/shadings of the letters *KY* and the letters *NECT*.

“Kay-why-nect”… This visual separation encouraged respondents to initially pronounce the word “Kay-why-nect.”

Color made little difference… The alternative colors in these two designs appeared to make little difference in the overall meanings or emotions that they communicated.

OTHER DESIGNS

"A medical emergency"

For most, the cross had clear healthcare connotations. It reminded some of the "Red Cross;" others of "Blue Cross Blue Shield." But several respondents interpreted this design's visual story as being one of a "medical emergency" or "quarantine" for the state.

The name "KY Health Link" had strong associations with the internet – driven by the word "Link" and the "KY" abbreviation.

"Young and careless"

This design's block-style, angled lettering and state graphic reminded respondents of "graffiti," "t-shirt logos," and "college hoodies." As such, it projected a very youthful, but also "careless" and even "irresponsible" feel.

OTHER DESIGNS

“Tight” and “constrained”

Without an additional design element to soften their meaning, the words “Kentucky Healthcare Marketplace” caused many respondents to think about the kinds of large, bureaucratic marketplaces they fear.

In addition, the “tightly packed” letters of this design left respondents feeling “constrained.” Thus, the design reinforced negative perceptions of Healthcare Reform limiting choice and controlling decisions.

NAME OPTIONS

NAME OPTIONS

Very different meanings

The words *Marketplace*, *Connection* and *Link* convey very different meanings to respondents when used in HBE names.

Marketplace	Freedom of choice, many options, best price; but potentially impersonal, overwhelming, uncaring
Connection	A place for interpersonal interactions, shared experiences, caring; a place to find information but not necessarily to make a purchase.
Link	The internet; a web site that links you to other web sites; does not have its own content.

NAME OPTIONS

The Kentucky Healthcare Marketplace

The name “The Kentucky Healthcare Marketplace” was the most consistently chosen among respondents as best fitting with a description of the HBE.

Mixed reactions on its own… However, when used outside of the context of any logo or art direction, the word ***marketplace*** received mixed reactions. In general, the concept of a marketplace is a positive among physicians and small business owners, for whom it symbolizes “choice” and freedom from government control. But for many disenfranchised and self-employed respondents, marketplace represents an uncaring and threatening environment where one “loses money” and that can be “overwhelming” and “intimidating.”

- Most respondents felt that the word “The” in this name added a sense of authority and uniqueness to the exchange.

NAME OPTIONS

The Kentucky Healthcare Marketplace

Context matters… However, as mentioned above, the meaning and relevance of the word marketplace changed dramatically among disenfranchised and self-employed respondents depending on the context of logo designs – most notably, the "Sunrise" logo design. In this design, the word took on a much more welcoming, positive feel.

A place to buy…. Finally, the word "marketplace" makes it clear that the HBE is a resource through which one can actually purchase insurance.

NAME OPTIONS

Kentucky Health Connection

The word ***connection*** triggers thoughts of meaningful interactions among people who care about and understand each other.

More interpersonal than transactional… Its connotation appears to be much more interpersonal than transactional. Respondents imagined a place where they not only connect to resources and information, but also to "people who care" about their well-being.

A broad resource… The name "Kentucky Health Connection," which also was consistently chosen across groups, suggests a resource that connects Kentuckians to a broad range of health and healthcare-related resources, including, but not limited to, insurance.

NAME OPTIONS

KY Health Link

And finally, the word ***link*** almost universally evoked thoughts of the internet.

Links to internet sites… It appears to possess the most specific and least robust set of meanings of the name options tested in this research. Most respondents immediately thought of links to internet sites.

- As such, the name KY Health Link suggested to many a site with no real content of its own. Rather, they imagined an internet site that merely listed "links" to other sites where health and healthcare related content and resources exist.

Digital abbreviation… Interestingly, the abbreviation "KY" contributed to this association with the digital world, causing many respondents to think of the kind of short-hand that is used when texting or writing email.

TAGLINE OPTIONS

TAGLINE OPTIONS

Accessibility is key

Respondents connected most consistently across groups with taglines promising widespread accessibility of healthcare coverage.

"Affordable" and "every"…. Many respondents identified with words like "affordable" and "every" as particularly powerful in their suggestion that all Kentuckians would be able to find an insurance plan right for them.

These two taglines were the most consistently chosen across focus groups as best fitting a description of the Kentucky HBE.

Affordable, quality health coverage. For every Kentuckian.

Connecting Kentuckians to affordable health coverage.

TAGLINE OPTIONS

Accessibility is key

Affordable, quality health coverage. For every Kentuckian.

The tagline “Affordable, quality health coverage for every Kentuckian” was the most frequently chosen because of its straightforward, unambiguous promise of accessibility to quality health insurance.

Connecting Kentuckians to affordable health coverage.

But some respondents also found the notion of “connecting” to affordable coverage relevant and meaningful. Again, this word added an interpersonal dimension to the tagline and, for some, suggested that the exchange would not just “link” them to insurance carriers but actually “connect” them to a specific plan that would be right for them.

QUALIFIED HEALTH PLANS AND PREMIUM ASSISTANCE

QUALIFIED HEALTH PLANS

A tall order

None of the alternative phrases tested in this research left respondents with a complete and accurate understanding of the intended meaning…that HBE plans are offered by private insurance carriers that have met certain standards.

Indeed, this research suggests that it may be very difficult to communicate the idea of the exchange's qualified plans with just a few words.

Private Health Plans

For most, this phrase suggested plans that are "exclusive," "expensive" and "not for "everyone." Very few respondents took this to mean insurance plans offered by private carriers.

Commercial Health Plans

This phrase was almost universally interpreted as health insurance plans offered by employers (as opposed to an individual health plan).

QUALIFIED HEALTH PLANS

A tall order

Qualified Health Plans

Many interpreted this phrase to mean that *they'd* have to qualify to be eligible for the plans, rather than the plans having met certain standards.

Select Health Plans

This phrase suggests plans that are "the best of the best," "special," or "premium"… "like a select cut of meat."

Choice Health Plans

This phrase triggered thoughts of "freedom of choice," "variety" and "options."

Affordable Health Plans

"Affordable" caused many to think "cheap" and "inexpensive." It created expectations of plans that would be cheap but also not cover necessary healthcare needs.

PREMIUM ASSISTANCE

Two different meanings

The phrase Premium Assistance was clearly understood among some respondents – primarily the Disenfranchised – but not among others. Respondents interpreted it one of two ways.

Help paying my premiums… Those who correctly interpreted the phrase understood that "premium" referred to their health insurance premium and "assistance" referred to a subsidy they would receive to help pay this premium.

Premium customer service… But for others, this phrase meant a heightened level of customer service. They imagined a level of assistance to answer questions, identify solutions and address their health insurance needs that was "premium," "special" or "exclusive" in some way.

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Focus Group Impressions

In general, the focus groups were consistent between Paducah, London, and Louisville. Most participants had very little knowledge of the ACA and the Benefit Exchange. If they know anything, it is that they will have to have insurance. However, it is not a major concern at this time. This is good for the Exchange because it gives us time to educate the public and provides a neutral playing field. Participants have not yet made up their mind about "Obamacare."

Take-Aways

- The #1 need is education. Even the physicians said they do not know much about the ACA, benefit exchanges, or how it will affect them.
- Choice is very important, but both too many choices and too few choices are bad. Consumers are worried that they will be overwhelmed when it is time to make a decision. The key here is that the website present rate/plan information in a user-friendly format. While it is not currently in the design, consumers want to be able to look at different plans at the same time like they do with Expedia.
- Connection to another person is important. We will need to emphasize our 24/7 Contact Center, as well as Navigators/In Person Assisters who will help face to face.
- "Affordable" and "quality" are not a natural fit. Many thought they were mutually exclusive; however "quality" is more neutral than negative. Also, affordable health coverage is seen currently by consumers as cheap payments with such high deductibles/co-pays as to be worthless. Explaining quality and affordability will be a necessary focus in our education phase.
- Healthcare coverage is definitely an economic decision for consumers who do not get it through their employers.

Design Comments

Names

- Important to say "Healthcare" which reads as insurance over "Health" which brings to mind wellness or doctors.
- "Connection" is broader and more appealing than "Link" which reads as impersonal.
- "Marketplace" does not initially test well bringing to mind a hectic, chaotic shopping experience; however, when softened by color and logo, it becomes acceptable.
- "*The*" Kentucky Healthcare Marketplace was more favorable than not, but not essential. "Kentucky*'s*" Healthcare Marketplace tested better than "Kentucky" Healthcare Marketplace.

Colors

- Blue = Kentucky. Consumers are comforted by blue. As a rule, the participants were resistant to other logo colors.

Logos

- In the post focus group debriefing, it was apparent that the choice comes down to two logos: the sun rise (E1) and the kynect arch (A2). Both are seem as approachable. The sun represents where Kentucky is today and its rural roots, while the arch was seen as a more professional, modern Kentucky.
- The sun logo read as "hopeful," and "a new day." It was seen as comfortable and non-threatening, universal. Consumers would go to a website with that logo. If chosen, it will need some type changes. The word "Healthcare" was perceived as too small and the type style read UK. Doe Anderson is working on revisions.
- The "kynect" logo with the arch was the logo many respondents felt best fit the Exchange when the Exchange was explained to them. The arch reads as "connection to all people in Kentucky." Most participants read "kynect" as "connect." Older participants struggled a little with the name, associating it with texting. One question would be how "kynect" would test with ESL citizens.

Taglines

- The two that tested best were:
    - Affordable, quality health coverage. For every Kentuckian. (H1)
    - Connecting Kentuckians to affordable health coverage. (K)
- In the two physician groups, there was blow back that the words "For every Kentuckian" were not true. Not everyone would be able to get insurance through the ACA. Consumers did not bring that point up. This could easily be fixed by saying "For Kentuckians."
- "Quality" is important to some people, and makes others think of the wool being pulled over their eyes. As a rule, women liked "quality", reasoning that quality is better than what they have now. The men were more likely to say that anything affordable is not quality. Affordable was the important concept, giving us room to decide if we want to include quality.
- The idea of "connecting" was key in tagline K. It has a personal feel to consumers. It says two-way street.

Website Terminology

- Consumers do not relate "Premium Assistance" to help with paying your insurance bill. Premium was most often read as "special or elite". Or, it was seen as a helpline to understand your premium. We might consider "Payment Assistance."
- The label "Private Health Plans" is also confusing. It reads as expensive and exclusionary. All words tested had similar problems, including "Qualified," "Select," "Choice," "Affordable," and "Approved." Of those tested, "Choice" was the best when the concept was explained.

United States

Reshaping Health Care

Best Performers Leading the Way

2013

18th Annual Towers Watson/National Business Group on Health Employer Survey on Purchasing Value in Health Care

National Business Group on Health

TOWERS WATSON

United States

2013

Employer Survey on Purchasing Value in Health Care

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Executive Summary

"While U.S. employers remain committed to health care benefits for active employees over the next five years, they are redefining their financial commitment in the short run and are more reluctant to commit to coverage for employees over a longer period."

The 2012 presidential election and the Supreme Court decision on the Patient Protection and Affordable Care Act (PPACA) are solidly behind us, and U.S. employers will move aggressively this year and next to comply with the requirements of the health care reform law. Their actions are driven in large measure by a need to manage rising costs and to avoid triggering the 2018 excise tax on high-cost plans. That is one of the key findings of the 18th annual Towers Watson/ National Business Group on Health (TW/NBGH) Employer Survey on Purchasing Value in Health Care.

Best Performers Spearhead change

Many respondents continue to employ strategies that manage costs, respond to health care reform, improve health care quality, and increase employee engagement in their personal health and use of health care services. But in this report, we've focused specifically on the actions taken by a group we call "best performers" — those in the top tier of respondents whose costs have increased over four years at a much lower rate than the TW/NBGH median. More than other respondents, these organizations are using emerging strategies to improve delivery and cost management. They are focusing on supply-side strategies, including vendor performance targets, cost transparency, value-based benefit designs and holding providers accountable. As a result, their employees' share of health care costs are also lower, their total rewards packages more competitive and their employee value proposition more successful.

A Continuing Commitment to Providing Benefits — at Least for Now

While U.S. employers remain committed to health care benefits for active employees over the next five years, they are redefining their financial commitment in the short run and are more reluctant to commit to coverage for employees over a longer period. Only 26% of respondents say they are very confident that health care benefits will be offered by their organization 10 years from now. This is not surprising given the breadth of changes that have occurred and will continue to occur in the health care landscape. For example, employers may be waiting to see whether the public exchanges (due to launch in 2014) will provide reliable alternative coverage for certain segments of their workforce, or even their entire workforce. They may want to understand how their

plans will fare under the 2018 excise tax provision. And they may want to wait and see what their competitors will do before they make major changes to their health benefit plans.

One thing is sure: Transformative changes to health care delivery and financing in the U.S. — discussed for decades and passed into law in 2010 — have begun in earnest. And employers, which collectively are among the biggest payers in the health care financing system, are bound to make major changes, both to stay competitive and to remain influential stakeholders.

Changes Ahead for Employees and, Especially, Retirees

Active employees and their dependents, as well as retirees, will be affected by coming changes. Employers — which by and large do not expect health care reform to lower their costs — will continue to redefine their financial commitment to employee health care. They will likely continue to seek more financial participation on the part of employees, either through greater across-the-board cost sharing or through other strategies such as reduced dependent subsidies.

Imminent change in employer strategy is also afoot for part-time employees who work 30 or more hours a week. For them, under the PPACA, employers may pay a penalty if affordable, qualified coverage is not made available.

For retirees, change is coming even sooner than for active employees. More employers are reducing or eliminating their commitment to post-65 retiree health care, with an eye to exploring opportunities that the public exchanges may create for pre-65 workers. Beginning next year, pre-Medicare retirees will be eligible for guaranteed coverage, potentially with a subsidy, depending on income through a completely new marketplace. Survey respondents have expressed a willingness to help with the cost, transition and communication related to alternative coverage for those interested in retiring before they qualify for Medicare.

Our survey report provides aggregate responses from 583 organizations with a collective $103 billion in total 2012 health care expenditures. Last year, we reported that the significant changes in the U.S. health care system and continually rising costs drove some employers to revisit their total rewards program (that is, the combination of basic rewards such as salary and benefits, performance-based pay, and nonfinancial rewards such as training and education). They aimed to recalibrate their reward portfolio to balance cost concerns with their employees' needs for competitive salary, access to affordable health care and a secure retirement. This year, the potential effect of the PPACA excise tax in 2018 on high-cost health care plans threatens that balance over the long term. The survey results show that many more employers — including those that sat on the sidelines waiting for political and judicial clarity — will seek strategies to lower costs, improve health and avoid the tax. The actions of our best performers may well provide a playbook that others can follow to achieve their goals. This is especially true for those whose strategies and tactics have led to less-than-desirable financial and health results.

"Transformative changes to health care delivery and financing in the U.S. — discussed for decades and passed into law in 2010 — have begun in earnest."

Key Themes

"More respondents say they will work with their health plan vendors to rethink plan design, and improve the quality and efficiency of member care."

Employers take aggressive action
After plan changes, average total health care costs per active employee are expected to reach $12,136 in 2013, up 5.1% from $11,457 in 2012. This is the lowest increase in 15 years and down slightly from a 5.2% increase in 2012. Since the mid-2000s, trend has moderated in the single digits, largely due to an increasing number of employers that manage costs by emphasizing employee accountability (including increased employee costs), and investment in programs and emerging technologies that support and cultivate a healthy and productive workforce. Now, with the PPACA taking effect, the excise tax looming in 2018 and medical trend still double the rate of inflation, we expect to see even more profound change — recalibrated strategy and aggressive action — among larger numbers of employers. More respondents say they will rethink plan design, and improve the quality and efficiency of member care. Strategies include greater vendor transparency, value-based pricing and new reimbursement models.

Best performers set up for long-term success
Our best performers (those whose costs have grown over four years at or below the TW/NBGH median) had an average trend of 2.2%, less than half the mean and roughly in line with general inflation. Their strategies focused on efforts to contain both their costs and their employees' costs so they have a greater share of their budget to devote to other aspects of their rewards, including salary increases and retirement, with an emphasis on value and effectiveness in achieving their attraction and retention goals.

Marketplace changes gaining momentum
Nearly all respondents (92%) anticipate at least modest changes in the health care marketplace over the next five years, and nearly half expect significant changes (44%) or a complete transformation (3%). Many believe the adoption of emerging technologies such as telemedicine, mobile applications, e-visits and data-enabled kiosks will create new access points for health care delivery. Respondents also expect provider reimbursements to be more closely tied to performance — including quality of care, efficiency and health outcomes — than they are today. While 49% of respondents are optimistic about price transparency emerging to support point-of-care decisions, very few (7%) expect health care cost increases to approach the rate of inflation in the next five years.

Rising employee costs impact affordability
Employees' share of premiums increased 8.7% between 2012 and 2013, with the dollar burden rising from $2,658 to $2,888. In fact, employees contribute 42% more for health care than they did five years ago, compared to a 32% increase for employers. Likewise, out-of-pocket expenses at the point of care continue to rise — up by 15% over the last two years, from 15.9% to 18.4%. The total employee cost share, including premiums and out-of-pocket costs, has climbed from about 34% in 2011 to 37% in 2013. Meanwhile, annual salary increases have averaged only 1.6% over the last three years. From a total rewards perspective, rising health care contributions are taking their toll on employee take-home pay. Employees are also paying more through out-of-pocket costs at the point of care. Continued increases in the cost of health care may motivate employees to use employer programs designed to contain and lower costs for both employers and employees by supporting healthier choices, greater accountability and acceptance of value-based plans.

Redefining contribution strategy
The increase in employee contributions includes a rise in the share of premiums paid by employees — from 22.5% in 2008 to 23.8% today. That increase is due partly to subsidy shifts for dependents: Over the last three years, more than 70% of companies increased employee share or premium contributions, and dependent coverage costs increased at a higher rate than single coverage.

Over the next three years, more than 80% of respondents plan to continue to raise the share of premiums paid by employees, and they anticipate

"Companies are increasingly embracing health plan strategies that use financial incentives to hold providers accountable."

increases in all coverage tiers. The use of surcharges for spouses is also growing. Twenty percent of respondents use them now, and an additional 13% plan to next year. Best performers lead all other employers in raising dependents' share of premium contributions as a percentage of total premiums.

As ABHPs evolve, their growth escalates

Account-based health plans (ABHPs) can be an important strategy for reining in costs in advance of the 2018 excise tax and facilitating the shift toward greater accountability from employees and more consumer-like behavior in their purchase of health care. Today, 66% of companies have an ABHP in place, and another 13% expect to add one by 2014. Total-replacement ABHPs are also on the rise. Nearly 15% of respondents with an ABHP use a total-replacement ABHP, up from 7.6% in 2010. Over the same period, median enrollment in ABHPs has nearly doubled, surging from 15% in 2010 to nearly 30% in 2013. This increase has been helped significantly by employers choosing complete replacement of their plans with an ABHP. Nearly one-quarter of all respondents may offer an ABHP as their only plan option in 2014 if they follow through with their current plans to make that change. ABHPs have also become more prevalent as they've been restructured to embed incentive strategies and align with postretirement strategies.

Employers still strongly committed to subsidizing health care benefits

Eighty-five percent of companies say their strategy for employee cost sharing for health care coverage will be an important component of their overall value proposition over the next five years — virtually unchanged from today (90%). However, confidence that they will continue to offer health care benefits 10 years from now remains low (26%), suggesting that employers are uncertain about the direction of the marketplace in the coming years. They may want to see how successful the exchanges turn out to be or how many leaders in their industry eventually choose to pay penalties to direct employees to an exchange rather than continue to offer health care.

Eroding coverage for retiree medical benefits

Employer subsidies for retiree medical coverage have sharply declined over the last two decades, with only 15% of companies offering them to newly hired employees today. Those that continue to provide some level of financial commitment are increasingly shifting to account-based designs. Some are facilitating retiree access to individual and group Medicare plans through a Medicare coordinator to ease this transition and lower subsidies for Medicare-eligible retirees.

Employers embrace incentives and emerging payment approaches to improve the quality of care delivered

Companies are increasingly embracing health plan strategies that use financial incentives to hold providers accountable. Although the percentage of respondents choosing these strategies remains under 25%, many more employers say they expect more provider accountability on these measures next year (33%). We expect this trend to grow now that Medicare, Medicaid and many insurance companies have started using value-based purchasing.

Raising the bar on engagement strategies

Nearly two-thirds of respondents offer employees and their spouses financial rewards to encourage participation in health management programs. All signs point toward tougher requirements for earning financial rewards in the coming years. This year, 6% more employers than last year, for a total of 16%, limited these rewards to participants who showed measurable improvement. Another 31% say they are considering this approach for 2014. But it's not all about financial incentives. Companies recognize they need to develop a supportive workplace culture to engage employees in their own well-being. They are designing creative approaches, leveraging new ideas from behavioral economics, using social media to personalize health messages, placing greater emphasis on the physical work environment and using senior leaders to champion workforce health goals.

About the Survey

The 18th annual Towers Watson/National Business Group on Health Employer Survey on Purchasing Value in Health Care tracks employers' strategies and practices, and the results of their efforts to provide and manage health benefits for their workforce. This report identifies the actions of best-performing companies as well as current trends in the health care benefit programs of U.S. employers with at least 1,000 employees *(Figure 1)*. Respondents were also asked about the specific implications of the PPACA for their health care benefit programs.

The survey was completed by 583 employers, between November 2012 and January 2013. It reflects respondents' 2012 and 2013 health program decisions and strategies, and in some cases, their 2014 plans. Respondents collectively employ 11.3 million full-time employees, have 8.5 million employees enrolled in their health care programs and operate in all major industry sectors (*Figures 2* and *3*). In 2013, respondents expect to spend, on average, $12,136 per employee on health care, which equates to a collective $103 billion in total health care expenditures.

Figure 1. Number of full-time workers employed by respondents

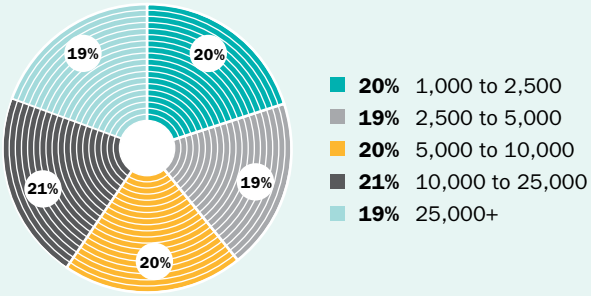


Figure 2. Region where the majority of benefit-eligible workforce is located

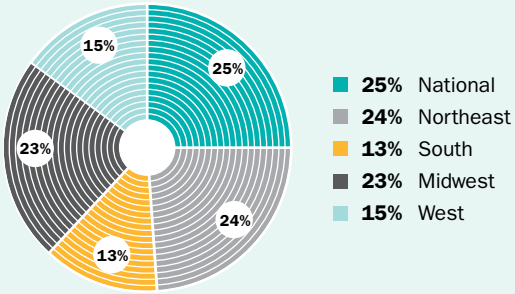
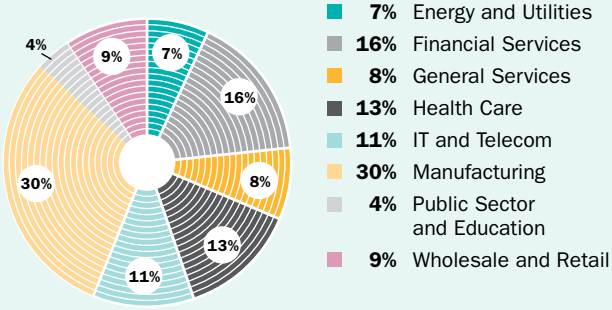


Figure 3. Industry groups



A Note About Health Care Costs

Health care costs and rates of increase throughout the report are based on aggregated company values, combining all plans — insured and self-insured — for all plan types and coverage tiers for actively enrolled employees. Health care cost measures include medical and pharmacy benefit expenses, company contributions to medical accounts — flexible spending accounts/health reimbursement arrangements/health savings accounts (FSAs/HRAs/HSAs) — and costs of administration, including any health management program costs and program participation incentives paid by the plan.*

Health Care Costs per Employee

The following terms are used to define health care costs throughout the report, which include the combination of employer and employee portions of health care expenses:

- **Employer costs** — Costs per employee, excluding employee contributions (from their paycheck) and point-of-care costs
- **Employee contributions** — Employee portion of total plan costs paid per paycheck
- **Out-of-pocket costs at point of care** — Employee spend on deductibles, copays and coinsurance; also called point-of-care costs
- **Total plan costs** — Total costs paid by the plan, including both employer costs and employee contributions
- **Total health care expenses** — Total costs considered for payment, including employer costs and employee contributions and point-of-care costs

Health Care Cost Trends

The rates of increase shown throughout the report are based on the change in the various health care cost measures (noted above) per actively enrolled employee. Trends are shown after changes to plan designs and employee contributions. Rates of increase are also provided if the responding companies made no changes to the medical or pharmacy plan designs, or employee contributions.

*Administration costs include claim-processing fees, network access fees, utilization review fees, stop loss premiums, and any health management program costs and program participation incentives paid by the plan.

Strategy and Planning

What's on the Horizon?

With the PPACA's main directives taking effect in January 2014, most employers foresee big changes ahead for employer-provided health care plans, but they are still not sure exactly what the changes will look like. When asked the degree to which they thought plans would change by 2018 — the year that the excise tax on high-cost plans takes effect — 92% of employers said the plans would be different, with 47% saying they anticipated significant or transformative change *(Figure 4)*. However, when asked which changes they thought were most likely, less than 50% pointed to the likelihood of any specific change in the next five years *(Figure 5)*. This could indicate that the details of these changes are still making their way into the employer mainstream. In fact, many respondents were neutral on the value of specific changes, perhaps because the landscape is rapidly evolving. This is true for both the emerging pay-for-performance strategies and the health care exchanges. The one exception is our best-performer group. Some best performers chose new strategies for 2013, and more plan to do so in 2014 (see Strategies Planned by Best Performers, page 32).

Companies were most confident they'd see advances in vendor price transparency by 2018, with 49% choosing it as an option. They may be hoping the investments they've made or plan to make in transparency tools will pay off. These tools are designed to help employees gain information about health care prices charged by different vendors and their health care results. Emerging technologies used to create new access points for health care, including e-visits, telemedicine and data-enabled kiosks, placed second, with 45% of employers saying they would have an impact on the marketplace in the next five years.

Figure 4. Anticipated change in employer-sponsored health care by 2018

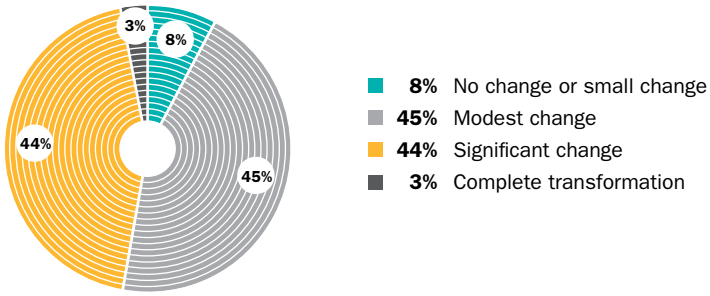


Figure 5. Likelihood of the following changes in the health care marketplace over the next five years

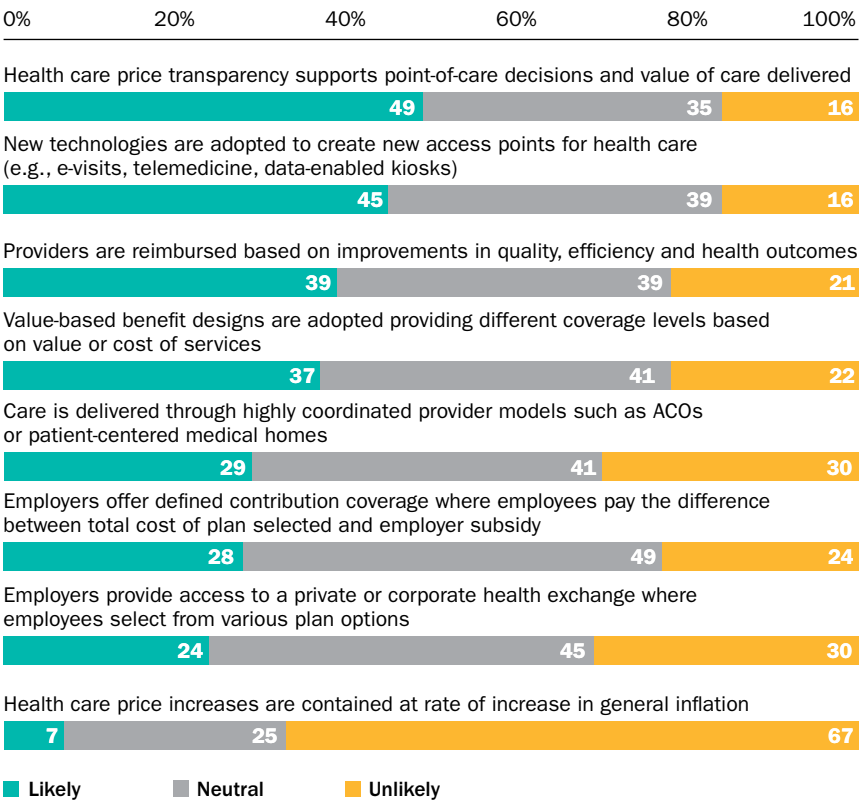
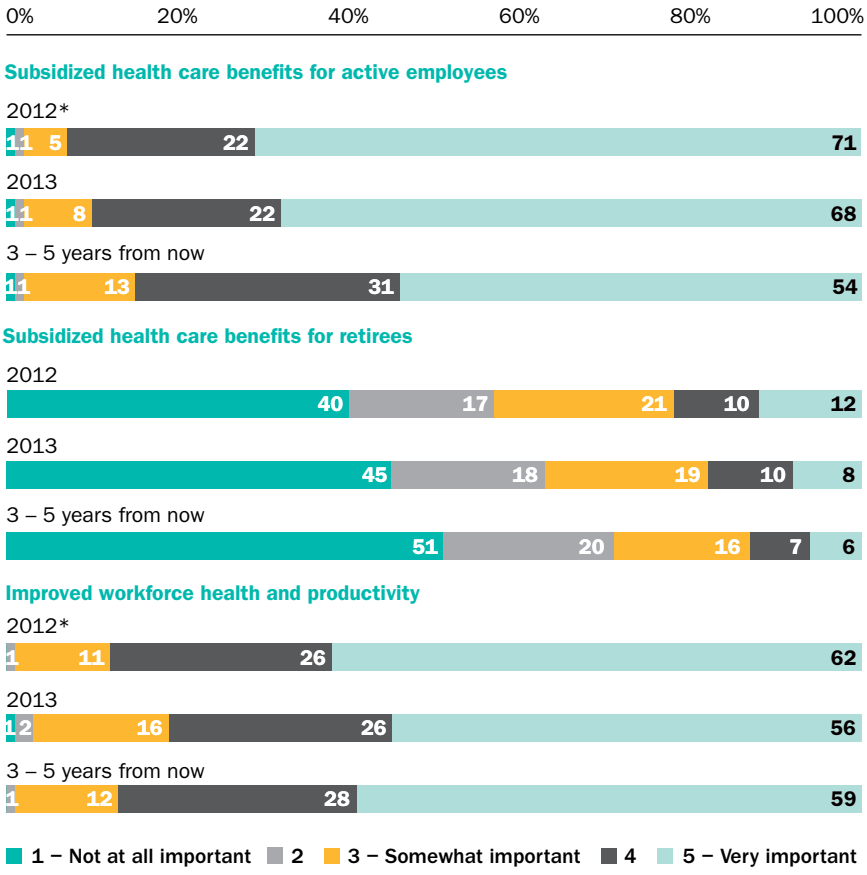
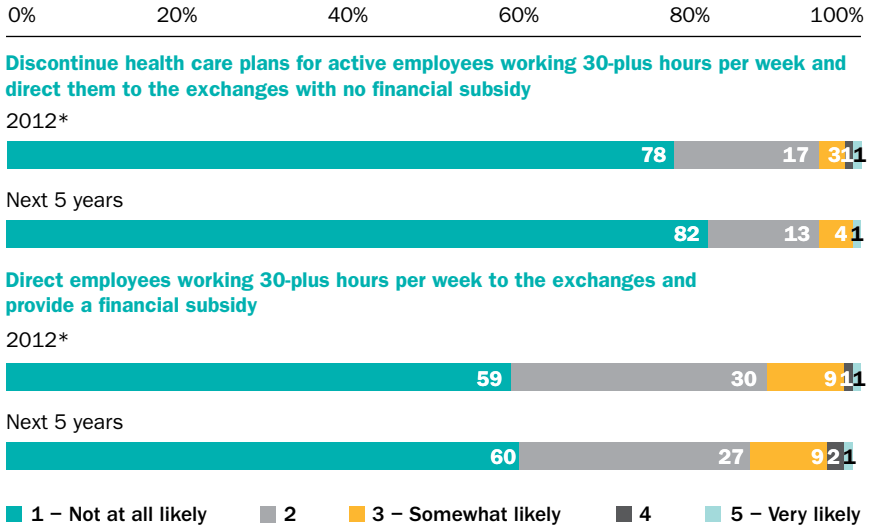


Figure 6. Importance of employer subsidies, and health and productivity to company's employee value proposition in 2012 and beyond



*17th annual TW/NBGH Survey

Figure 7. Likelihood organizations will take the following action in the next five years with their full-time, active health care programs



*2012 Health Care Changes Ahead Survey

While not ranked as highly as other marketplace changes and largely still in development, the use of private exchanges where employees would select from options was selected by one in four employers as likely to be a new channel for coverage over the next five years.

With the exact future of the health care marketplace still unclear, one thing is certain: Employers, under across-the-board cost pressure, do not anticipate any change in the steady rise of the cost of health care over the next five years. A full 67% said that it was unlikely that annual increases would slow down to the rate of inflation anytime soon, and another 25% took a neutral position probably because they are not sure how the PPACA might affect costs.

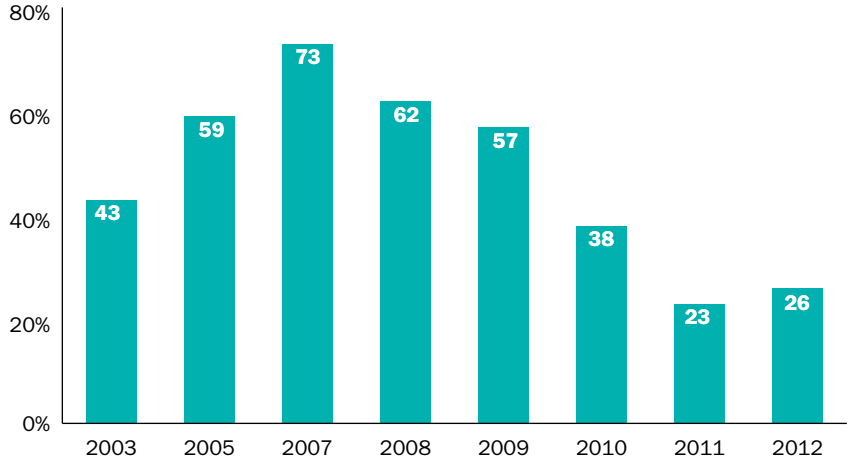
Commitment to Employer-Sponsored Health Care

Most respondents (71%) said subsidized health care benefits for retirees will not be important to their employee value proposition (EVP) in three to five years *(Figure 6)*. However, employers believe their subsidies for health care, and improved health and productivity for active employees, will remain a key component of their EVP in the next five years, although somewhat less important than today. Further, 82% of respondents said it is not at all likely that their organization will direct active employees to a public exchange without a subsidy in the next five years. Even with a subsidy, most organizations haven't changed their minds about directing actives to an exchange: 59% said it was unlikely in 2012, and 60% say it is unlikely by 2018 *(Figure 7)*.

Confidence About the Long Term

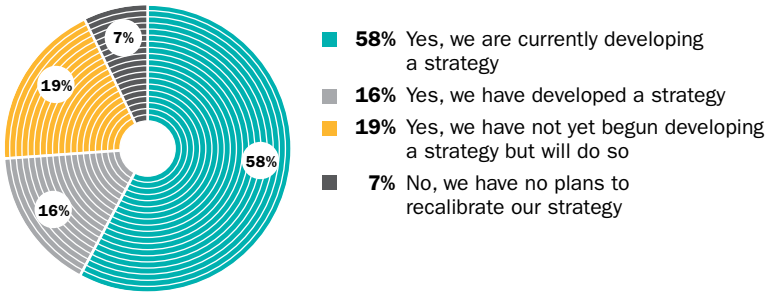
Despite the deceleration in health care cost increases in recent years (e.g., a median of 8% in 2006, to 5.9% last year and 5.1% this year), respondents' confidence that their organization would provide health care benefits a decade from now has declined since the passage of the PPACA in 2010 *(Figure 8)*. A full 93% of respondents say they have updated or will be updating their health benefit strategy *(Figure 9)*. Not surprisingly, 57% say they are changing their strategy due to the impact of provisions in the PPACA. These employers would do well to study the actions of our best performers for strategies that engage employees, health care providers and vendors in thinking about the cost and value of health care (see page 30).

Figure 8. Employers' confidence that health care benefits will be offered at their organization a decade from now remains low



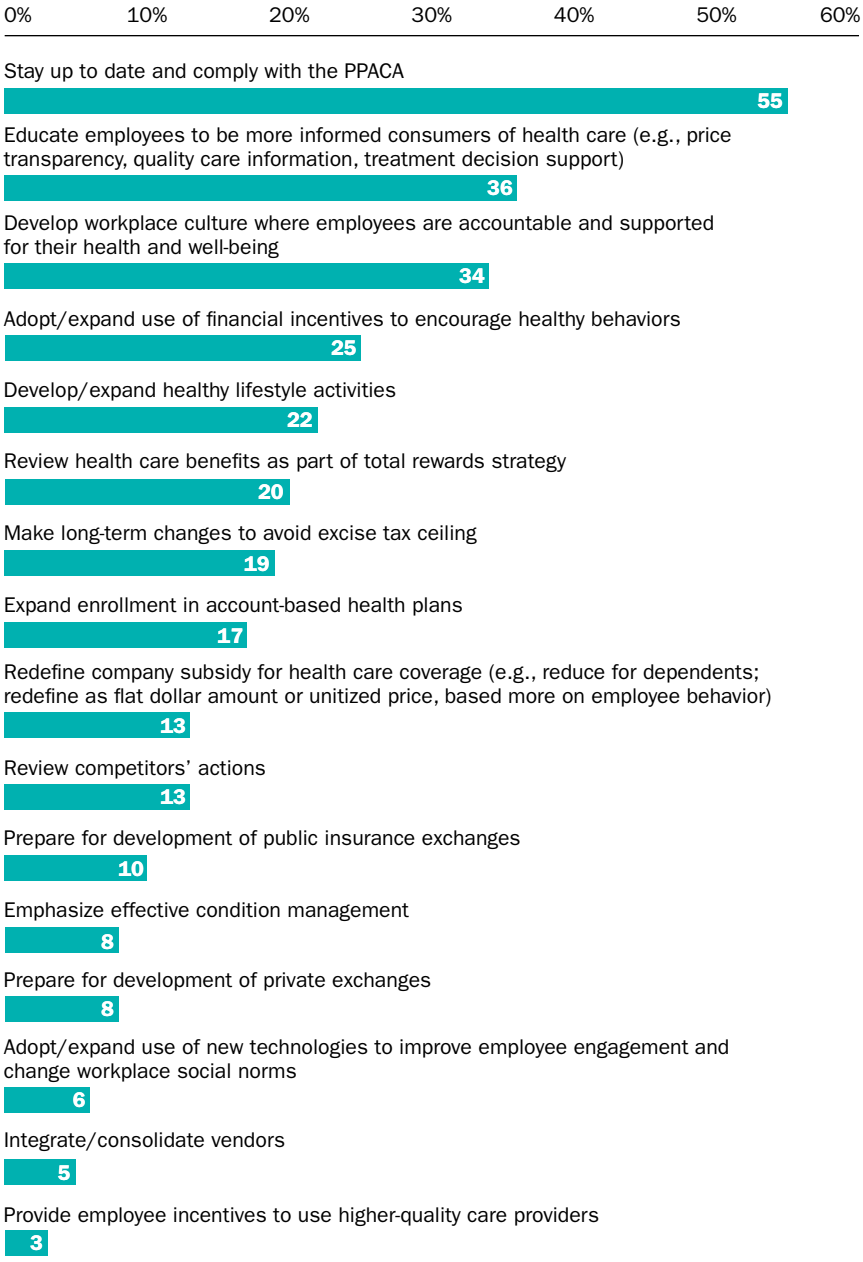
Note: Indicates responses of "very confident"

Figure 9. Many companies are focused on recalibrating their health care strategy for 2014 and beyond



"These employers would do well to study the actions of our best performers for strategies that engage employees, health care providers and vendors in thinking about the cost and value of health care."

Figure 10. Top focus areas of employer's health care strategy in 2013



Top Focus Areas

With the exchanges looming and other regulations being implemented, staying up to date with the PPACA returns as the top priority of employers in 2013, just as in 2011. Last year, it fell to second place behind building a supportive workplace culture — including physical environment, leadership support, and education and information to support more informed decisions, which rate in the second and third positions of overall top priorities in 2013 *(Figure 10)*. All indications are that employers will continue to focus on the most effective ways to control rising costs and improve employee health and well-being.

Cost Trends

In a recent Bank of America/Merrill Lynch survey of CFOs, 60% cited health care costs as their top concern for 2012. That's a new trend for corporate finance leaders, who traditionally have left health care benefits in the hands of HR. What's more, in a recent Towers Watson survey of CFOs and CHROs, Finance respondents anticipated a growing role for themselves in benefit strategy. At the moment, the HR/Benefits function still manages employee health care at 58% of companies.

It should be no surprise that health care is on CFOs' radar screen in a bigger way than ever before. The PPACA's major provisions and attendant penalties that could affect the bottom line, coupled with the continued increase in health care costs, have brought the issue front and center to the C-suite and the board.

Although medical cost trends have stabilized at between 5% and 7% over the last five years as a result of plan design and contribution changes, these benefit costs are still growing at twice the rate of inflation and have outpaced wage growth for more than a decade *(Figure 11)*. In fact, wages have been rising between 2.0% and 3.5% annually for much of the last decade, dipping to 1.6% over

HR/Benefits still in charge (at most companies)

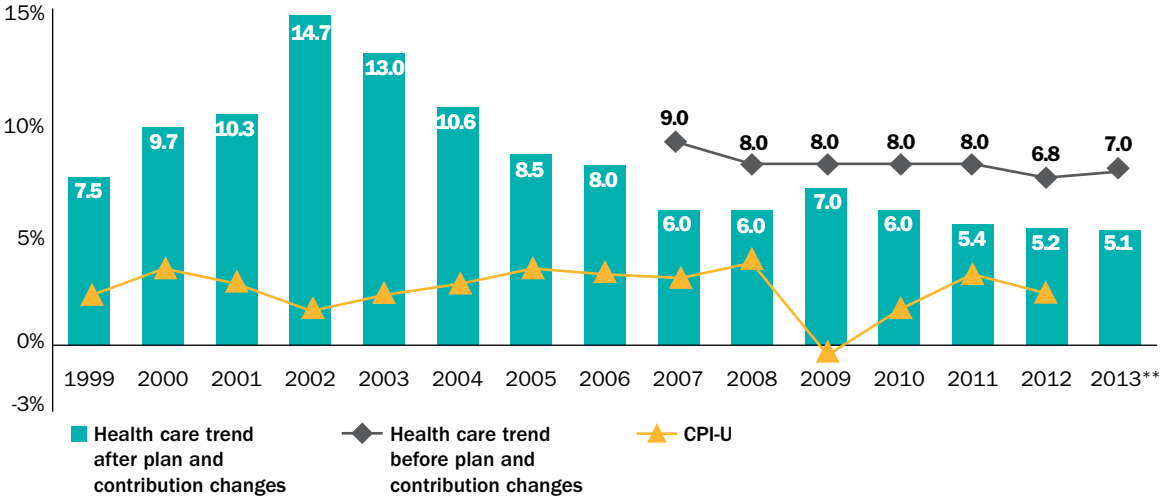
58% **of companies govern their health care plan(s) exclusively through their Benefits department, whereas**

11% **of companies use only a separate non-board level committee.**

Many companies (24%) use several committees, with the majority using a combination of the Benefits department and a separate non-board committee to oversee the health care plan (12%).

Statoid

Figure 11. Health care cost increases have leveled off*



Note: Median trends in employer costs for actively enrolled employees; CPI-U extracted from the Department of Labor, Bureau of Labor Statistics

*A company's medical benefit expenses for insured plans include the premium paid by the company. For a self-insured plan, these expenses include all medical and drug claims paid by the plan, company contributions to medical accounts (FSAs/HRAs/HSAs), and costs of administration minus employee premium contributions. The annual change in costs is based on costs for active employees after plan and contribution changes. Respondents are asked to report trends directly in the survey.

**Expected

"For some employees, the question of affordability becomes even more evident as their paycheck deductions for health care premiums rise while their wage increases shrink."

the last three years. The slower pace of health care cost trends, then, does not diminish the growing affordability challenge for active employees, who see an increasing share of their total rewards going to health care benefits. Unquestionably, organizations where HR and Finance are aligned on a total rewards strategy will be best positioned to assess both the cost and talent implications of decisions in the future.

In 2012, medical costs after plan and contribution changes rose 5.2%, compared to 5.4% in 2011, and are expected to increase by 5.1% in 2013. To put this stabilization in context, it is important to realize that without changes in plan design and increases in employee contributions, average cost trends would have been 6.8% in 2012 and would be anticipated to be slightly higher (7.0%) next year. Pharmacy costs after plan changes rose 4.5% in 2011, 5% in 2012 and are also expected to grow at 5% in 2013. Again, without plan changes, the rates would have grown 6% in 2011 and 2012, and would be 7% next year. It is clear that changes in plan strategy can help hold the line on costs, but the most successful companies embrace a more holistic strategy (see Strategies for Long-Term Success, page 33).

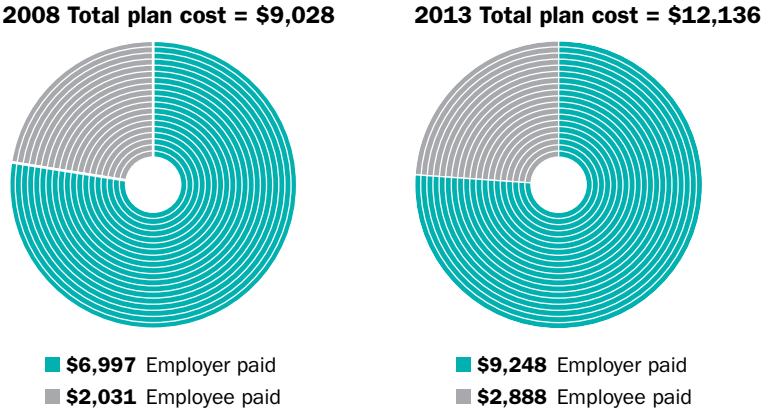
Figure 12. PEPY medical and drug costs

	Total plan costs		Employer costs	
Percentile	**2012**	**2013***	**2012**	**2013***
Mean	**$11,457**	**$12,136**	**$8,799**	**$9,248**
25th	**$9,507**	**$9,867**	**$7,236**	**$7,593**
50th	**$10,909**	**$11,461**	**$8,595**	**$8,900**
75th	**$12,672**	**$13,592**	**$10,158**	**$10,700**

Note: Costs include medical and drug claims for actively enrolled employees. Total per-employee per-year (PEPY) costs include both employer and employee shares. Employer costs are less employee contributions.

*Expected

Figure 13. Total employee/employer health care costs



Active Employees

Employers anticipate total costs paid by the plan will reach $12,136 per active employee in 2013 — up from $11,457 in 2012 — a 5.9% increase in total costs *(Figure 12).* The average employer share of total plan costs continues to climb at a rate greater than the CPI and wages — $9,248 in 2013, compared to $8,799 in 2012, up 5.1%. They pay 32% more than they did five years ago, while employees contribute over 42% more *(Figure 13).*

Employees paid, on average, 23.2% of total premium costs in 2012 and are expected to pay 23.8% in 2013 as companies take steps to control their costs. In paycheck deductions, this translates into an average employee contribution of $2,658 to premiums in 2012, which is expected to rise to $2,888 in 2013 — an 8.7% increase in one year.

In addition to premium increases, companies anticipate that employees' out-of-pocket expenses at the point of care will rise to 18.4% of total allowed charges in 2013, compared with 17.8% in 2012 and 15.9% in 2011.

For some employees, the question of affordability becomes even more evident as their paycheck deductions for health care premiums rise in order to fund higher health care costs while their wage increases shrink. Altogether, the share of total health care expenses, including premium and out-of-pocket costs paid by employees, is expected to be 36.9% in 2013, up from 35.9% in 2012 and 34.4% in 2011.* This means that for every $1,000 in health care expenses in 2013, employees pay $369 for premiums and out-of-pocket costs, and employers pay the remaining $631.

Over the last year, companies have stepped up actions to position their programs for long-term success, especially with the PPACA's excise tax scheduled to take effect in 2018. Evidence of this trend to try to control costs can be seen in the rise of ABHPs and increased employee enrollment in them (see Account-Based Health Plans, page 24).

As employers begin to change their strategies to comply with the PPACA and avoid the excise tax, it's important to note the dramatic difference between the average company's costs and those of companies that have employed strategies that

*Total health expenses include employer and employee portions of the premiums and employee out-of-pocket costs at the point of care (including deductibles, copays and coinsurance).

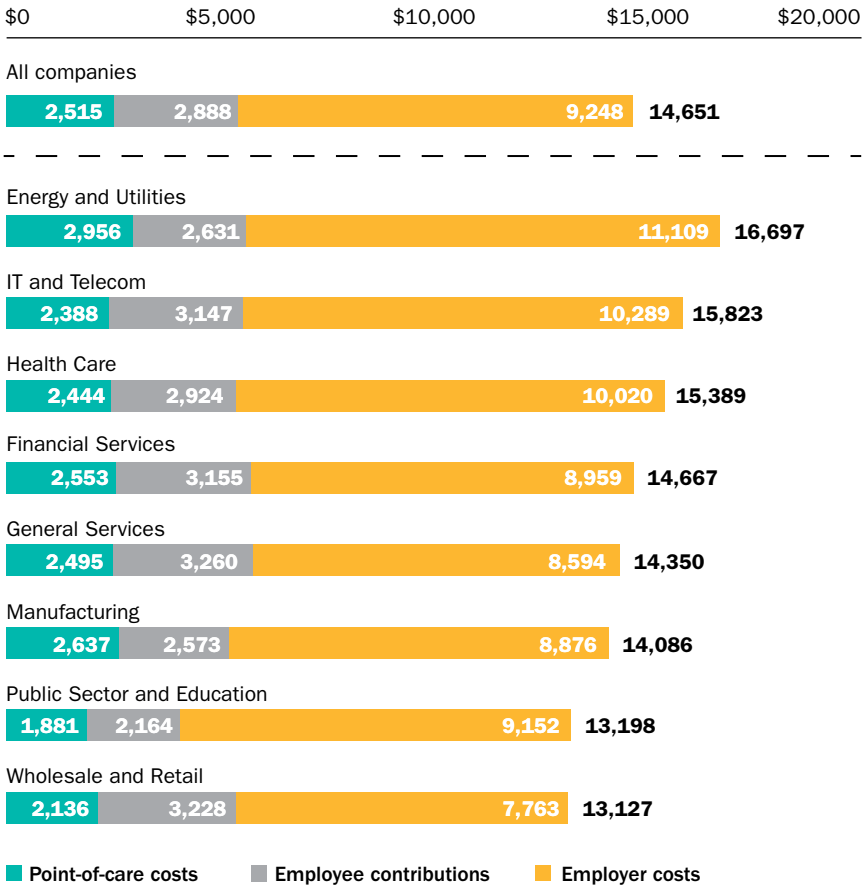
put them in the lowest quartile of costs. These companies' costs are nearly 20% lower than average. At current rates, those performing at the average are four years ahead of the trend curve. In other words, those companies with costs in the lowest quartile in Figure 12 won't reach the cost levels of the average company today until 2017.

A Look at Industry Differences

There is nearly a 30% difference between low- and high-cost industries in our survey *(Figure 14)*. While this represents, in part, differences in demographics and family size, as well as overall plan values, this variation in costs suggests that health care has a larger role in the total rewards design in some industries. It's particularly interesting that total employee costs (the dollar amount of out-of-pocket expenses at the point of care plus employee contributions) are relatively similar across all industries except the public sector. This means that employer costs for health care benefits range even more broadly. For instance, the energy industry, on average, spends 43% more than the retail industry for employee health care. This disparity telegraphs that some industries will need to be more aggressive than others to bring their costs under the excise tax limits.

"It's particularly interesting that total employee costs (the dollar amount of out-of-pocket expenses at the point of care plus employee share of premiums) are relatively similar across all industries except the public sector."

Figure 14. Total health care expense per employee per year by industry, 2013



Note: Total health expenses include employer and employee portions of the premiums and employee out-of-pocket costs at the point of care (including deductibles, copays and coinsurance).

Pre-65 and Post-65 Retirees

Retirees, especially pre-Medicare eligible, face even greater affordability challenges than active employees and pay a considerably larger share of coverage costs. Once retirees reach age 65 and become eligible for Medicare benefits, affordability improves: They pay, on average, $2,086 per year for single-only coverage and $5,377 for family coverage.

However, retirees under age 65 pay more than twice that — nearly $4,701 per year in premiums for single-only coverage and over $11,363 per year for family coverage. Without some form of subsidy such as an employer plan, many of these employees may find it difficult to retire and secure affordable coverage. Even with an employer subsidy, some may still find it too costly.

The realization that their subsidy is too little for retirees to afford coverage (especially those pre-65) is leading some companies to reassess the value of their retiree medical benefit as well as the role retiree health benefits play in their total benefit mix. The opening of the health care insurance exchanges in 2014, which could provide access to comparable health care at lower rates, may prove a more cost-effective alternative for some companies and their retirees (see Retiree Medical Plans, page 16).

Figure 15. Annual premiums and rates of increase for retiree-only and family coverage for 2013

	Annual total premiums		Retiree premium share		Rates of increase	
	Retiree only	Family	Retiree only	Family	2012	2013*
Retirees under age 65	**$9,064**	**$21,126**	**51.9%**	**53.8%**	**6.1%**	**6.5%**
Retirees age 65 and older	**$4,584**	**$11,283**	**45.5%**	**47.7%**	**4.8%**	**4.1%**

*Expected

Best Performers Deliver Sustained Results

Organizations continue to show dramatic differences in their ability to manage their health care cost trends. A group of organizations we refer to as "best performers" has been successful in maintaining health care cost trends at or below the TW/NBGH norm for each of the last four years (see Active Employees, page 12).

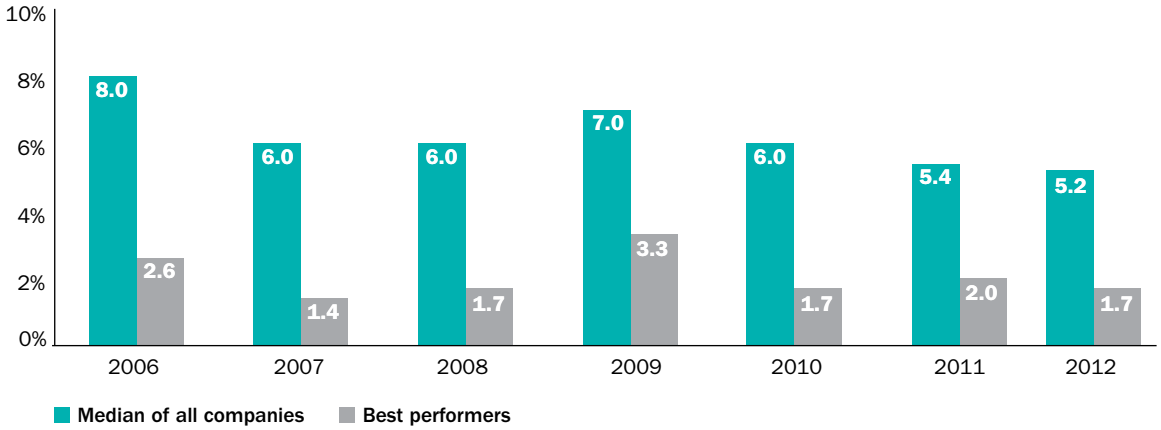
Our research this year identified 45 companies that qualify as best performers.* *Figure 16* shows that the ability to keep cost increases low over an extended period of time distinguishes these companies from other organizations. In fact, the median trend across the last four years was 5.9%, versus 2.2% for best performers.

By contrast, some companies have experienced

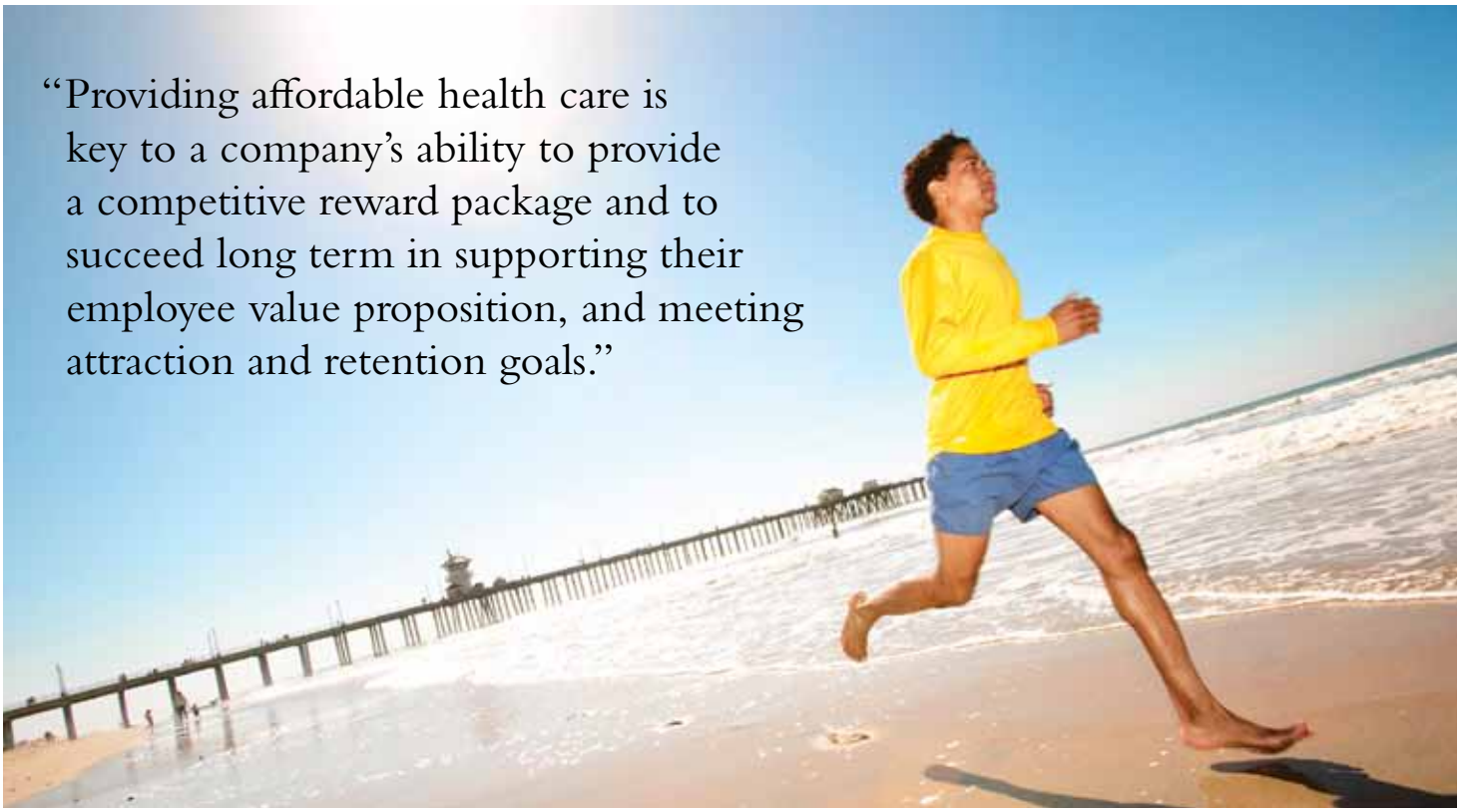
*A company had to complete this year's survey and the 2011 or the 2012 TW/NBGH survey to be eligible to be a best performer. The number of best performers is based on 246 eligible companies, which translates to 18% of companies reporting an annual trend at or below the all-company median for each year from 2009 to 2012.

The company profile of the best performers looks very similar to other companies that responded to the survey. For example, every major industry is represented by the best performers, with a similar average age, male/female ratio and similar percentage of employees electing dependent coverage as the overall sample. However, best performers are larger than the average company in the overall sample — averaging 51,000 versus 28,000 employees.

Figure 16. Best performers versus median annual cost trends (after plan and contribution changes) 2006 – 2012



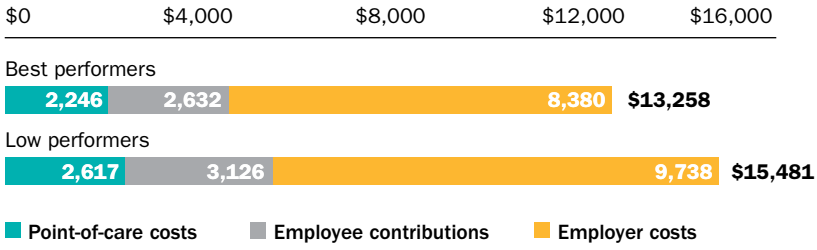
Note: Median trends are for employer costs for actively enrolled employees, after plan and contribution changes. Best performers are based on cost trends between 2009 and 2012.



greater challenges in managing their cost increases. Low-performing companies — whose two-year average cost increases are in the top 25% — have a median 10.3% cost trend.

As shown in *Figure 17,* best performers are noticeably ahead in terms of total cost management. In 2013, the cost difference between best performers and low performers is $2,225 per employee. For the average best performer with 10,000 employees, this equates to a cost advantage of over $22 million per year. Likewise, employees working for a best performer also fare much better than their counterparts at low-performing companies, paying nearly $500 less per year in premiums and nearly $400 less per year in point-of-care charges. In addition to the obvious advantage of reducing health care costs for themselves and their employees alike, affordable health care is key to a company's ability to provide a competitive reward package and to succeed long term in supporting their employee value proposition, and meeting attraction and retention goals.

Figure 17. Total health care expense by performance group in 2013

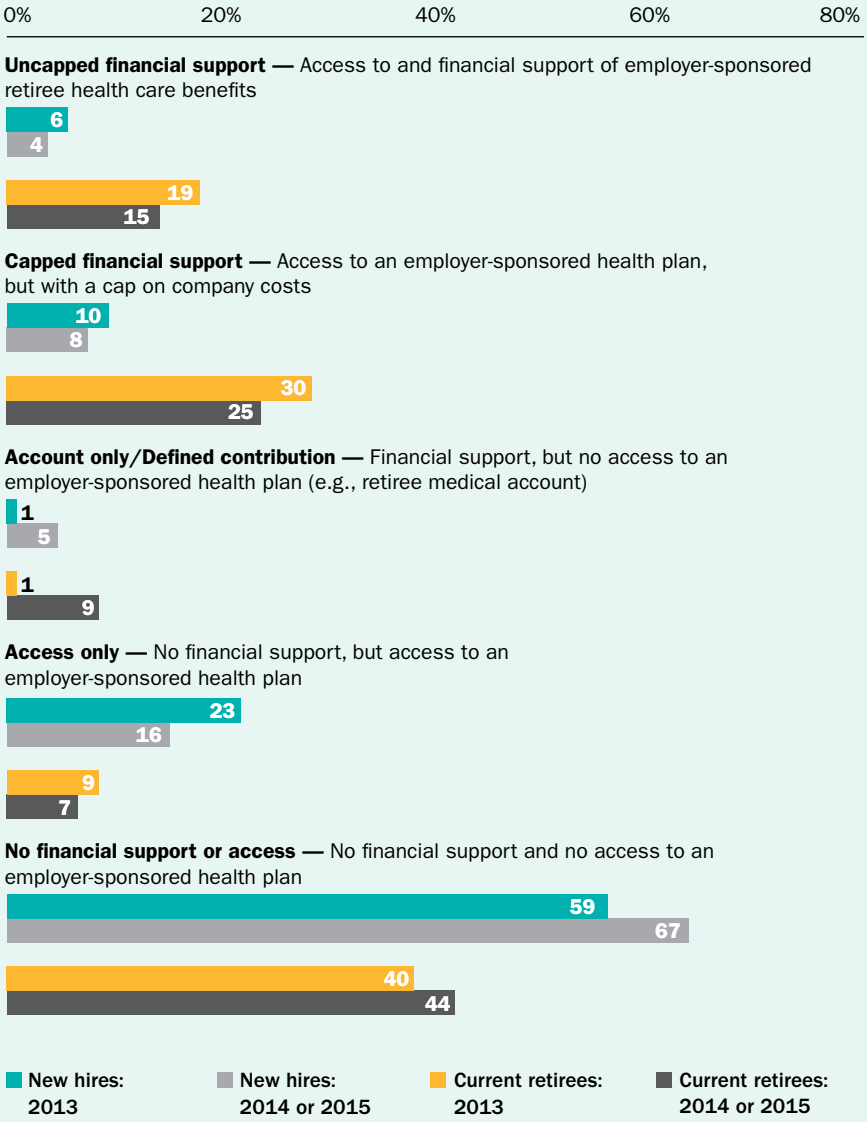


Note: Total health expenses include employer and employee portions of the premiums, and employee out-of-pocket costs at the point of care (including deductibles, copays and coinsurance). Best performers comprise 45 companies that have maintained trends at or below the TW/NBGH median trend for each of the last four years. Low performers are based on the highest quartile of two-year average trend.

Retiree Medical Plans

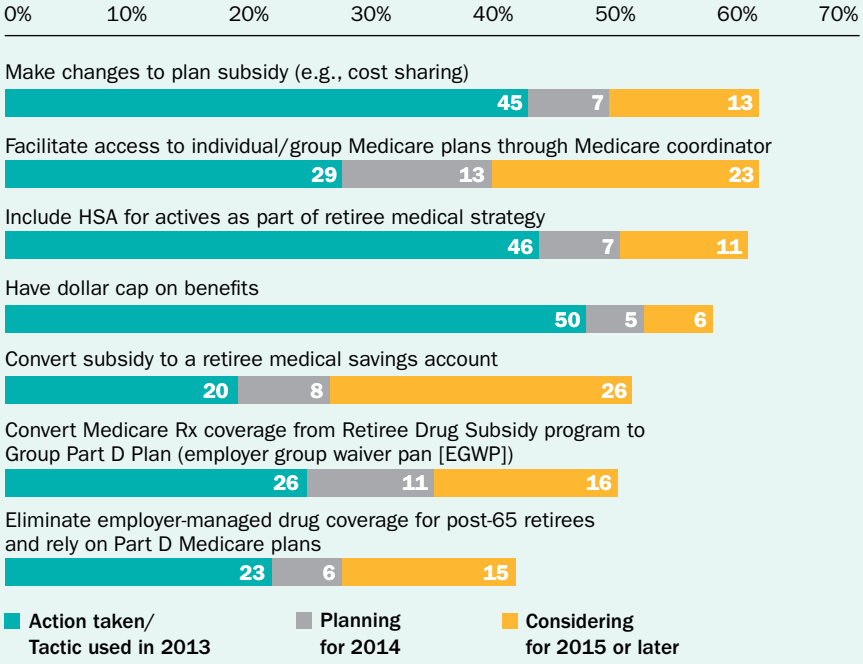
About 60% of all companies offer some form of retiree medical support — either subsidies or access to coverage through a Medicare coordinator. For several decades, employer subsidies have been steadily eroding as employers have reassessed their commitment to these programs. In fact, the cost challenges have reached a point where, for many pre-65 retirees, retiree medical coverage is largely unaffordable even when subsidized by their employer. Public exchanges have the potential to expand affordable coverage for many current and future retirees for whom health care coverage is unattainable today, especially for those ineligible for Medicare. Likewise, 13% of employers expect to facilitate access to individual/group Medicare plans for their post-65 population in 2013, and 23% are considering it for 2015 or later.

Figure 18. Pre-65 retiree medical support for various subgroups of the workforce for 2013, and expected for 2014 or 2015



As they redefine their subsidies under these programs, some employers are considering account-based solutions to help retirees transition to the public exchanges when they open. In particular, one-third of best performers with a retiree medical program today are planning to convert their employer subsidy to a retiree medical savings account by 2015. In addition, HSAs for active employees are increasingly being positioned as part of the overall retiree medical strategy. Ten percent of best performers have adopted this strategy for 2013, and a similar number are planning to do so by 2014.

Figure 19. Declining subsidies for retirees with health accounts becoming more prevalent



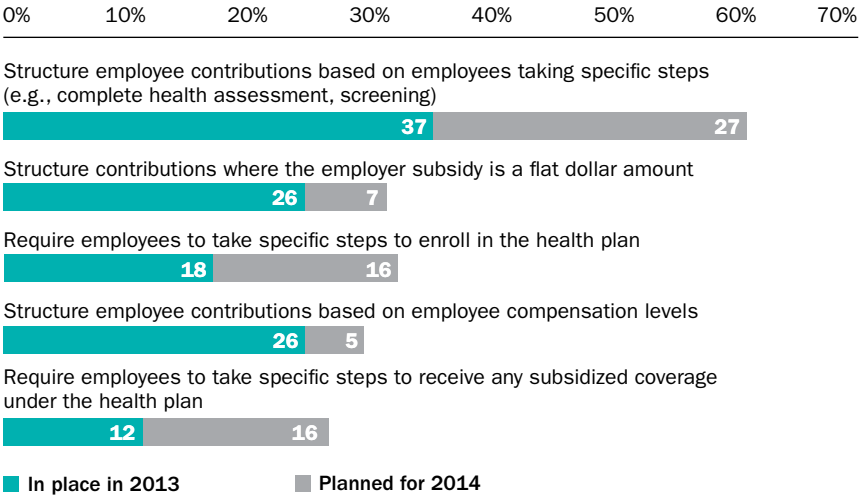
Note: Based on respondents that provide financial support or access to coverage in 2013 and excludes responses of "not applicable"

Emerging Trends

Changes in Contribution Strategies

Tying employee contributions to successful completion of specific tasks such as health assessments and screenings remains the most popular change in contribution strategies as employers continue to redefine their financial commitment to employee health care. However, other strategies are just emerging *(Figure 20)*. Nearly 40% of companies in the financial sector structure their contributions based on employee compensation, a significantly higher percentage than the IT/telecom sector (14%) or the energy sector (19%). It's a strategy other industries might consider emulating to make health care more affordable for lower-paid employees, and one that about 30% of all respondents have taken or plan to take this year.

Figure 20. Changes in contribution structure

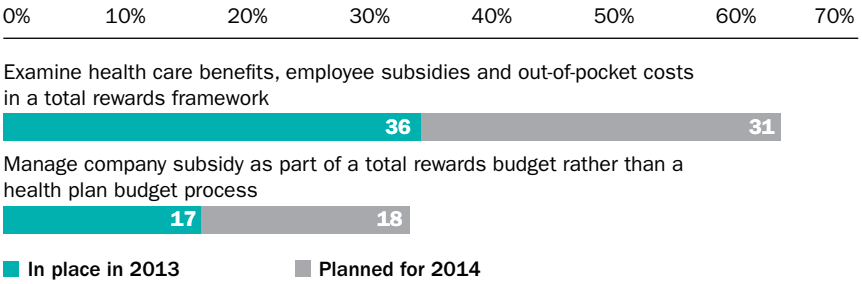


Twenty-nine percent of best performers today (compared to 21% of low performers) structure contributions so that employees pay the difference between the total cost of the plan selected and a flat dollar employer subsidy. An additional 11% of the best performers plan to adopt this structure for 2014. They are also ahead of low performers in requiring employees to take steps to enroll in their health plan (18% versus 13%), as opposed to automatic enrollment.

Best performers are also likely to have integrated their health care benefits into a broader total rewards framework, which allows them to view health benefit costs in relation to pay and other benefits, and reallocate resources to establish an employee value proposition that attracts, retains and motivates employees *(Figure 21)*. They are even more likely than low performers to make this a priority in 2014. In fact, 43% of best performers are expected to manage their subsidies as part of a total rewards budget rather than a health plan budget process by 2014, compared to only 27% of low performers.

Most respondents (71%) say they have raised dependents' share of premium contributions (as a percentage of total premiums) over the last three years. Over the next three years, 83% plan to raise the percentage of premiums paid for coverage tiers with dependents, and more than half of those plan medium to large increases.

Figure 21. Health care in a total rewards framework



Over the last year, best performers are leading the way by increasing employee contributions in tiers with dependents at higher rates than single coverage (47%, compared to 33% of low performers). And this strategy continues to grow among best performers: 71% expect to use it in 2014. The most successful companies are also more likely to have increased employee contributions per each dependent covered (13%, versus low performers at 6%) and to have expanded the number of coverage tiers (20% versus 11%). These two tactics are expected to rise to 27% and 31%, respectively, among best performers by 2014.

New Delivery Models

Not surprisingly, the IT/telecom industry is leading the way in the use of telemedicine, and 26% offer it to their employees today. But it's rapidly catching on in other sectors. Beginning in 2014, one-third of energy and retail companies plan to adopt telemedicine. Best performers across the industry spectrum have embraced onsite health services, and 41% already have a clinic in at least one location, with another 11% planning to adopt an onsite center by 2014.

Spousal surcharge

20% of respondents levy a penalty for spousal coverage (roughly $100 a month).

An additional 13% will begin next year, indicating a growing trend to rethink employee dependent subsidies.

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Figure 22. Redefining the commitment to dependents

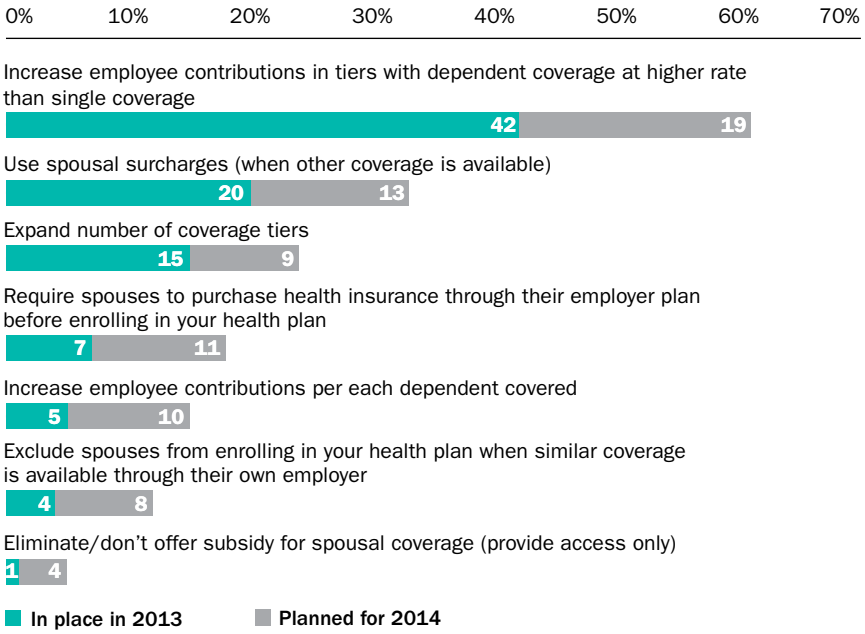


Figure 23. New delivery models

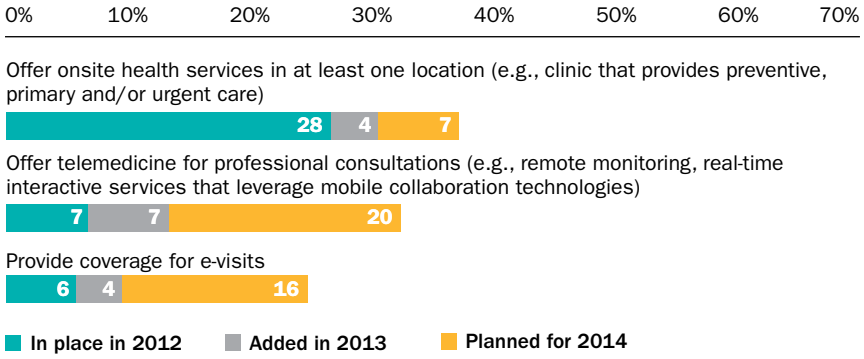
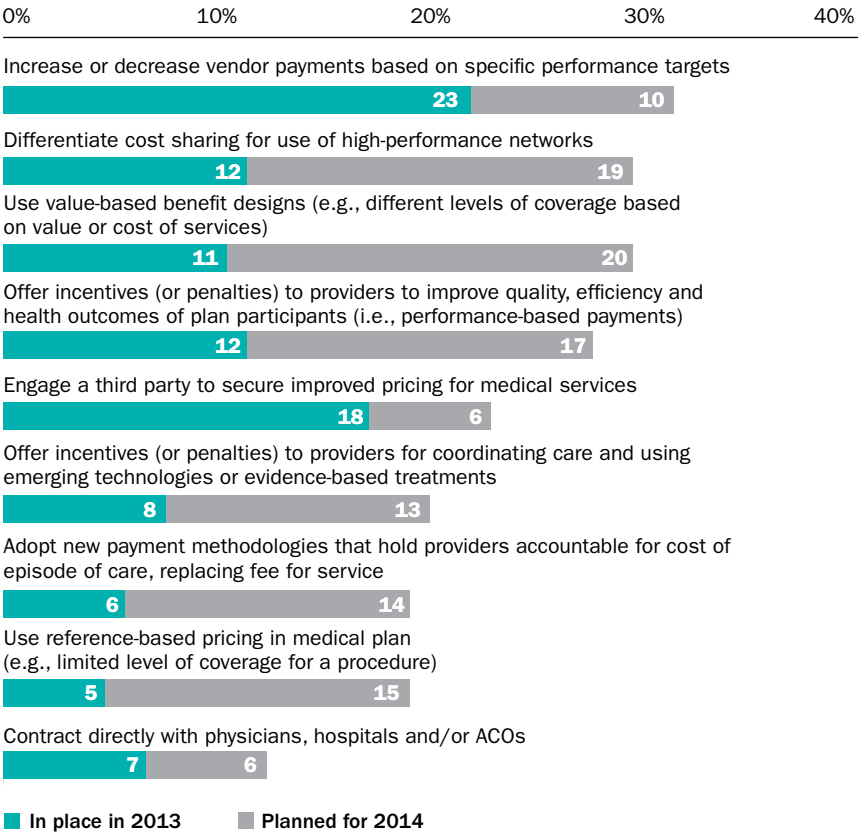


Figure 24. Using incentives and emerging payment approaches to improve the quality of care delivered



Historically, employers have focused on demand-side tactics — managing plan designs, network options and consumerist measures to stimulate employee accountability. Now there is also growing interest in more effectively managing the supply side. Employers are adopting various payment reforms and provider strategies to improve quality of care and stimulate provider accountability.

In addition, the PPACA payment reform provisions — including value-based purchasing, accountable care organizations (ACOs), bundled payments and medical homes — target improvements in quality and efficiency. Several key pay-for-performance programs created by the PPACA have already begun to roll out, including the hospital value-based purchasing (VBP) program and the hospital readmission reduction program. (Value can be broadly considered to be a function of quality, efficiency and cost.) Medicare and Medicaid — the largest health care payers in the country — and some large insurance companies are already using VBP measures under the PPACA, and many employer plans are following suit. We fully expect employer plans to implement these changes with increasing rapidity over the next few years *(Figure 24).*

Best performers are clearly leading the way and are planning to expand the use of these strategies over the coming year *(Figure 25).*

Figure 25. New provider strategies are favored by best performers

	Best performers		Low performers	
	2013	2014*	2013	2014*
Increase or decrease vendor payments based on specific performance targets	36%	44%	20%	30%
Differentiate cost sharing for use of high-performance networks	13%	31%	12%	25%
Use value-based benefit designs (e.g., different levels of coverage based on value or cost of services)	11%	33%	12%	32%
Offer incentives (or penalties) to providers to improve quality, efficiency and health outcomes of plan participants (i.e., performance-based payments)	22%	47%	5%	28%
Engage a third party to secure improved pricing for medical services	18%	24%	19%	30%
Offer incentives (or penalties) to providers for coordinating care and using emerging technologies or evidence-based treatments	16%	38%	4%	21%
Adopt new payment methodologies that hold providers accountable for cost of episode of care, replacing fee for service	16%	38%	2%	13%
Use reference-based pricing in medical plan (e.g., limited level of coverage for a procedure)	9%	27%	5%	21%
Contract directly with physicians, hospitals and/or ACOs	13%	31%	7%	13%

*Includes companies indicating "planned for 2014"

Price Transparency

Health plans are expanding their tools in the area of price transparency, which could be driving greater adoption by employers. Thirty-three percent of respondents report using these tools, and an additional 10% plan to do so in 2013 *(Figure 26)*. Currently, 32% encourage vendors to share online medical information with employees, and another 14% plan to do so over the next two years. In a related strategy, 40% of employers require vendors to provide data for employee outreach and integrated reporting, and an additional 15% plan to do so in 2013 or 2014.

Communication and transparency are core strategies for managing costs, especially as many more employers migrate their workforce into ABHPs. It's essential that employees in these programs be armed with the best available information to make smarter health care decisions so they can reduce their costs without sacrificing quality.

Today, 45% of best performers are putting pressure on plans and providers to offer patients access to online medical information, compared to 29% of low performers.

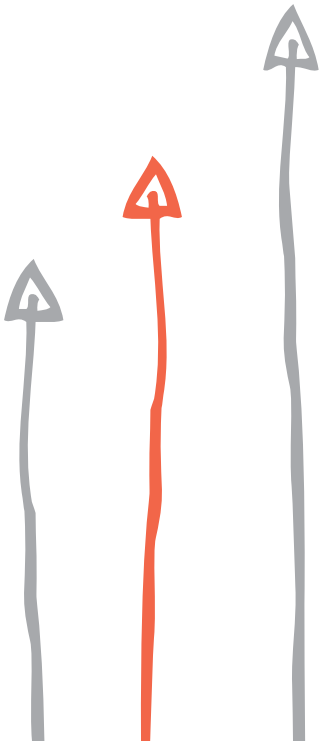
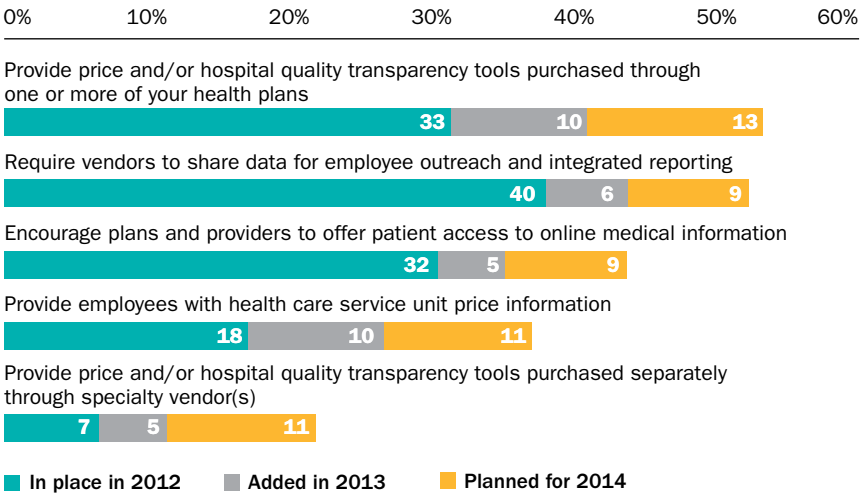


Figure 26. Access to price and quality information on the rise



Private health exchanges

Private health exchanges are among the newest delivery approaches. Only a handful currently exists, although others are in development.

Less than 1% of respondents offer their employees access to a private health exchange, but 15% are considering doing so in 2014.

Statoid

Using Financial Incentives and Requirements to Engage Employees

Growth in the use of penalties to engage employees in health program participation has slowed over the last two years in favor of outcome-based incentive designs. This is a continuation of a strategy companies have followed over the last few years to impose tougher requirements to earn financial rewards or avoid penalties. These requirements are increasingly focused on results and on holding employees accountable for achieving specific health standards. Tobacco use has been on companies' radar screens for many years, and the use of tobacco-use surcharges continues to grow, up from 35% in 2012 to 42% in 2013 (See Getting Tough on Tobacco, below). It is expected to reach 62% by 2014. More recently, companies have been expanding biometric outcomes to include achievement of specific body mass index levels and

"More recently, companies have been expanding biometric outcomes to include achievement of specific body mass index levels and target cholesterol levels."

Getting Tough on Tobacco

36% of companies reward employees for participating in a **smoking-cessation program.**

9% of companies use penalties for **tobacco users** not joining a smoking-cessation program.

42% of companies use surcharges for **tobacco users,** at roughly **$50/month.**

52% of companies today **ban smoking** directly *outside buildings* or *on campus.*

8% of companies plan to *adopt* this **ban policy** in **2014.**

4% of companies have *adopted* a policy **not to hire smokers** in states where it is legal to do that.

2% of companies plan to *adopt* this **no-hire policy** in **2014.**

Statoid

target cholesterol levels. Today, 16% of companies align their rewards/penalties to specific biometric targets (other than tobacco use), and another 31% are considering this strategy for 2014 *(Figure 27).*

There is growing interest in expanding financial incentives to include spouses, and 59% of respondents anticipate doing so by 2014, up from 23% that did so in 2012. Expanding financial incentives to spouses can be an effective way to engage employees as well.

Adoption of new technologies — including telemedicine, mobile apps for e-visits and data-enabled kiosks — will help increase employee engagement, facilitate communication, and monitor and support employee decision making.

Best performers have led the way in the use of achievement-based standards. Today, 51% of them use incentives based on tobacco-use status, and 33% are using biometric outcomes. Meanwhile, 44% of low performers use incentives tied to tobacco use cessation, but only 19% use biometric outcomes. Interestingly, best performers are less likely to use penalties to encourage program participation than low-performing companies (16% versus 23%). And best performers have extended their incentives to include spouses and other dependents, recognizing that healthy lifestyles are a family affair. In fact, 40% of best performers apply their incentives to employees and spouses alike, compared to 30% of low performers.

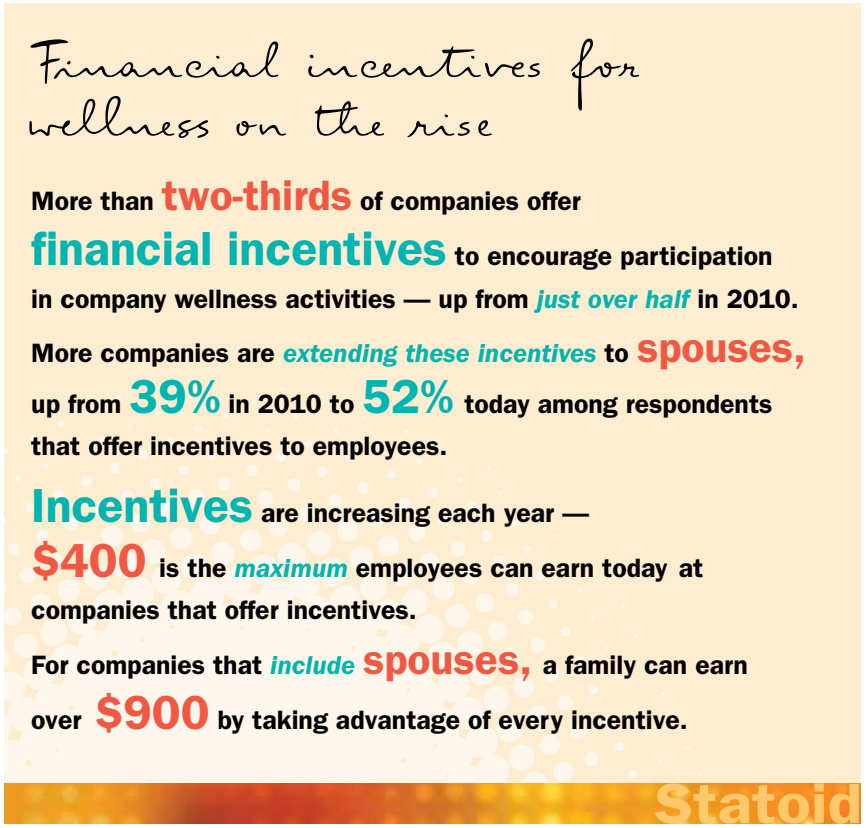


Figure 27. Wellness incentives and tougher requirements expand in use

	2011	2012	2013	2014*
Use financial rewards for individuals who participate in health management programs/ activities (i.e., positive incentives)	54%	61%	62%	81%
Use penalties (e.g., increase premiums and/or deductibles) for individuals not completing requirements of health management programs/activities	19%	20%	18%	36%
Require employees to complete a health risk appraisal and/or biometric screening to be eligible for other financial incentives	35%	42%	54%	75%
Require employees to validate participation in healthy lifestyle activities in order to receive a reward or avoid a penalty (e.g., evidence of fitness center use, engagement with a primary nurse case manager)	–	23%	33%	59%
Reward or penalize based on smoker, tobacco-use status	30%	35%	42%	62%
Reward or penalize based on biometric outcomes other than smoker, tobacco-use status (e.g., achievement of weight control or target cholesterol levels)	12%	10%	16%	47%
Apply rewards or penalties and/or requirements under your health management programs/activities to employees and spouses alike	19%	23%	31%	59%

*Includes companies indicating "planned for 2014"; Data from 2011 and 2012 are based on the 17th annual TW/NBGH Survey.

Account-Based Health Plans (ABHPs)

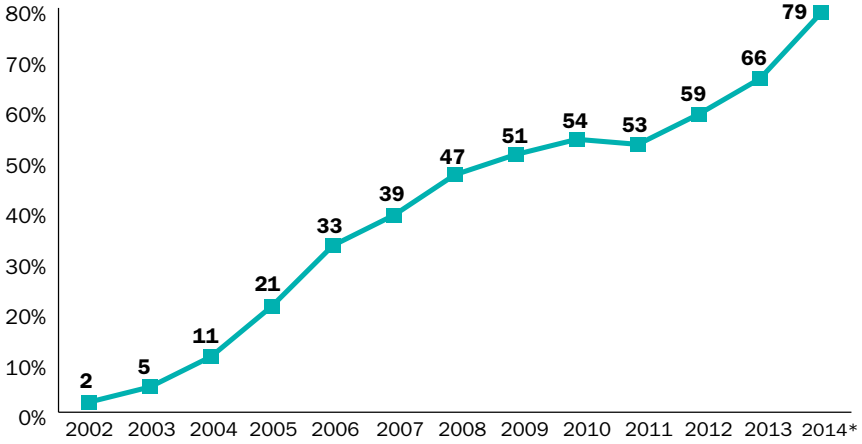
Tax-advantaged ABHPs are widespread across all industries except the public sector, where only 40% of organizations have an ABHP in place.

We define an ABHP as a plan with a deductible offered together with a personal account (i.e., an HSA or an HRA) that can be used to pay a portion of the medical expense not paid by the plan. ABHPs typically include decision support tools that help consumers better manage their health, health care and medical spending.

Not all ABHPs are created equal. Their effectiveness depends on a number of factors, including whether the ABHP is full replacement for other plans, the size of the deductible, the degree to which employees enroll in an HSA or HRA, and whether wellness initiatives are included to encourage employee engagement in their health and well-being. Employer adoption of ABHPs had been marked by significant increases in deductibles, which negatively affected enrollment. But ABHPs continue to evolve, embedding incentive strategies and aligning with retirement strategies. Employers have now moved to reduce the dollar burden on employees, contributing funds to an HSA and subsidizing premiums of ABHPs at a higher level than other options. More companies are helping ease the transition to ABHPs through a year-round communication strategy. And companies with an ABHP are much more likely to provide price and/or hospital-quality transparency tools than others (54% versus 30%), and more likely to offer decision support tools for preference-sensitive care (33% versus 17%).

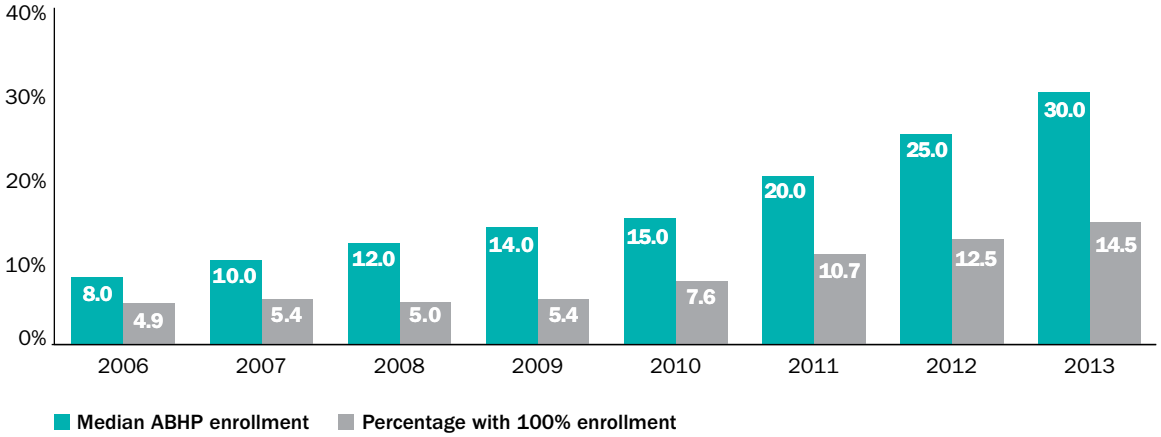
More and more employers are tying their contributions to positive employee actions to improve health. By aligning their ABHP strategy with their health management strategy, companies have been able to move to a full-replacement ABHP more quickly. And full replacement has resulted in a substantial increase in employee enrollment in these plans, which has risen significantly over the last three years, from 15% to 30% *(Figure 29)*. We've seen a steady increase in enrollment in both account types, with HSA enrollment rising from 13% in 2011 to 20% today, and HRA enrollment rising from 28% to nearly 40% in 2013.*

Figure 28. Take-up in ABHPs on the rise



*Planned for 2014

Figure 29. ABHP enrollment rates rising at a rapid pace



Note: Estimates are based on companies that offer an ABHP in various years: 2006 is based on the 12th annual National Business Group on Health/Towers Watson survey; 2007 is based on the 13th annual survey; 2008 is based on the 14th annual survey; 2009 is based on the 15th annual survey; 2010 is based on the 16th annual survey; 2011 is based on the 17th annual survey, and 2012 and 2013 are based on the 18th annual survey (current).

*Based on companies offering an HSA and HRA, respectively; Enrollment rates for 2011 are based on the 17th annual TW/NBGH Survey.

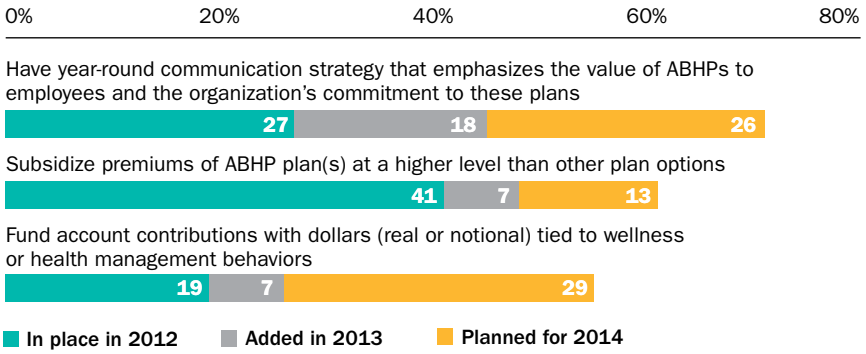
"By aligning their ABHP strategy with their health management strategy, companies have been able to move to a full-replacement ABHP more quickly."

Figure 30. ABHPs as the only plan option is on the rise

	2007	2010	2012	2013	2014*
ABHP with HRA	20%	20%	23%	26%	32%
ABHP with HSA	25%	38%	48%	53%	67%
Contribute funds to an HSA	15%	30%	39%	42%	57%
Offer an ABHP as our default plan option	–	11%	17%	22%	40%
Offer an ABHP as our only plan option among our self-insured plan options	–	–	9%	12%	23%
Offer an ABHP to collectively bargained employees	–	–	17%	21%	27%

Note: Based on all companies with or without an ABHP; 2007, 2010 and 2012 are based on prior years of the TW/NBGH Survey.
*Includes companies indicating "planned for 2014"

Figure 31. Linking health management incentives to ABHPs is on the rise



Note: Based on companies with an ABHP or planning to adopt an ABHP in 2014

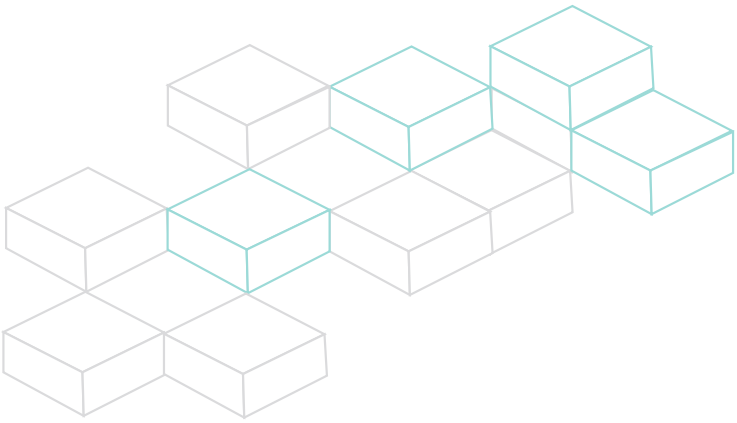
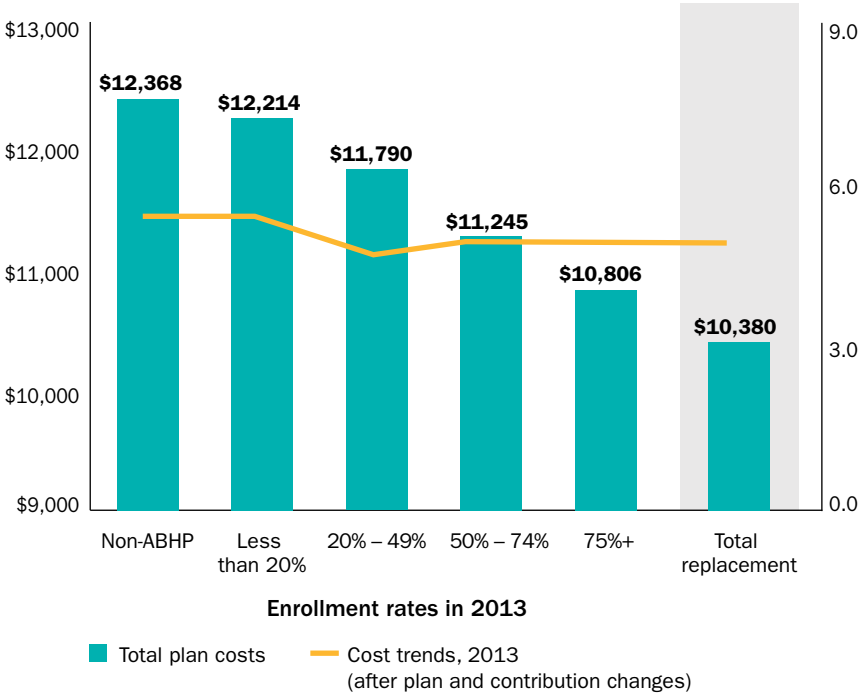


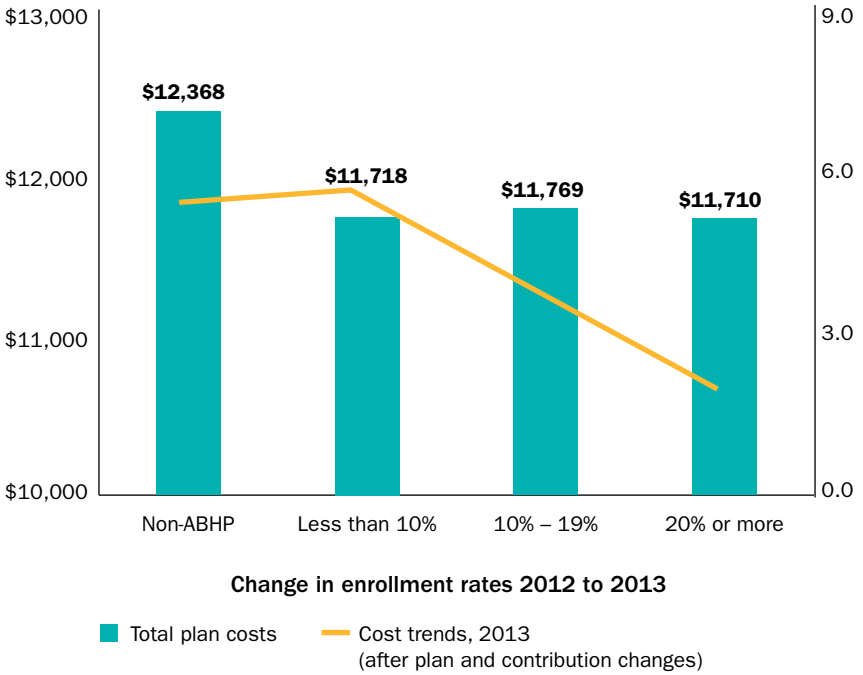
Figure 32. ABHP enrollment linked to lower health care costs



Companies able to successfully migrate employees into an ABHP stand to reap significant savings. Our research shows again this year that companies with at least 50% of employees in an ABHP report total costs per employee that are more than $1,000 lower than companies without an ABHP *(Figure 32)*. However, an ABHP alone, even with high employee enrollment, does not guarantee long-term success. Companies with more than half of their employees enrolled in an ABHP report a two-year average trend nearly identical to the TW/NBGH norm. Where we do see a cost trend advantage is among companies transitioning their workforce into an ABHP. In fact, companies increasing enrollment by 20% or more to their ABHP over the last year report average cost trends of only 2% over the period *(Figure 33)*.

Long-term success involves more than changing plan design. Where we see a significant difference, year after year, is in the comprehensive approach best performers take to increase employee and provider accountability, help cultivate smarter health care consumers and take advantage of emerging trends in a rapidly changing provider marketplace. These companies prove most successful at holding the line on costs.

Figure 33. Increased ABHP enrollment linked to lower trends



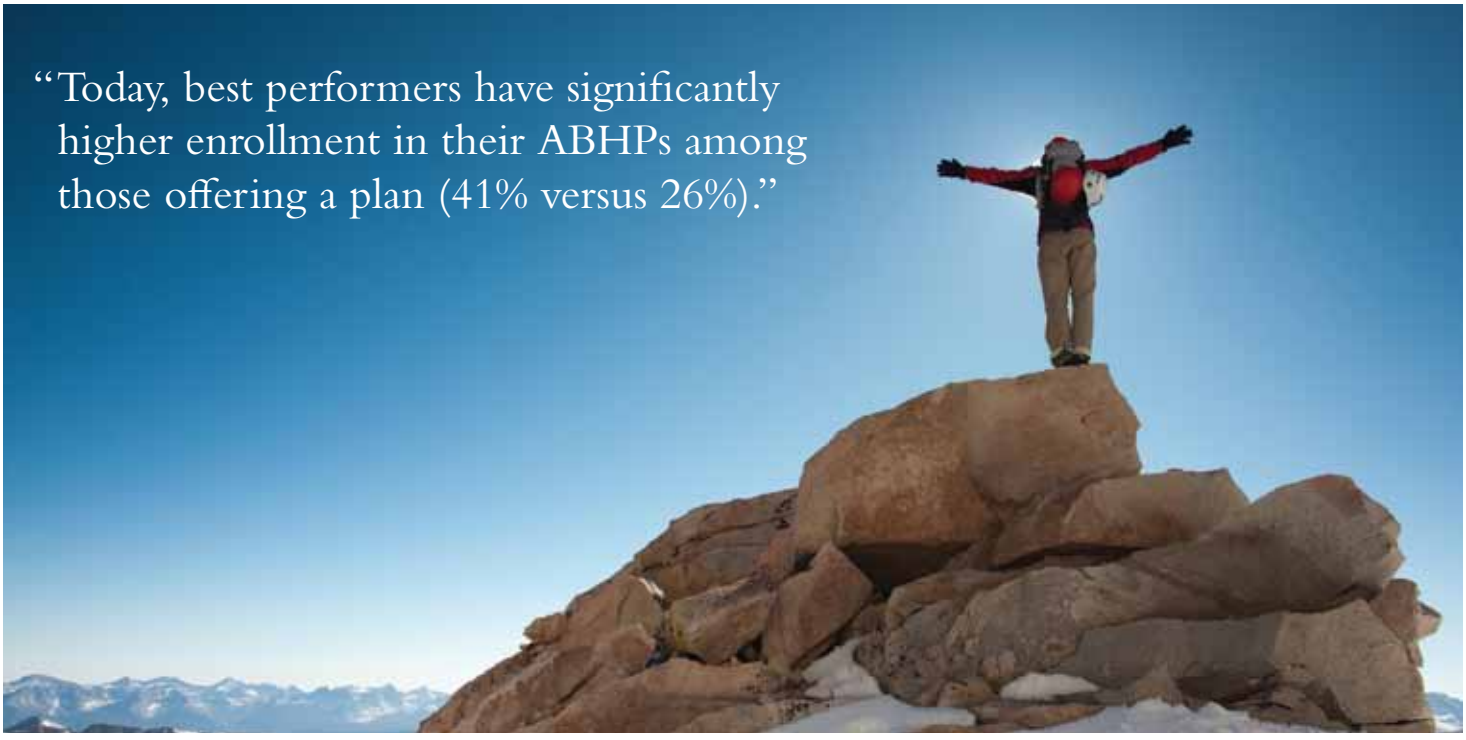
Best Performers Lead the Way on ABHPs

Today, 78% of best performers have an ABHP in place, compared to 64% of low performers. But now, low performers are taking more aggressive steps than best performers to adopt ABHPs and boost enrollment in advance of the 2018 excise tax rules. In fact, 14% of low-performing companies are planning to add an ABHP in 2014, compared to only 2% of best performers. Today, best performers have significantly higher enrollment in their ABHPs among those offering a plan (41% versus 26%). But that imbalance will change quickly, since twice as many low performers as best performers plan to go to total replacement by 2014 (14% versus 7%) *(Figure 34)*. As such, 27% of today's low performers could be total replacement by 2014, compared to 22% of today's best performers. The effect on their performance remains to be seen.

Figure 34. ABHPs and performance groups

	Best performers		Low performers	
	In place in 2013	Planned to add for 2014	In place in 2013	Planned to add for 2014
Offer an ABHP	**78%**	**2%**	**64%**	**14%**
Offer an ABHP with an HSA	**64%**	**11%**	**49%**	**16%**
Contribute funds to an HSA	**53%**	**9%**	**42%**	**17%**
Offer an ABHP with an HRA	**31%**	**0%**	**25%**	**6%**
Offer an ABHP as our only plan (i.e., total replacement) among our self-insured plan options	**16%**	**7%**	**14%**	**14%**

Note: Based on all companies in respective groups



Specialty Pharmacy

Specialty drugs — groundbreaking biologics, injectables and other innovations developed to treat complex illnesses such as cancer and rheumatoid arthritis — are the fastest-growing cost segment of employer-provided pharmacy plans. Despite the high costs of these drugs, it is often challenging for employers to obtain comprehensive and specific cost and utilization information on specialty drug spend, particularly for medications covered through medical plans *(Figure 35)*. When this information is available, however, many employers are exploring financial and clinical management approaches to mitigate drastic cost increases, including prior authorization, step therapy and formulary management *(Figure 37)*.

While 20% of respondents have adopted incremental solutions, managing high cost trends requires more aggressive approaches. This remains a strategic challenge.

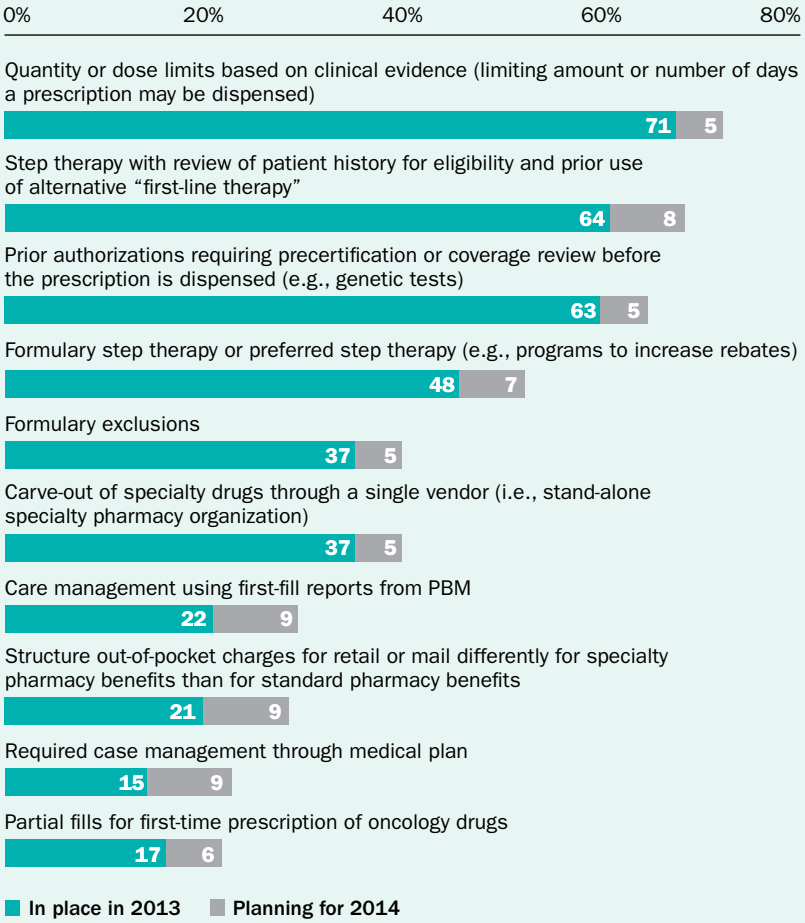
Figure 35. Familiarity with specialty pharmacy costs

	Very familiar	Somewhat familiar	Not at all familiar
Through medical plans	**19%**	**49%**	**32%**
Through pharmacy benefit programs	**43%**	**38%**	**19%**

Figure 36. Percentage of total pharmacy spend through the pharmacy benefit manager (PBM) that specialty pharmacy represented in 2012

Less than 10%	**9%**
10 to 19.9%	**36%**
20% or more	**31%**
We don't track specialty pharmacy spend	**4%**
Don't know	**20%**

Figure 37. Activities to manage specialty pharmacy benefits



Part-Time Employees

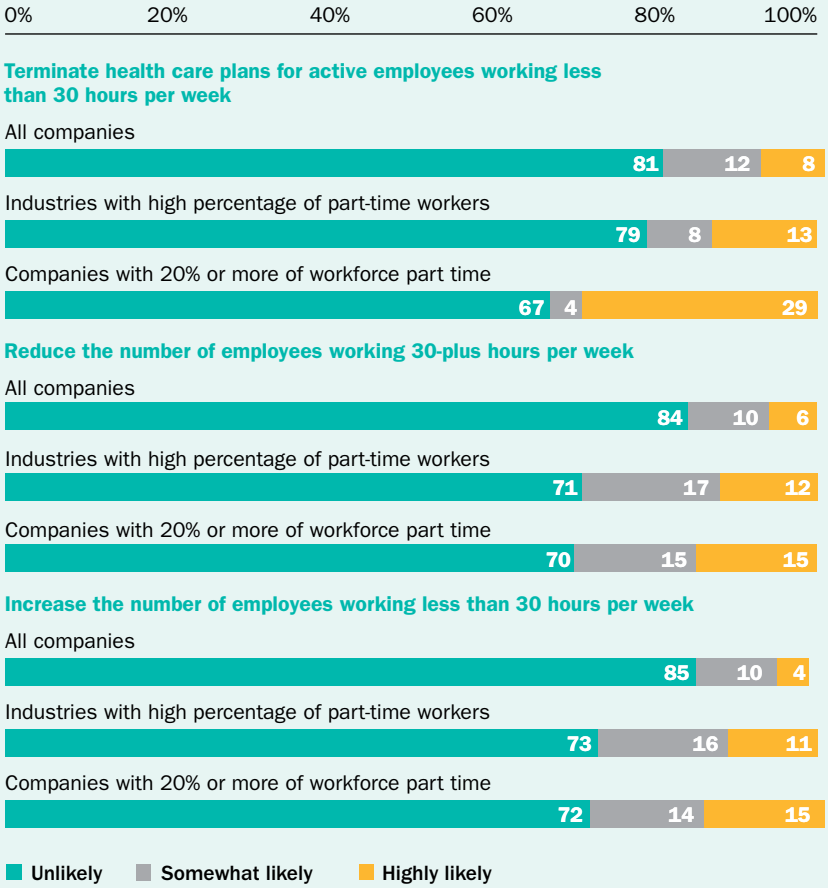
With the public exchanges opening next year, the PPACA rules will require employers that offer health care benefits to cover part-time employees working 30 or more hours a week, or pay penalties. For many employers, this change could significantly increase the number of employees eligible to receive coverage and drive industries that rely on part-timers to manage their costs more aggressively. So far, few seem to be changing their strategy *(Figure 39),* which may reflect their uncertainty regarding exchanges and an interest in waiting to see how competitors will respond. We expect that reluctance to change significantly in the next year out of necessity, especially if costs or employees will be lower through the public exchanges.

Figure 38. Offering of health care benefits to part-time employees

	All companies	Industries that use a high number of part-time employees	Companies with at least 20% of employees working part time
Yes, with the same options as full-time employees	38%	26%	20%
Yes, but with more limited coverage or subsidy than full-time employees	29%	42%	42%
No, we do not offer coverage to part-time employees	29%	30%	37%
No, we do not have part-time employees	4%	2%	1%

Note: High part-time concentration includes companies in the following industries: health services, hospitality, entertainment, professional services, retail and wholesale trade.

Figure 39. Likelihood organizations will take the following action in the next five years with their part-time health care programs and workers



How Best Performers Get Ahead

With economic challenges persisting and landmark reform scheduled to transform the health care landscape, there has never been a more critical time for employers' health benefit programs to operate efficiently. Our research over the last few years has repeatedly shown that the most successful companies separate themselves from their competitors by making significant strides in six core areas:

- **H**ealth improvement
- **E**ngagement
- **A**ccountability
- **L**inking provider strategies
- **T**echnology
- **H**ealthy environment

There is a lot to learn from these companies by looking at what they have been doing and where they are headed. How do the most successful companies get ahead? Simply stated, these companies have universally made greater strides in each of the six core areas, and they use health care metrics to gauge their strategies' impact on two critical success factors: cost reduction, and improvements in workforce health and productivity.

Strategies Implemented by Best Performers in 2013

The best performers took a number of significant steps in 2013 to improve the efficiency of their health care programs *(Figure 40):*

- Consolidated vendors to improve delivery and coordination of health management programs; also taking steps to incent providers to invest in new technologies to improve the coordination of care
- Focused more on communication to help employees make smarter health care decisions, leveraging popular culture technology like social media to make sure they have the best information on health care providers available
- Stepped up emphasis on transparency in provider prices as well as quality and results
- Invested in case management to more proactively and effectively manage their high-cost cases
- Placed more responsibility on employees, tying financial incentives to measurable improvements in their health; extended these incentives to spouses
- Started implementing new payment methods to providers, placing greater responsibility on them to deliver high-quality, efficient care

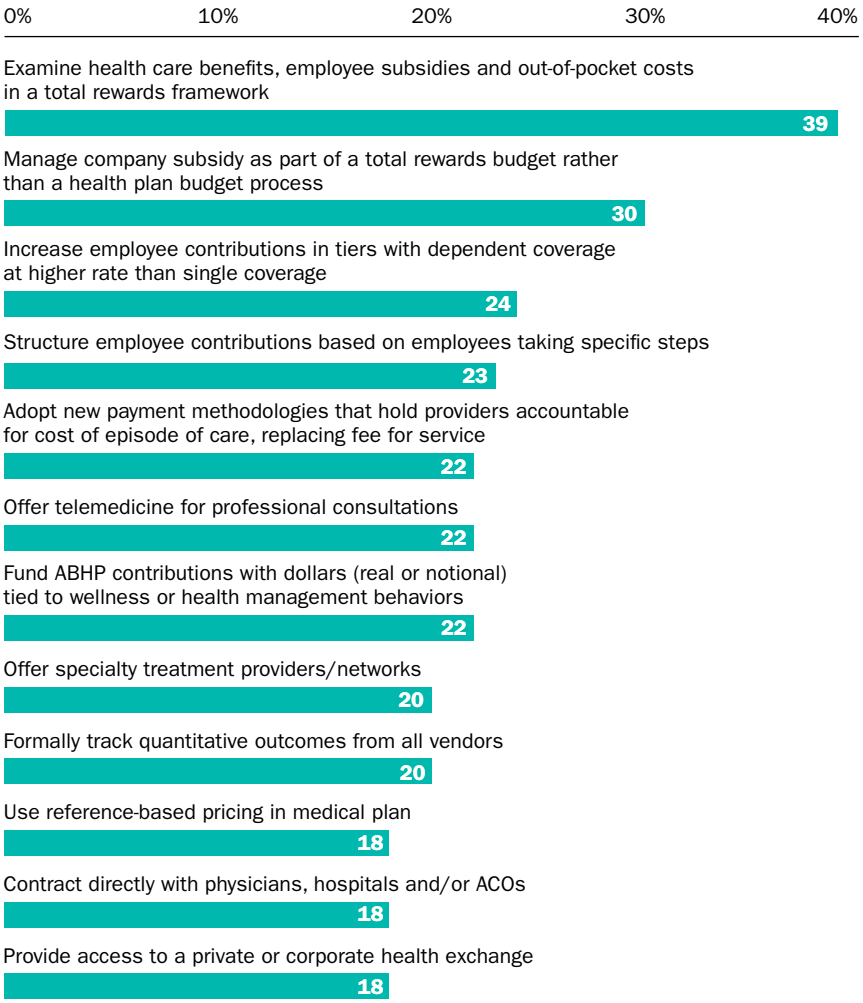
Figure 40. Most implemented strategies of best performers in 2013

On the Drawing Board for 2014

Best performers are successful over the long term because they continue to look for new ways to lower costs *(Figure 41).* Their plans for next year include:

- Optimizing their health care spending by approaching it as part of their total rewards strategy. They intend to make plan design changes and redefine subsidies for dependents. Taking this broader view helps them remember that rising health care costs take their toll on other parts of compensation employees consider important, like salary and retirement contributions.
- Integrating their contribution strategy with their health management and wellness activities. Many more companies are tying their wellness incentive strategy to their ABHP account contributions.
- Focusing more on the supply side of employee health care — holding providers and other vendors accountable through payment reforms, delivery improvements, value-based designs and measurement of outcomes.
- Continuing to explore the development of private exchanges as a possible alternative to the current system of employer-provided health care.

Figure 41. Top strategies planned by best performers for 2014



Conclusion

While health benefit cost trends continue to stabilize, they are still significantly above the overall rate of inflation. With the excise tax looming, the pressure is on employers to better control costs. As more of that burden shifts to employees, employers are looking to other strategies — particularly through changes in vendor relationships, use of ABHPs and a greater emphasis on wellness — to manage costs.

Most employers are waiting to see how the PPACA will play out before making radical changes to their plans, and most expect to continue providing health benefits over the next five years.

In our view, health benefits continue to be a differentiator for top organizations when it comes to attracting and retaining talent, but they should be viewed in the context of a total rewards program that carefully balances employee needs and employer costs, and leaves enough money in the budget for the most efficient employers to reward top performers.

The following strategies offer employers a way to manage health benefit costs, prepare for the PPACA, encourage employees to take an active role in their own health and well-being, and mitigate risks.

Strategies for Long-Term Success

Take a strong hand in financial management
Take steps to improve efficiency, including:

- Use data and metrics to understand the cost drivers of your health plan, vendor efficiency and population risk profile.
- Analyze health management programs designed to address population health risks, and evaluate ROI and cost savings.
- Negotiate financial arrangements with your vendors, including pharmacy benefit managers, that include risks for both parties.
- Audit claims and clinical programs to ensure plan designs and programs are administered appropriately.
- Develop a workplace culture that holds employees accountable for managing their health.

Understand the excise tax and your options for addressing it

The purpose of the excise tax, which starts in 2018, is to lower the high cost of employer-provided plans. The government believes these high-cost plans lead to the overuse of the health care system and fuel rising costs. If you have a high-cost plan, now is the time to recalibrate your health care strategy to lower costs and avoid the excise tax. This will mean:

- Restructuring your plan
- Adopting ABHPs
- Using spousal surcharges and dependent tiers
- Emphasizing accountability in year-round health care decision making
- Engaging employees in programs that promote healthy choices and responsibility for their health
- Restructuring and rethinking retiree health care
- Ensuring cost and quality transparency from vendors and providers

Keep an eye on the development of new delivery channels for health benefits

Consider whether the public or any of the emerging private exchanges might provide reliable alternative coverage for certain segments of your workforce. Pay special attention to the role public exchanges might play in covering pre-65 retirees, part-timers who work 30 or more hours a week, and lower-paid employees who might be eligible for subsidies. Watch the actions of competitors and leading companies in other industries.

Rethink retiree medical

Review your retiree medical in the context of your total rewards philosophy, and reconsider your role in providing this benefit. Even with employer contributions, the cost of retiree medical is becoming unaffordable for many workers, especially those not yet eligible for Medicare. Consider the benefits to both you and your employees of the public exchanges opening in 2014, which offer guaranteed coverage at likely lower costs. With the improvements in Medicare (especially drug coverage), take the opportunity to review your Medicare supplement plans. Finally, encourage active employees to invest in tax-advantaged medical savings accounts (HSAs and HRAs) that can be used in retirement.

Consider a total-replacement ABHP — and recognize that not all ABHPs are created equal

ABHPs can be very effective in helping to control both employee and employer costs, but long-term success is dependent on a comprehensive approach that emphasizes employee and provider accountability, cultivation of smarter health care consumers and taking advantage of the rapidly changing provider marketplace. Align your ABHP strategy with your health management strategy, and consider incentives and penalties to encourage the right employee behaviors. Encourage employee enrollment in your ABHP by tying your contributions to their HSAs and HRAs. Stress the tax and retirement savings advantages of those accounts in employee communications. Rethink subsidies for dependents. Finally, consider making an ABHP your only plan, and offer low premiums, reasonable deductibles and attractive contribution strategies. Remember, significant employee enrollment is key to the success of an ABHP. And don't forget spouses: Extend your incentives and communications to them as well.

"Remember, significant employee enrollment is key to the success of an ABHP. And don't forget spouses: Extend your incentives and communications to them as well."

Influence engagement through employee education and communication

To overcome poor employee health habits — one of the biggest challenges to maintaining affordable benefit coverage — develop a culture of health. In addition to working with vendors to improve employee health through better information on health outcomes and cost, consider social media and incentives to drive change. Use behavioral techniques such as online discussion groups and games, team-based and individual competitions, online and in-person classes, and other strategies that encourage healthy behaviors.

Consider biometric and achievement standards initiatives

Go beyond providing incentives for participating in biometric screening. Provide meaningful rewards for employees who meet health improvement goals such as losing weight or quitting smoking. Consider following the lead of companies that charge penalties to smokers who do not enroll in smoking-cessation programs. Involve spouses as allies in reward programs.

Emphasize accountability and vendor partnerships

Leverage the PPACA's reform provisions (value-based purchasing, ACOs, bundled payments and medical homes — all targeted at improving quality and efficiency) to lower your costs. Implement performance-based contracts with vendors and set specific performance targets. Differentiate cost sharing for use of high-performance vendor networks, and offer incentives and penalties to providers to improve quality, efficiency and health outcomes. Require vendors to share information on care outcomes and costs to guarantee your employees have access to quality information they can use to make their health care decisions.

Get in front of the specialty pharmacy trend curve now

More employers are becoming acutely aware of the impact specialty drugs have on their total health care spend and in particular, their pharmacy spend. However, a relatively small number of employers actually know how much they spend in this area. Specialty drugs are trending at an exorbitant rate

relative to traditional products, and it is estimated that employer spend in this area will double in the next three to five years. In light of this, employers should understand their total specialty pharmacy cost exposure and explore new strategies to address this fastest-growing area of pharmacy, including utilization management, site-of-care optimization, specialty pharmacy networks and formulary management.

Take advantage of new care delivery models and treatment settings

Follow the progress of companies that are experimenting with lower-cost alternatives to doctor visits and high-cost emergency rooms. Consider offering onsite health care (e.g., a clinic that provides preventive, primary or urgent care) in at least one location. Explore telemedicine (remote monitoring and real-time interactive services that leverage mobile collaboration technologies) for professional consultations. Monitor the experience of the technology industries that have been early adopters of telemedicine.

Consider your health plan in the context of total rewards

Are you using your rewards to drive employee engagement and organizational performance? If so, what role do your health benefits play? Your health care costs may be depleting resources that could be better spent elsewhere, such as on performance bonuses, base salary or any of the other components of a total rewards program. By making these trade-offs transparent to employees, you can help them understand the impact that increasing health care costs have on rewards and benefits.

Adapt the strategies of best performers

Best performers use a variety of these strategies. The key is to first understand your costs, employee demographics and overall employee health profile. Armed with that information, you can begin to understand how the PPACA will affect your current health plans and your employees. For example, how many of your employees will fall into the part-time category? Will any employees be eligible for a subsidy? Is your plan high cost? If so, how will you avoid the excise tax? Once you've identified areas to target for improvement, you can work with vendors and providers to develop a strategy that focuses first on your most pressing issues. Build in metrics so you can track the progress of your initiatives.

About the National Business Group on Health

The National Business Group on Health is the nation's only nonprofit membership organization of large employers devoted exclusively to finding innovative and forward-thinking solutions to their most important health care and related benefits issues. The Business Group identifies and shares best practices in health benefits, disability, health and productivity, related paid time off and work/life balance issues. NBGH members provide health coverage for more than 50 million U.S. workers, retirees and their families. For more information about the NBGH, visit www.businessgrouphealth.org.

About Towers Watson

Towers Watson is a leading global professional services company that helps organizations improve performance through effective people, risk and financial management. With 14,000 associates around the world, we offer solutions in the areas of employee benefits, talent management, rewards, and risk and capital management.

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Health, Equity, and the Bottom Line

Workplace Wellness and California Small Businesses

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JEREMY CANTOR, MPH, AND JASON WURTZ ■ PREVENTION INSTITUTE

About the Greenlining Institute

The Greenlining Institute is a national policy, research, organizing, and leadership institute working for racial and economic justice. We ensure that grassroots leaders are participating in major policy debates by building diverse coalitions that work together to advance solutions to our nation's most pressing problems. Greenlining builds public awareness of issues facing communities of color, increases civic participation, and advocates for public and private policies that create opportunities for people and families to make the American Dream a reality.

About Prevention Institute

Prevention Institute is a non-profit, national center dedicated to improving community health and wellbeing by building momentum for effective primary prevention. Primary prevention means taking action to build resilience and to prevent problems before they occur. The Institute's work is characterized by a strong commitment to community participation and promotion of equitable health outcomes among all social and economic groups. Since its founding in 1997, the organization has focused on injury and violence prevention, traffic safety, health disparities, nutrition and physical activity, and youth development. This, and other Prevention Institute documents, are available at no cost on our website.

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PARTNERSHIP

The Greenlining Institute and Prevention Institute partnered on this project because of a shared interest in promoting prevention and health equity and a common understanding that workplace wellness programs, if implemented correctly, can greatly contribute to improved health. Our collaboration creates a unique perspective that we hope will inform the implementation of workplace wellness programs in California and the rest of the nation. We wish to express our gratitude to everyone who contributed to this brief particularly the owners and directors of small business and non-profits who spent valuable time to provide us their insight and pragmatic perspective on these issues.

The Greenlining Institute would like to thank **The California Endowment** and **The California Wellness Foundation** for their generous support. Prevention Institute would like to thank **The California Endowment** for the support that made this project possible.

INTRODUCTION

Preventable chronic disease is a significant drain on California's economy, resulting in $22 billion a year in medical costs and lost productivity.[1] These costs have an impact on the public sector and businesses of all sizes. Additionally, there are typically over 400 preventable deaths and over 400,000 preventable injuries annually in workplaces across the state.[2,3] The workplace is an appealing venue for prevention because most people spend a significant portion of their lives at work and changes to the social and physical workplace environment can be made quickly. Workplace wellness programs (WWPs) have captured the attention of business and health leaders, policy makers, and insurance companies as a potential strategy to prevent chronic disease and contain health care costs.

The passage of the Affordable Care Act (ACA) has heightened the emphasis on prevention in the workplace by including provisions specifically encouraging implementation of WWPs. Research suggests that WWPs can improve the health of employees and yield a significant return on investment for employers. However, the research and evidence-based practice is far from complete. Significant questions remain about the relative effectiveness of the range of workplace wellness approaches in different work environments and among diverse employee populations.

Over the next couple of years, California policymakers, employers, business and labor groups, and health leaders are going to be considering and implementing approaches to workplace wellness. The impact of those approaches will depend upon how solutions are designed and applied throughout the population. "One-size fits all" solutions will inevitably work more effectively for certain groups of people, while leaving others behind. In this brief, **The Greenlining Institute** and **Prevention Institute** lay out key questions to consider about workplace wellness for California's small business and diverse workforce. We did a review of the academic and policy literature and conducted a series of 10 interviews with high-level staff of small businesses and non-profit organizations owned or operated by people of color. We focused our attention on these businesses both because of the ethnic diversity of California's workforce and in order to understand the implications on the businesses and employees who may be most sensitive to the economic and health implications of workplace wellness programs. The recommendations herein reflect a desire to see equitable, non-punitive, and functional programs that benefit all California workplaces.

Under Section 10408 of the ACA, the federal government has appropriated $200 million of grant money in order to help businesses with 100 or fewer employees to develop workplace wellness programs.[4] The ACA also includes a provision that allows an employer to decrease an employee's premium contribution by up to 30 percent (federal officials could agree to raise this to 50 percent) of the total cost of coverage if the employee chooses to participate in a workplace wellness program and the employee meets specified health benchmarks established by the health plan and/or employer.[5] The ACA further states that employers must offer an alternative standard for an individual for whom it is unreasonably difficult or inadvisable to participate in the wellness program[6], however, clarification for what "unreasonably difficult" might mean is not offered.

BACKGROUND

California's Small Business Landscape

California is a state with incredible diversity; approximately 60 percent of the population is a race other than white.[7] In addition to the array of ethnic and racial groups, California's business landscape varies from huge corporations like Google to more modest mom and pop shops in local communities. Our policymakers should strive to develop equitable, non-punitive, and functional plans for small businesses.

- Nearly **four million** Californians are employed by a firm with **fewer than 50 employees.**[8]
- **One million** Californians are employed by a **small business owned by a person of color.**[9]
- Owners of color tend to **hire more people of color.**[10]
- Most small employers believe that employee health is important to the bottom line yet only 22% offer WWPs to employees.[11]
- Ethnic small businesses are more concentrated in "blue collar" industries.[12]

PROCEDURES AND METHODS

The Greenlining Institute and Prevention Institute conducted an extensive review of the peer-reviewed literature, gray literature, and publicly available employment data to develop the findings and recommendations that follow. Additionally, we interviewed ten small business and non-profit organization owners and executive directors of color from Northern and Southern California as key informants on the realities of workplace wellness. Interviewees represented a diverse grouping of informants: 2 Female, 8 Male; 6 For-Profit, 4 Non-Profit; and 2 Asian, 2 Black, and 6 Latino.

Interviews were analyzed independently by readers from Prevention Institute and The Greenlining Institute who categorized key themes and trends from each interview and identified congruent findings. The interviews do not reflect a representative sample but they do inform the research findings and provide the perspective of diverse small business owners on WWPs and their needs and barriers when it comes to implementation of such programs.

Definitions

For our research purposes we defined small businesses with owners of color as: (1) businesses or non-profits that (2) had owners or executive directors of color and (3) employed between zero and fifty employees. Additionally, workplace wellness programs were defined as a set of practices, policies, and/or programs that businesses can implement to improve their employee's health.

FINDINGS

Workplace wellness programs have the potential to reach some 16.5 million Californian workers.[13] Employers stand to benefit from reduced health care payments, less employee absenteeism, and greater worker productivity. Research has documented the health benefits and cost-effectiveness of well-designed, comprehensive workplace wellness programs. Estimated benefits range from $3 to $6 for every $1 invested in WWPs.[14,15] A recent study by the Urban Institute indicated that well-designed initiatives could save the California Public Employee Retirement System (CalPERS) as much as $54 million annually.[16] However, the majority of current research on workplace wellness programs focuses on large white collar settings. Looking at the evidence through the lens of small businesses, particularly those with diverse leadership and employees and those in blue collar and service industries, a number of key themes emerge, including:

Strategies that involve punitive measures or incentives should be avoided:

The majority of corporations have incorporated wellness plans that make use of incentives and/or penalties.[17] These incentives or penalties are usually financial, often increasing or decreasing the employee contribution to health premiums, and are tied to a range of benchmarks from health status (e.g., blood pressure) to health behavior (e.g., use of tobacco) to participating in a specific wellness activity (e.g., screening for risk, health education class, etc.). The difference between penalties and incentives is largely semantic; the result either way is one group of employees end up with a financial advantage based on achieving a health benchmark. Given allowances in the ACA for using incentives and penalties as part of workplace wellness programs, implementation is likely to go up among employers in businesses of all sizes. However, punitive measures and incentives are problematic for a number of reasons:

Employers interviewed reported two distinct approaches to promoting employee health: through specific benefits offered to employees (e.g. gym memberships, nutrition classes) and through the workplace environment (e.g. providing healthy snacks, ergonomic-related activities, organize lunchtime walks). **However, these approaches were not incorporated as part of a formal, comprehensive plan or policy.**

- The evidence does not demonstrate effectiveness: There is some evidence that punishments/rewards increase participation in wellness programs, but it is unclear that any improvements in health are achieved.[18] Punitive measures are specifically identified as being unproductive, in part because penalizing employees for not participating in programs or not achieving certain health outcomes is likely to instill resentment.[19] This should be of particular concern among small businesses where employees and management often work more closely together. A few corporations have received significant attention for claiming to have lowered health care costs through the use of incentives, but those claims have been roundly questioned and in some cases evidence to the contrary has been presented.[20,21]

- The result can be less affordable care: When incentives impact health care premiums, the ability of employees to purchase coverage for themselves and their families can be affected. There are significant fairness and equity considerations of creating tiers of employees based on health benchmarks (discussed below), and as Families

USA put it in their analysis of these measures, "The bottom line is that these programs can have the same effect as an insurer charging a person more for coverage based on pre-existing conditions—a practice that the Affordable Care Act is designed to end entirely by 2014."[22] The impacts of shifting costs to less healthy employees are likely to be even more significant in small businesses where employers and employees already pay more for coverage.[23]

- Lower-income employees and people of color will be unfairly impacted: People of color and low-income individuals are more likely to suffer from chronic health problems, to lack resources to improve their health, and to receive poorer quality health care and are, thus, disproportionally penalized by incentive plans that tie premium amounts to their health.[24] Additionally, in cases where incentives are tied to health status benchmarks, those benchmarks are often arbitrary and inadequate proxies for health. For example, in some incentive programs, employees with a Body Mass Index (BMI) of 30 or above are penalized. Not only is BMI alone not a good indicator of overall health, but the difference between 29 and 30 is less than the difference between 26 and 29. The result is not insubstantial: according to the Washington Post, "American families with average health benefits could have $6,688 a year riding on blood tests and weigh-ins."[25] Certain employees will be more able to achieve incentives based on factors such as their access to places to be physically active (e.g., clean safe parks, fitness facilities, walkable streets) and access to affordable, healthy food.[26]

Targeting workers with the poorest health outcomes can produce the biggest health gains:

People of color and low-wage workers experience higher rates of chronic disease, but are the least likely to have access to effective WWPs.[27,28] Even when they do have access, these groups are less likely to participate because of concerns about discrimination, perceived or actual cost of participation, lack of cultural relevance and incompatible work schedules (particularly low-wage workers working multiple jobs to make ends meet).[29] Policy solutions will need to provide clear guidance on how to develop culturally relevant WWP recruiting and delivery strategies that align with worker priorities, beliefs, values, perceptions, practices and availability to maximize participation by low-wage workers and workers of color.

In general, interviewees expressed an interest in implementing a workplace wellness program in their business/non-profit. However, all of the small businesses and non-profits reported that **cost would be a major consideration in whether or not they would implement a workplace wellness program.**

Comprehensive approaches that focus simultaneously on individuals and their environment have the greatest impact:

> "[Workplace wellness programs] must promote a healthy work environment and address individual health & well-being."
>
> – Director, non-profit housing development agency

The evidence points toward the efficacy of more intensive and multifaceted strategies.[30] The most effective programs include individualized risk-reduction assessment, health awareness programs, and a "healthy company" culture.[31] However, though 90% of workplaces report engaging in some sort of wellness "activity," less than 7% provide multiple elements of a comprehensive approach.[32] **Even though well-designed, comprehensive WWPs are cost-effective, they are rarely implemented, especially at smaller worksites.**[33] A review of common approaches reveals six primary elements of worksite wellness initiatives (that can be implemented in coordination):

- **Work environment** policies or practices that support a "healthy workplace," such as banning smoking near state office buildings, encouraging use of stairs, and establishing food guidelines (cafeterias, vending machines, etc).[34]
- **Programs and events,** such as fitness challenges, bike to work days, and walking clubs.
- **Assessment and monitoring,** identifying key risk factors and establishing individual goals and benchmarks.
- **Counseling and information,** connecting employees to on-site and off-site support and providing individual and whole-staff education.
- **Community environments:** in situations where employees (and potentially, retirees) make up a significant portion of the population of a community, strategies targeting positive changes to the community environment make sense and can be aligned to support changes within the workplace.

CASE STUDY

San Francisco Housing Development Corporation (SFHDC)

SFHDC is a small non-profit organization focused on reversing gentrification in communities of color. SFHDC believes employee health and well-being is critical to its mission and has cultivated a healthy work environment to enable staff to make healthful choices by default. For example, SFHDC provides fruits and vegetables during staff meetings and encourages lunch-time walking activities. In addition, the agency attends to individual employee health needs by occasionally offering onsite massages and acupuncture and providing affordable health care. SFHDC also recognizes that the surrounding community – where many of its employees live – plays a crucial role in shaping the health and well-being of its staff. In addition to its many housing projects, the agency has also developed a local grocery store, an organic restaurant that sources its produce from a community garden across the street (also developed by the agency) and has encouraged corner stores to carry more fruits and vegetables.

Employees and management should collaborate on the development and implementation of the program and equitably share fiscal benefits:

WWPs are more likely to be successful when they are developed collectively and not imposed as a top-down directive. Employees should understand program objectives, have a voice in selecting program elements, and have a clear mechanism for sharing in the potential benefits.[35,36,37] This also ensures that the program developed is culturally relevant for the specific employees who will participate. During interviews, employers expressed that they want to engage employees about health and wellness, but approached the topic with caution because they do not want to appear as telling their employees what to do. Working collaboratively helps address this concern.

> "I would consider [a workplace wellness program] if it was designed for small businesses. It should be flexible enough that the number of participants doesn't determine success. A lot of programs are geared for big offices."
>
> – Owner, temporary employment agency

Identify a range of workplace wellness activities.

Public, non-profit, and private sector employers and employees should be given guidance on effective workplace wellness practices but also given options in order to develop approaches that are most appropriate for the given circumstances.[38] In particular, there is a robust history and demonstrated effectiveness of occupational health and safety practices (which are more applicable to blue collar and service workplaces with acute physical dangers), and those elements should be incorporated into workplace wellness programs. It doesn't make sense, for example, to prioritize and implement strategies to address chronic disease if employees are missing work due to back injuries.

RECOMMENDATIONS

Based on our review of the literature, practice examples, existing policy and interviews with high-level staff of small businesses and non-profit organizations owned or operated by people of color, we see a number of factors and approaches that are critical for consideration as state officials and others consider how to legislate workplace wellness. These issues require additional research and discussion to increase understanding of challenges and potential solutions.

1. Policy:

- Encourage comprehensive approaches that include an emphasis on creating healthy and safe workplace environments.
- Identify ways to seamlessly incorporate workplace wellness policies into existing incentive and regulatory structures.
- Facilitate small business participation by minimizing paperwork and red tape and designating a state-level office to provide design, implementation and evaluation support.
- Eliminate the use of health outcome benchmarks in order for an individual employee to receive an incentive for participating in a WWP.

2. Research:

- Establish a work group among state health officials, business and employee stakeholders, and public health advocates, to review existing literature and develop recommendations on implementing WWPs in small-business settings, including:

  - ❑ Conducting a survey with a representative sample of small business owners of color to determine best practices, needs and interest in implementing WWPs;
  - ❑ Tailoring programs for "blue collar" settings;
  - ❑ Best practices for implementing WWP within diverse communities; and
  - ❑ Best practices for using non-punitive incentives to encourage participation in a WWP.

- Review health data from small-business employees to identify patterns of illness and injury based on workplace characteristics, demographic data, etc., and to identify potential high-impact opportunities to improve employee health.

3. Education & Outreach:

- Create materials designed specifically for employers and employees in small businesses that are culturally and linguistically appropriate and include: clear rationale for implementing workplace wellness, advice about best practices, and contact information for potential resources and supports.

- Enlist business associations and labor unions in providing support for small businesses, including conducting outreach and education, technical assistance in implementing a WWP, and evaluating the effectiveness of programs, which should include incorporating employee feedback and suggestions on what does and does not work in a WWP.

> "I'd like to get a [workplace wellness] plan tailored to businesses like mine through an association like the Hispanic Chamber of Commerce."
>
> – Owner, public relations firm

- Create a venue(s) for discussing ways that small business can work together with large businesses to address factors in the community environment that are negatively affecting the health of employees (e.g., access to healthy food, safe routes to work).

CONCLUSION

We are cautiously optimistic about the potential of workplace-wellness programs to help contain healthcare costs and to improve the health and well-being of millions of California's workers. Preventing illness and injury through workplace-based strategies potentially benefits employees and their families, employers, and public and private insurance providers. There is emerging evidence about the effectiveness of WWPs in improving chronic disease outcomes, and a long history of occupational health and safety practices reducing workplace injury and death. Incentives in the ACA have the potential to serve as a catalyst for expanding WWP's broadly in California. However, policy solutions need to respond to potential unintended consequences and account for the state's incredibly diverse communities and businesses in order to make wellness programs work for all Californians.

If policies and programs are developed and implemented carelessly, workplace wellness programs could be ineffective or potentially detrimental to employees, and/or exacerbate health inequities. Therefore, a critical need exists to have a robust dialogue that engages a range of stakeholders—including employers, employees, public health advocates, and health experts—to develop a strategic and comprehensive approach to workplace wellness in small businesses, especially those who employ and are operated by people of color.

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